SHRC
Scottish
Human Rights
Commission

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

October 2026

0131 297 5750 | hello@scottishhumanrights.com | www.scottishhumanrights.com |
Scottish Human Rights Commission, Bridgeside House, 99 McDonald Road, Edinburgh, EH7 4NS

Executive Summary

The SHRC is concerned that the Code does not apply to restrictive practices used in mental health treatment settings that do not involve the physical restriction of a person's movement. The Code focuses on restraint, which it defines as preventing someone from physically moving freely by various means. However, as outlined in this submission, human rights protections also regulate conduct capable of restricting the patient's freedom beyond physical prevention of movement. This response also makes clear that human rights compliance requires the State put in place a wider range of effective safeguards than currently proposed.

In addition, if the aim of a 'rights-based' Code is to be achieved, it should go beyond mere compliance and seek to implement best practice which most fully realises the letter and the spirit of human rights standards, in line with the Scottish Government's commitment to take a 'maximalist' approach to human rights. This submission highlights opportunities to strengthen the Code by adopting standards outlined by international human rights bodies. It also makes reference to the work carried out by Baroness Hollins in England[1] which outlines robust human rights-based safeguards based on an extensive programme of inquiry.

The Scottish Human Rights Commission (the SHRC) published a briefing paper in September 2026 that examined the human rights issues arising from the use of restrictive practices in adult mental healthcare. It outlined the SHRC's preliminary exploration, including the evidence we have about these practices and the gaps in this evidence. We compared this evidence with the standards required by human rights treaties. And we outlined our concerns with the gap between those standards and the situation in Scotland and calls for the Scottish Government to act with urgency.

This submission builds on the findings of the briefing paper on restrictive practices, and provides a more detailed articulation of the relevant standards and specific proposals for the improvement of the proposed Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Code').

Introduction

The SHRC is a public body created by the Scottish Commission for Human Rights Act 2006. We are an independent, expert body that works with and for the people of Scotland; we monitor, listen, speak up for all of our rights and respond when things go wrong. The SHRC is also part of the international human rights system. It is accredited by the United Nations as its trusted organisation to provide impartial

evidence on the enjoyment of human rