

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

Briefing paper

Summary

The Scottish Human Rights Commission (SHRC) is concerned that protections for the human rights of people in Scotland's mental healthcare settings are insufficient. SHRC is concerned that they do not adequately protect people from inhuman and degrading treatment and, in some cases, threats to life. Further, we are not satisfied that there is sufficient data nor safeguarding infrastructure to assure us that this is not the case.

The rights at stake are fundamental. They include the right to life and the right to be free from inhuman and degrading treatment. People in mental health inpatient settings are often in a particularly vulnerable position because they are under the control of the State. Safeguards and oversight should reflect the seriousness of these risks.

Restrictive practices can be harmful. Although they may, in some circumstances, be permissible under European human rights law, improperly used, they can violate a person's human rights. While the use of force is involved in compulsory treatment, it should be an exceptional measure. People should only be restrained as a measure of last resort to prevent imminent harm to themselves or others, and restraints should always be used for the shortest possible time. Means of restraint should never be used as punishment, for the convenience of staff, because of staff shortages, or to replace proper care or treatment.

Legislative protections in adult mental healthcare in Scotland are lacking. While some welcome steps are being taken to monitor and improve practice, the SHRC is concerned that Scotland lacks sufficient safeguards to both prevent and remedy excessive use of restrictive practices across the mental health estate.

The SHRC is concerned about what may remain hidden. Where restrictive practices are not subject to strong regulation and oversight, people must have effective ways to raise concerns, seek redress and hold services to account. Mandatory reviews,

independent oversight and clear time limits for review of restrictive practice are steps that Scotland has yet to take, and which could make a real difference.

Other jurisdictions such as England have implemented stronger safeguards and scrutiny. While human rights law does not set the specific safeguards required in all instances, these examples demonstrate more robust ways to ensure human rights compliance. They have demonstrated good practice is possible - and that Scotland is falling behind.

Safeguard	Scotland	England and Wales
Independent review of practice	No	Yes
Independent Care and Treatment Reviews	No	Yes
Enforcement powers	No	Yes
Accountability and transparency laws	No	Yes
Detailed statutory guidance	Under consultation	Yes

The SHRC believes Scots law must seek to achieve greater alignment with relevant human rights obligations and good practice standards which are already applicable in comparable jurisdictions. We therefore recommend that the Scottish Government must:

1. Identify the true scope and scale of the use of restrictive practices, for example, by carrying out an investigation.
2. Ensure legislation provides specific safeguards for restrictive practices including restraint and seclusion, including timeframes for mandatory review and independent review processes.
3. Ensure that the Mental Welfare Commission has robust, adequately funded enforcement powers.

The SHRC will monitor progress against these recommendations alongside other developments on safeguards for restrictive practices. If necessary, we will explore all

options within our powers to take further action to ensure that the rights of people in Scotland's mental health settings are not being violated.

About this briefing paper

The Scottish Human Rights Commission (SHRC) is Scotland's National Human Rights Institution responsible for promoting awareness, understanding and respect for all human rights – economic, social, cultural, civil and political – to everyone, everywhere in Scotland, and for encouraging best practice in relation to human rights.

This briefing paper examines the human rights issues arising from the use of restrictive practices in adult mental healthcare. It outlines the SHRC's preliminary exploration, including the evidence we do have about these practices and what evidence is either not publicly available or not held. It compares this evidence with the standards required by human rights treaties. It outlines our concerns with the gap between those standards and the situation in Scotland and recommends that the Scottish Government act with urgency.

Also included with this paper is a detailed assessment of the relevant elements of the human rights framework and case examples.

The SHRC's work in this area sits within a wider context of a need for reform of mental health laws to ensure that detention is avoided wherever possible. The SHRC is also concerned with where these issues intersect with barriers in access to justice and the impact of the lack of progress on social care reform which may lead to people being hospitalised who need not be, and staying there, where they may experience restrictive interventions.

Introduction

The SHRC is concerned that Scotland does not have strong enough safeguards to prevent, monitor and remedy excessive uses of restrictive practices in the mental health estate where they occur. This would breach Article 3 rights under the ECHR. Due to a lack of evidence and safeguarding infrastructure to demonstrate otherwise, SHRC is concerned that there may be serious human rights violations hidden in plain sight.

The SHRC's work on the institutionalisation of people with learning disabilities and autistic people, published in 'Tick Tock' in January 2025, found that Scotland risks violating the human rights of these groups by allowing people to remain detained for long periods.¹

During this work, people with learning disabilities, autistic people, family members, civil society organisations and mental health professionals described to us restrictive practices used in inpatient settings. These included restraint, long-term seclusion, limits on contact with family members and restrictions on everyday decisions such as diet and dress.

Restrictive practices in detention settings have a serious impact on the human rights of people who experience them. If staff misuse them or use them unnecessarily, they can amount to inhuman and degrading treatment. In the most serious cases, they have been linked to deaths. This has been more frequently publicly reported in criminal justice settings, and the tragic case of Allan Marshall showed the risk to life that restraint can pose when it is not used safely.² Although this happened in a prison setting, it highlights the need to ensure that all restraint is lawful, proportionate and consistent with human rights standards, wherever it takes place.

Restrictive practice may be used in education, social care, health, and criminal justice environments. There is a patchwork of guidance and regulators across all of these sectors. The focus of this briefing is on mental health settings.

People in inpatient mental health settings are often detained and under the control of the State. Human rights law therefore requires strong safeguards. Staff should only use practices such as restraint or seclusion as a last resort to prevent an immediate risk of harm. They should use them for the shortest possible time. Staff must never use restrictive practices as punishment, for convenience, because of staff shortages or as a substitute for proper care and treatment.

The European Convention on Human Rights (ECHR) and international human rights treaties require public bodies to monitor restrictive practices and take proactive steps to reduce and ultimately eliminate them.

Recent events have raised concerns about whether existing safeguards are sufficient. In 2025, the BBC documentary 'Kids on the Psychiatric Ward' reported concerns about excessive restrictive practices and allegations of abuse in children's and adolescent's inpatient services. Follow-up scrutiny by the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland found concerns about how some services used restraint, and about the quality of recording and follow-up processes in some units.³

Elsewhere in the UK, investigations have uncovered serious human rights concerns linked to restrictive practices. These include allegations of abuse and neglect in a private mental health hospital in England⁴, inquiries into an NHS trust where three young women died by suicide while receiving inpatient care⁵, and the inquiry into the

abuse of people with learning disabilities and autistic people at Muckamore Abbey Hospital in Northern Ireland.⁶

Scotland has taken some positive steps:

- The Scottish Parliament recently passed the Restraint and Seclusion in Schools (Scotland) Act 2026 which addresses restrictive practice in education settings.
- Following concerns about Skye House, the Mental Welfare Commission, Healthcare Improvement Scotland and the Children and Young People's Commissioner Scotland have strengthened scrutiny of child and adolescent mental health services (CAMHS).
- The Scottish Government has also committed to updating the Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice to include guidance on restraint and seclusion for children, young people and adults in inpatient mental health settings.
- It has also committed to a new role for the Mental Welfare Commission in national monitoring and reporting on the use of restraint and seclusion.

The SHRC's current focus is on adult mental health inpatient care. This is because other organisations such as the Children and Young People's Commissioner for Scotland (CYPCS) are already focusing on restrictive practice on children and young people.

Oversight and resourcing to avoid restrictive practices in social care settings may be an area which merits further investigation but is, for now, out with the scope of this paper.

There is an absence of publicly available data or clear efforts to establish the present situation. The SHRC is concerned that Scotland does not have a clear picture of how often restrictive practices are used in adult inpatient settings or how people experience them. Without reliable information, it is difficult to assess whether safeguards are working or whether people's rights are being violated. Many of the most serious concerns identified elsewhere in the UK came to light only after family campaigns or media investigations.

The Scottish Government and duty bearers must not be complacent. The right to life and the right to be free from inhuman and degrading treatment are fundamental human rights. Public bodies must take proactive steps to understand peoples'

experiences, identify risks and provide assurance that services respect human rights.

The SHRC will continue to monitor developments and consider all options within its powers to strengthen safeguards and accountability for restrictive practices in mental health inpatient care.

What do restrictive practices look like in mental healthcare?

In a mental healthcare context, restrictive practices are practices which take place in mental health settings, and which restrict a person's liberty or freedoms. The most serious forms of restrictive practice include the use of force, such as restraint and seclusion. However, there are a range of restrictions which may be applied in mental health detention including:

- Chemical restraint i.e. the use of medication to control behaviour rather than to treat illness;
- Denying people access to visitors, family and friends;
- Restrictions on diet and dress;
- Limits/bans on access to the outside world, both physically and via communication tools.

Some forms of physical restraint, particularly face-down (prone) restraint, can dangerously compress the chest or obstruct the airways. This can create a serious risk to life.⁷

"I do not remember all incidents of restraint and forced injection. I recall some clearly. Others I have no memory of, as I dissociated at the time and was later told about them by my consultant. On one occasion, my consultant told me I had been held down in a wheelchair and the marks on my arms and bruising, consistent with being forcibly held down, were recorded in my notes — something I have no memory of.

For the incidents I do remember, I recall the sheer terror of being held down by several staff, completely overpowered, my body treated as something to be controlled rather than a person to be heard, understood, and met with compassion. On one occasion, this happened because I refused to come in from an enclosed garden — I was forced to the ground. On another, I was pinned face down on a bed by male nurses, my arms forced behind my back. The fear that my clothes might be removed in order to inject me was overwhelming — degrading, exposing, and deeply violating.

On another occasion, after self-harming and in acute distress, I was locked alone in a padded room and left to "calm down". I was not free to leave. There was nothing calming about it. It was isolating, frightening, and intensified my distress at a time when I needed care, connection, and safety.

There were times when I was so overwhelmed I curled up in a corner in fear — just as I did as a child, retreating into myself and dissociating while parts of me endured abuse. Instead of being met with empathy and understanding, I was told that if I did not get up, I would be denied access to my bed space for the rest of the day, in what felt like punishment for a trauma response I had no control over."

Person with lived experience

What people told us

In December 2025, the SHRC brought together mental health professionals, civil society organisations and people with lived experience to discuss restrictive practices in mental health settings. Participants highlighted a range of concerns and priorities. Despite different perspectives they identified several common themes:

- Recognising restrictive practices when they happen: professionals and people with lived experience agreed that restrictive practices are not well recognised or understood. This means that individuals sometimes think treatments such as restraint are normal or to be expected. Similarly, staff are not always clear on whether their actions amount to restrictive practices. This means they are not always aware that they are taking actions which must be carried out carefully in compliance with human rights standards, such as use as a last resort.
- Lack of definitions: part of this challenge stems from the fact that there is no clear definition of the types of treatment that are restrictive. This contributes to the difficulty in recognising restrictive practices. This lack of clarity plays out in a range of ways. For example, people do not always know what amounts to seclusion in a hospital environment, or whether it is appropriate to use medication to control a patient's behaviour rather than to treat a medical condition.
- The impact of restrictive practices: many participants raised that restrictive practices have a significant detrimental effect on people who experience them and on staff carrying them out. This impact extends beyond the event and is rarely recognised. Even where a restrictive practice is accepted as necessary, the way it is carried out can make a huge difference to the experience of both the patient and the staff.

"When we were discussing restraint and seclusion recently at a meeting, I became very tearful. I feel if I had received proper help from staff at that time, instead of being forcibly restrained, I would have been able to process where my trauma was coming from and it would not have been a stumbling block throughout my adult life. It is forty-two years since, as a child, I had that experience of being restrained and I am still traumatised and weeping at the thought."

Person with lived experience

- Lack of alternatives: participants identified that restrictive practices are often a fallback. They are used when there are no clear alternatives, or where people feel unable to propose other solutions. Restrictive practices become the only resort instead of the last resort.
- Fear of reprisals: participants explained that people who experience restrictive practices, those who advocate for those people, and staff who identify poor practice all fear that if they raise challenge, they will face reprisals. Whether real or perceived, this fear prevents restrictive practices from being brought to light and remedied.

"I have spoken on radio and TV on these subjects. There were immediately defensive reports put out by a Health Board. From my observations of the Health Board's response to other parents raising these issues, great hostility follows towards them. Families can be fearful of making the situation worse for their loved ones."

Parent

- Lack of accountability: neither professionals nor people with lived experience felt confident that there was accountability, or remedies when restrictive practices were used improperly. In particular, people who had challenged restrictive practices for themselves or family members felt that systems for complaints or redress were inaccessible and did not lead to a resolution.
- Resources: participants identified that the physical environment, staffing capacity and culture of inpatient environments have a significant impact on the extent to which restrictive practices are used. Environments where there is a high degree of temporary staffing are associated with a higher risk of inappropriate use of restrictive practices.
- The range of 'less seen' restrictive practices: while restraint and seclusion are broadly recognised as restrictive, there are a range of practices that take place, especially outside psychiatric inpatient settings, which are also restrictive. These can have a significant impact on people's autonomy. These include restrictions on older people in general hospital settings, constant monitoring of day-to-day activity, and limits on using funds.

Human rights at stake

The European Convention on Human Rights

While the use of force is involved in compulsory treatment, it should be an exceptional measure. People should only be restrained as a measure of last resort to prevent imminent harm to themselves, or others and restraints should always be used for the shortest possible time. Means of restraint should never be used as punishment, for the convenience of staff, because of staff shortages or to replace proper care or treatment.

People who are subject to restrictions, restraint or seclusion while in mental health care are protected under Article 2 and 3 of the European Convention on Human Rights (ECHR). These are absolute rights. Interference with absolute rights is never permissible, even to protect the person or others and irrespective of the patient's behaviour. Caselaw from the European Court of Human Rights provides both universal principles to be applied and specific examples of where safeguards have been found lacking.

Prohibition of torture, inhuman or degrading treatment under Article 3

Article 3 ECHR prohibits torture and inhuman or degrading treatment. This right protects people from very serious harm, so a 'minimum threshold of severity' needs to be reached for Article 3 to apply.⁸

The treatment of people detained for mental healthcare can meet the minimum threshold and amount to inhuman and degrading treatment. The State's obligations to prevent violations of Article 3 include providing adequate treatment through a 'comprehensive therapeutic strategy'⁹ and ensuring there is no use of forced restraints or restrictions unless absolutely therapeutically necessary.

The right to private and family life under Article 8 ECHR

Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for Article 3 may still breach a patient's Article 8 rights if it has a sufficiently adverse effect on the person's private life, including their moral and physical integrity.

The right to life under Article 2 ECHR

Under this Article, the State has an obligation to take reasonable measures to protect the patient's life if the State is aware, or ought to be aware, of the imminent

risk to the patient's life.¹⁰ The States' obligations may include a duty to make adequate provision for securing high professional standards among health professionals and ensuring hospitals adopt appropriate measures for the protection of patients' lives, especially considering the vulnerability of people experiencing mental ill health.

Procedural obligations under Articles 3 and 2 ECHR

States have an obligation to investigate allegations of torture, inhuman or degrading treatment and threats to life as soon as an arguable complaint of these are made or if there are otherwise sufficiently clear indications of a possible breach of Article 2 and 3.

To comply with the obligations under the ECHR, investigations must be 'effective' - adequate¹¹ independent¹², prompt and open to public scrutiny¹³ and victim participation.¹⁴

Non-discrimination

All people must benefit from their rights without discrimination, including rights under Articles 2 and 3.

A failure to properly investigate allegations of ill-treatment because the person making the allegation has intellectual disabilities will violate Article 14 taken with Article 3. Every person, regardless of their mental capacity, is entitled to the same robust investigative process.

UN Convention on the Rights of Persons with Disabilities (CRPD)

The UN Convention on the Rights of Persons with Disabilities (CRPD) aims to ensure that disabled people are treated on an equal basis with others. The issue of restrictive practices particularly affects disabled people as those receiving adult mental healthcare are receiving treatment for their disability, often against their wishes. CRPD sets the highest standards, requiring the elimination of coercive practices including mental health detention.¹⁵

CRPD protects a number of relevant rights:

- Article 12: provides that disabled people must be treated equally before the law. They have the right to legal capacity and to be supported to make decisions, rather than those decisions being made on their behalf by others. This requires that medical treatment be based on the rights, will and preference of the individual.
- Articles 14 and 25: the right to liberty and security and the right to health require that disabled people must be able to give free and informed consent to any treatment, which would not allow for forced treatment to be imposed.
- Articles 15, 16 and 17: these articles protect physical and mental integrity and freedom from torture, violence, exploitation and abuse. Forced treatment is considered to violate these rights. The Committee highlights the "deep pain and trauma"¹⁶ resulting from forced treatment.

The Committee on the Rights of Persons with Disabilities (the CRPD Committee), which monitors the implementation of the CRPD, issues concluding observations about countries' compliance with the treaty's obligations. These help authoritatively articulate the obligations states have under the CRPD and shortcomings in current national practice.

The Committee has expressed concern about the continued use of physical, mechanical and chemical restraint on disabled people in healthcare and other settings, as well as practices of segregation and seclusion. The Committee was also concerned about the absence of a unified strategy to review these practices.¹⁷

- In its review of evidence from the UK, including Scotland, it recommended that across its constituent 'regions', the UK should adopt appropriate measures to eradicate the use of restraint for reasons related to disability within all settings;
- set up strategies, in collaboration with monitoring authorities and national human rights institutions, to identify and prevent the use of restraint for children and young persons with disabilities.¹⁸

The Committee has also expressed concerns at the results of the on-going staffing crisis in UK social care and mental healthcare. It noted its concerns that "staffing shortages have been linked to the increasing use of physical restraint and unsafe practices on mental health wards".¹⁹

Other international standards

UN bodies including the Committee Against Torture and the Committee on the Rights of the Child, and the European Committee for the Prevention of Torture (CPT) have made repeated recommendations to address restraint in particular, none of which have been addressed in Scotland.²⁰ These require:

- Abolishing its use for certain purposes – to inflict pain, for reasons of disability;
- Reducing disproportionate use for certain groups e.g. ethnic minority groups;
- Collecting disaggregated data on use;
- Investigating allegations of ill-treatment; and
- Developing statutory guidance for its use (on children in particular).

Further detail on the human rights framework and case examples is set out in the Annex to this paper.

What is the law in Scotland?

The Scottish Human Rights Commission (SHRC) is concerned that Scots law does not provide clear safeguards for restraint and seclusion in mental health settings. The Mental Health (Care and Treatment) (Scotland) Act 2003 contains no specific provisions governing restraint or seclusion, and it does not regulate many other forms of restrictive practice.²¹

The Code of Practice that supports the Act contains very little guidance on restraint and does not specifically address seclusion. The Scottish Mental Health Law Review in 2022 identified this gap and recommended stronger legal safeguards. Although the Scottish Government has committed to wider reform of mental health law, it has not set a timetable for these changes.

In the short term, the Scottish Government committed, in October 2025, to updating the Code of Practice under the Mental Health (Care and Treatment) (Scotland) Act 2003. The revised guidance will cover the use of restraint and seclusion in inpatient mental health settings for children, young people and adults. It will also set minimum expectations for reporting. These changes will support a new role for the Mental Welfare Commission in national monitoring and reporting on the use of restraint and

seclusion.²² These changes do not extend to wider restrictive practices. It is not yet known when these changes will come into effect.

Other settings have stronger safeguards. In prisons, legislation sets out detailed rules on the use of restraint and segregation. These include time limits, mandatory reviews, oversight by the Governor, written reasons for decisions and opportunities for prisoners to make representations.

Schools now have stronger protections as well. The Restraint and Seclusion in Schools (Scotland) Act 2026 requires guidance on a wide range of issues, including:

- inspection of restraint and seclusion practices
- staff training
- complaints processes
- action to resolve complaints and provide remedies.

It is notable that this Act arose from a Member's Bill in the Scottish Parliament and was not legislation proposed by the Scottish Government. The SHRC is concerned that people in mental health inpatient settings do not benefit from the same level of legal protection and oversight. As the NHRI, we are clear that the Scottish Government must now act with serious intent to address this lack of protection for vulnerable rights holders.

What more can be done?

"My son's experience of the long-term harm of trauma is echoed by other families I speak with, whose sons have similarly encountered restrictive practices in NHS hospital units, third sector care placements and schools. By contrast, a parent-friend whose daughter has care arrangements that have avoided restrictive practices has no trauma, likewise, other parents whose sons have avoided them."

Parent

Everyone we have spoken to believes that good practice is achievable, given the right structures, support and resources. There are already examples of law and policy in other Scottish institutions that could inform positive change, for example in Scottish prisons where restraint and segregation must be reviewed after clear time periods. There are also progressive international examples of good practice. In Victoria, Australia, legislation requires mandatory reviews of restrictive interventions

at specific time periods along with a range of safeguards and a long-term goal to eliminate restrictive interventions within ten years.²³

As a starting point, comparisons with England offer examples of a stronger safeguards, all of which are missing in Scotland. The following table summarises these differences.

Safeguard	Scotland	England and Wales
Independent review of practice	No	Yes
Independent Care and Treatment Reviews	No	Yes
Enforcement powers	No	Yes
Accountability and transparency laws	No	Yes
Detailed statutory guidance	Under consultation	Yes

Action taken to improve legislation, policy and practice in England and Wales

- A review by the Care Quality Commission (CQC) in 2019 “Out of sight, who cares?": This report looked at the use of restraint, seclusion and segregation in care services for people with a mental health condition, a learning disability or autistic people. It disclosed significant numbers of people in seclusion and long-term segregation ranging from a few days to 13 years. It concluded that people’s human rights were at risk of being breached in too many instances.²⁴
- Independent Care and Treatment Reviews: following the CQC report, a system was established to review the situations of those in long term segregation (more than 48 hours) and any other restrictive practices they experienced, including mechanical and chemical restraint. The reviews are carried out by an independent panel made up of a person with lived experience, a medical professional, a commissioner of services and a CQC representative. Since the introduction of these reviews, numbers of those in segregation have significantly reduced.

- Enforcement powers: The CQC is the independent regulator of health and adult social care in England. It has significant enforcement powers ranging from warning notices setting out required improvements, to close supervision of the quality of care, to issuing fines and prosecuting cases where people are harmed or placed in danger of harm.²⁵

In contrast, the MWC is not established as a regulator and does not have enforcement powers.

- Seni's Law: England has introduced the [Mental Health Units \(Use of Force\) Act 2018](#) – known as 'Seni's Law' after Olaseni Lewis who died as a result of being forcibly restrained in 2010. It was introduced to clearly set out the measures that are needed to prevent the inappropriate use of force, and to ensure accountability and transparency about the use of force in mental health units. It requires:
 - the appointment of a responsible person in each unit,
 - publication of a policy on the use of force,
 - patients' rights information,
 - training in the appropriate use of force,
 - recording of use of force,
 - annual published statistics,
 - mandatory annual review of any Coroner's report relating to the death of a patient as a result of the use of force in a mental health unit by staff,
 - guidance requirements when a patient dies or suffers a serious injury in a mental health unit,
 - a requirement for use of police body cameras when attending a mental health unit.
- In NHS England, routine public data monitoring is provided via the [Restrictive Intervention Dashboard](#). It provides monthly up to date information on numbers of restrictive interventions, the duration of restrictive interventions and health inequalities. Its data covers both mental health and learning disability services and both children and young people and adults.
- Code of Practice: English mental health legislation is accompanied by a code of practice²⁶ with a chapter detailing how a range of restrictive

practices may and may not be used including definitions of these practices, defined processes for use of seclusion, timeframes, and provisions for independent and external reviews for certain practices.

- Further safeguards outlined: Even with the safeguards established in England, a final report on progress from an independent review to the UK Government has recommended that more safeguards are required to bring the appropriate urgency. They have proposed that long term segregation for children and young people under the age of 18 should be ended with immediate effect, and that its use for people with a learning disability and/or autistic people should be severely curtailed and time limited. They also outline minimum standards for long term segregation including legal compliance, minimum accommodation standards, access to social contact, outside space and activities, adjustments and provisions for people in solitary confinement, training and reviews.²⁷

Our concerns

The Scottish Human Rights Commission's (SHRC) initial review of commitments, actions and outcomes relating to restrictive practices raises concerns about the strength of existing safeguards. Current law, policy and oversight arrangements do not appear to be sufficient to prevent, identify and remedy the excessive use of restrictive practices, either at an individual level or across the system, or to ensure they adhere to human rights standards.

We have heard evidence from people with lived experience that excessive restrictive practices take place in Scotland. This reflects concerns raised by international human rights bodies. However, there is a lack of information about the extent to which restrictive practices are being used in Scotland and whether they comply with human rights standards. As a result, the SHRC and other interested parties cannot be confident that existing safeguards adequately protect human rights.

Restrictive practices are a routine feature of compulsory mental health care. Despite this, safeguards for practices such as restraint and seclusion are less detailed and less robust than those in other settings, including prisons and schools.

Proposed changes to the Code of Practice accompanying mental health legislation in Scotland may help clarify expectations and support more rights-compliant practice. The Mental Welfare Commission's new monitoring role in national monitoring and reporting on the use of restraint and seclusion should also improve understanding of how these practices are used and help identify patterns of concern, including any disproportionate impact on particular groups.

These are important steps. However, monitoring and guidance alone cannot guarantee compliance. Scotland still lacks a system of effective enforcement powers that can require action when human rights concerns are identified. Without stronger accountability mechanisms, there is a risk that excessive restrictive practices will continue without effective challenge or remedy.

"Monitoring alone cannot ensure compliance but it is a starting point."

Mental Welfare Commission for Scotland

The Scottish Human Rights Commission (SHRC) is concerned about what may remain hidden. Where restrictive practices are not subject to strong regulation and oversight, people must have effective ways to raise concerns, seek redress and hold services to account.

Too often, people who believe they have experienced poor care, or human rights violations have had to rely on media coverage and public campaigns to have their concerns heard. This places an unfair burden on individuals and families.

Scottish duty bearers have an opportunity to take a more proactive approach. They should improve understanding of the use of restrictive practices by listening to the experiences of people who have been subjected to them and by examining the impact these practices have on their lives. In the SHRC's experience, many people with lived experience are willing to contribute to this work and help improve practice.

Independent scrutiny can drive meaningful change. Experience elsewhere in the UK shows that investigations into human rights concerns can expose poor practice and lead to stronger systems of accountability and oversight. These systems help ensure that concerns are identified early, addressed effectively and reported transparently. They can also help people live with fewer restrictions and greater respect for their rights.

The rights at stake are fundamental. They include the right to life and the right to be free from inhuman and degrading treatment. People in mental health inpatient settings are often in a particularly vulnerable position because they are under the control of the State. Safeguards and oversight should reflect the seriousness of these risks.

While recent initiatives to improve practice are welcome, the SHRC believes that Scotland must go further. Stronger safeguards in law would provide greater protection, improve accountability and help prevent human rights violations.

The SHRC will continue to monitor developments and consider all options within its powers to strengthen safeguards and accountability for restrictive practices.

Recommendations

The SHRC recommends that the Scottish Government:

1. Identify the true scope and scale of the use of restrictive practices, for example, by carrying out an investigation.
2. Ensure legislation provides specific safeguards for restrictive practices including restraint and seclusion, including timeframes for mandatory review and independent review processes.
3. Ensure that the Mental Welfare Commission has robust, adequately funded enforcement powers.

By the end of 2026, SHRC would like to see timebound commitments to progressing these recommendations.

Annex: The human rights framework

The European Convention on Human Rights

Prohibition of torture, inhuman or degrading treatment under Article 3

Article 3 ECHR prohibits torture and inhuman or degrading treatment. This right protects people from very serious harm, so a 'minimum threshold of severity' needs to be reached for Article 3 to apply.

The 'minimum threshold' depends on the effect a treatment has on the individual experiencing it. How people experience things can depend on their specific vulnerabilities, including mental illness.²⁸

The treatment of people detained for mental healthcare can meet the minimum threshold and amount to inhuman and degrading treatment. The state's obligations to prevent violations of Article 3 include:

- Adequate treatment: States must provide treatment which involves a 'comprehensive therapeutic strategy' aimed at adequately treating the patient's health problems or preventing their aggravation, rather than just addressing symptoms. The Court will generally expect that the patient has a 'care plan', capable of evidencing that these requirements are being met.
- If the State fails to provide the patient with 'adequate care' for the problem(s) diagnosed, while the patient is being forcibly detained for treatment, this can violate Article 3 if it meets the 'minimum threshold'.
- Forced restraints or restrictions: Forced medical interventions such as the administration of medication, restriction or restraint can also violate Article 3 if they meet the 'minimum threshold'. This is not the case if the intervention is of therapeutic necessity according to established medical practice.²⁹ However, if, for example, the applicant has no care plan or the care plan fails to show how a measure aims to treat the patient's health, the court may determine that the measure was not medically necessary. It must always be clear that therapeutic necessity is shown, and this must be coupled with procedural safeguards capable of protecting the patient from abuse or improper treatment.

Case Study: V.I. v Moldova³⁰

The applicant was a minor who was placed in psychiatric hospital, which he opposed but his guardian permitted. His admission documents referred to his intellectual disability rather than another mental illness. While at the hospital, he was treated with neuroleptics and tranquilisers. The applicant alleged that neither the hospital admission nor the medication were therapeutically necessary.

The Court stated that an intellectual disability is in itself insufficient ground for placement in a psychiatric hospital.³¹ It highlighted evidence that the hospital placement was seemingly chosen because of the absence of other care options for the applicant. The Court found that the lack of a care plan suggested that involuntary hospitalisation was not a therapeutic necessity. In addition, medication was being used merely to control his behaviour. The effect of the medication had been to diminish his opposition, and the Government had failed to provide a therapeutic plan that could justify the medication or the hospital placement.³²

The applicant's hospital placement and the medication violated his right to be free from inhuman and degrading treatment.

The 'manner in which' an intervention is carried out can also amount to a violation of Article 3 if the manner of the intervention is not therapeutically necessary and is, therefore, excessively humiliating or degrading.³³

Case Study: Ciorap v Moldova³⁴

The applicant was force fed, after going on hunger strike. Regardless of whether force feeding was necessary, the manner in which it was done violated Article 3. He had been handcuffed, forced to open his mouth and had his tongue moved with metal tongs which was punishing and unnecessarily painful and humiliating. The Government had failed to show a different method or manner of feeding would be inappropriate - for instance, it had failed to respond to the applicant's request to be fed intravenously.

The applicant's treatment violated his right to be free from inhuman and degrading treatment.

There must be adequate procedural safeguards in place to ensure that use of restraints and restrictions, even when therapeutically necessary do not fall foul of Article 3. The safeguards must be capable of demonstrating the measures used were absolutely necessary, are proportionate, and are only a last resort.³⁵ This likely requires evidence that less intrusive measures were not capable of satisfactorily

containing the risk of harm or treating the patient, like evidence that medical professionals considered less intrusive interventions.

Equally, the State must be capable of showing that the intervention lasted only as long as strictly necessary. To this end, the patient must be under close supervision, and every use of restraint must be properly recorded. Restraints should only be used to avoid immediate harm.³⁶

The right to private and family life under Article 8 ECHR

Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for Article 3 may still breach a patient's Article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

The right to life under Article 2 ECHR

Under this Article, the State has an obligation to take reasonable measures to protect the patient's life if the State is aware, or ought to be aware, of the imminent risk to the patient's life. The States' obligations may include a duty to make adequate provision for securing high professional standards among health professionals and ensuring hospitals adopt appropriate measures for the protection of patients' lives, especially considering the vulnerability of mentally ill persons.

Case Study: V. v Czech Republic³⁷

The applicant's brother ('PZ') had paranoid schizophrenia and hypertension. He died following a restraint in a psychiatric facility to which he was admitted because he had been aggressive towards his family.

He became agitated during the night; he allegedly tried to strangle a medical orderly with a fire hose. The police were called. Two police officers managed to force P.Z. to the ground in a prone position, but they were unable to restrain him or secure his hands behind his back. Given this, the police considered PZ posed an imminent threat to everyone present. They tased him three times, following which a nurse administered further tranquilising medication. He was then discovered not to have a pulse. The police officers had not been warned of PZ's hypertension and vulnerability.

The Court drew attention to the risks of the prone position, which may lead to positional asphyxia. The Court was struck that PZ was tased three times in quick succession and medicated, all before he had been turned over onto his back. It highlighted that mere fact that PZ was a psychiatric patient should have prompted the police to realise that he was vulnerable and he was a person with mental health issues and that it was very likely that he had received medication, which ought to have made them exercise caution in the measures they chose.

The Court considered that there is nothing unusual about persons hospitalised in a psychiatric clinic being violent, so psychiatric institutions must be appropriately staffed and equipped to safely handle such patients by their own means rather than calling in the police. Here, no evidence of an appropriate strategy, appropriate preventive measures or de-escalation techniques at the psychiatric institution was submitted.

The handling of PZ's restraint amounted to a failure to take measures to preserve PZ's life, violating his right to life.³⁸

Procedural obligations under Articles 3 and 2 ECHR

States have an obligation to investigate allegations of torture, inhuman or degrading treatment and threats to life as soon as an arguable complaint of these are made or if there are otherwise sufficiently clear indications of a possible breach of Article 2 and 3.

To comply with the obligations under the ECHR, investigations must be 'effective' - adequate³⁹ independent⁴⁰, prompt and open to public scrutiny⁴¹ and victim participation.⁴²

Non-discrimination

All persons must benefit from their rights without discrimination, including rights under Articles 2 and 3.

A failure to properly investigate allegations of ill-treatment because the person making the allegation has intellectual disabilities will violate Article 14 taken with Article 3. Every person, regardless of their mental capacity, is entitled to the same robust investigative process.

Case Study: Clipea and Grosu v Moldova⁴³

The applicants alleged that the State had failed to properly investigate their allegations of ill-treatment because of their intellectual disabilities.

The authorities had relied on the applicants' diagnosis to uphold the discontinuation of the investigation. The authorities had dropped the investigation after only hearing the hospital heads and the applicants; the prosecutor had reconciled their two accounts by referring to the applicants' psychological disabilities which, he found, prevented them from fully understanding the circumstances of their treatment at the hospital, and thus undermined the credibility of their claims.

The Court condemned this approach. As with other alleged victims, any dismissal of a complaint must be based on an objective analysis of all the evidence obtained as part of an effective investigation.

The fact that a person complaining of such treatment has a disability is no reason for shifting the focus of the investigation from objectively verifying the facts to determining whether the person fully understands what happens to him or her.

In the Court's view, therefore, there was no reasonable justification for rejecting the applicants' complaints on the sole basis of their disability after having heard only from the hospital, namely the party most interested in the investigation's discontinuation.

UN Convention on the Rights of Persons with Disabilities (CRPD)

The UN Convention on the Rights of Persons with Disabilities (CRPD) aims to ensure that disabled people are treated on an equal basis with others. The issue of restrictive practices particularly affects disabled people as those receiving adult mental healthcare are receiving treatment for their disability, often against their

wishes. CRPD sets the highest standards, requiring the elimination of coercive practices including mental health detention.⁴⁴

CRPD protects a number of relevant rights:

- Article 12: provides that disabled people must be treated equally before the law. They have the right to legal capacity and to be supported to make decisions, rather than those decisions being made on their behalf by others. This requires that medical treatment be based on the rights, will and preference of the individual.
- Articles 14 and 25: the right to liberty and security and the right to health require that disabled people must be able to give free and informed consent to any treatment, which would not allow for forced treatment to be imposed.
- Articles 15, 16 and 17: these articles protect physical and mental integrity and freedom from torture, violence, exploitation and abuse. Forced treatment is considered to violate these rights. The Committee highlights the "deep pain and trauma"⁴⁵ resulting from forced treatment.

The Committee on the Rights of Persons with Disabilities (the CRPD Committee), which monitors the implementation of the CRPD, issues concluding observations about countries' compliance with the treaty's obligations. These help authoritatively articulate the obligations states have under the CRPD and shortcomings in current national practice.

The Committee has expressed concern about the continued use of physical, mechanical and chemical restraint on persons with disabilities in healthcare and other settings, as well as practices of segregation and seclusion. The Committee was also concerned about the absence of a unified strategy to review these practices.⁴⁶

It recommended that the UK State and its regions should

- adopt appropriate measures to eradicate the use of restraint for reasons related to disability within all settings;
- set up strategies, in collaboration with monitoring authorities and national human rights institutions, to identify and prevent the use of restraint for children and young persons with disabilities.⁴⁷

The Committee has also expressed concerns at the results of the on-going staffing crisis in UK social care and mental healthcare. It noted its concerns that "staffing shortages have been linked to the increasing use of physical restraint and unsafe practices on mental health wards".⁴⁸

Other International Standards

UN bodies such as the Committee Against Torture and the Committee on the Rights of the Child, and the European Committee for the Prevention of Torture (CPT) have made repeated recommendations to address restraint in particular, none of which have been addressed in Scotland⁴⁹. These require:

- Abolishing its use for certain purposes – to inflict pain, for reasons of disability;
- Reducing disproportionate use for certain groups e.g. ethnic minority groups;
- Collecting disaggregated data on use;
- Investigating allegations of ill-treatment; and
- Developing statutory guidance for its use (on children in particular).

Endnotes

- ¹ Moving from institutions to independent living | SHRC Spotlight Projects
- ² [Scottish Prison Service admits unlawful death of man in custody - BBC News](#)
- ³ Report on the joint visit: Royal Hospital for Children and Young People Melville Unit 12-16 May 2025; [Report on the joint unannounced visit/safe delivery of care inspection: Dudhope YPU, NHS Tayside October 2025](#)
- ⁴ NHS orders hundreds of patients to be removed from crisis-hit hospital following string of police investigations | The Independent
- ⁵ Teenage patients 'ignored' before fatal NHS trust failures - BBC News
- ⁶ Muckamore Abbey Hospital Inquiry
- ⁷ Department of Health and Social Care, ['New drive to end deliberate face-down restraint'](#) (2014)
- ⁸ V. I v Republic of Moldova no. 38963/18 (ECtHR, 26th of March 2025).
- ⁹ Rooman v Belgium, no 18052/11 (31st January 2019).
- ¹⁰ V v Czech Republic, no 26074/18 (ECtHR, 7th of December 2023).
- ¹¹ X and Others v Bulgaria, no. 22457/16 (ECtHR, 02nd February 2021), §§ 179-186.
- ¹² Virabyan v Armenia, no. 40094/05 (ECtHR, 02nd October 2012), § 165-167.
- ¹³ Oleksiy Mykhaylovych Zakharkin v Ukraine, no 1727/04 (ECtHR, 24th June 2010), § 67.
- ¹⁴ Charnega and Others v Ukraine, no 74768/10 (ECtHR, 18th June 2019), § 165.
- ¹⁵ "The Committee has called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by

eliminating the use of seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restraints. The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the Convention." Committee on the Rights of Persons with Disabilities, [Guidelines on the right to liberty and security of persons with disabilities](#) at para. 12

¹⁶ Committee on the Rights of Persons with Disabilities, General Comment No.1 – Article 12: Equal Recognition before the law (2014) at para. 42

¹⁷ Committee on the Rights of Persons with Disabilities, '[Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland](#)' (2017)

¹⁸ Ibid at 37

¹⁹ Committee on the Rights of Persons with Disabilities, '[Advance unedited version: Report on follow-up to the inquiry concerning the United Kingdom of Great Britain and Northern Ireland](#)' (2024)

²⁰ SHRC '[Review, Recommend, Repeat: An assessment of where human rights have stalled in places of detention](#)' (2024)

²¹ There are additional safeguards relating to certain treatments in Part 16 of the Mental Health (Care & Treatment)(Scotland) Act 2003. Sections 281 to 286 of the Act, and their associated regulations contain the regulations for restricting access to correspondence, use of telephones and access to personal items

²² [Consultation on Updates to the Code of Practice for the Mental Health \(Care and Treatment\) \(Scotland\) Act 2003 - gov.scot](#)

²³ Mental Health and Wellbeing Act 2022; [Restrictive interventions | health.vic.gov.au](#)

²⁴ [Out of sight – who cares?](#)

²⁵ Taking action - Care Quality Commission

²⁶ Code of practice: Mental Health Act 1983 - GOV.UK

²⁷ [Independent Care \(Education\) and Treatment Reviews: final report, 2023 - GOV.UK](#)

²⁸ Kaganovskyy v Ukraine no. 2809/18 (ECtHR, 15th September 2022), § 122.

²⁹ V. I v Republic of Moldova no. 38963/18 (ECtHR, 26th of March 2025), § 94.

³⁰ *ibid*

³¹ *Ibid*, § 137.

³² *Ibid*, §§ 138-142.

³³ Ciorap v Moldova no.12066/02 (ECtHR, 19th June 2007), § 84.

³⁴ *ibid*

³⁵ Makki v Denmark no 10297/23 (ECtHR, 31st of March 2026), § 92.

³⁶ Aggerholm v Denmark no. 45439/18 (ECtHR, 15th of September 2020).

³⁷ V v Czech Republic, no 26074/18 (ECtHR, 7th of December 2023), §§ 82-87.

³⁷ *Ibid*, §§ 90-101.

³⁸ *Ibid*, §§ 90-101.

³⁹ X and Others v Bulgaria, no. 22457/16 (ECtHR, 02nd February 2021), §§ 179-186.

⁴⁰ Virabyan v Armenia, no. 40094/05 (ECtHR, 02nd October 2012), § 165-167.

⁴¹ Oleksiy Mykhaylovych Zakharkin v Ukraine, no 1727/04 (ECtHR, 24th June 2010), § 67.

⁴² Charnega and Others v Ukraine, no 74768/10 (ECtHR, 18th June 2019), § 165.

⁴³ Clipea and Grosu v Moldova, no 39468/17 (ECtHR, 19th of November 2024), § 92.

⁴⁴ "The Committee has called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restraints. The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the Convention." Committee on the Rights of Persons with Disabilities, [Guidelines on the right to liberty and security of persons with disabilities](#) at para. 12

⁴⁵ Committee on the Rights of Persons with Disabilities, General Comment No.1 – Article 12: Equal Recognition before the law (2014) at para. 42

⁴⁶ Committee on the Rights of Persons with Disabilities, ['Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland'](#) (2017)

⁴⁷ Ibid at 37.

⁴⁸ Committee on the Rights of Persons with Disabilities, ['Advance unedited version: Report on follow-up to the inquiry concerning the United Kingdom of Great Britain and Northern Ireland'](#) (2024)

⁴⁹ SHRC ['Review, Recommend, Repeat: An assessment of where human rights have stalled in places of detention'](#) (2024)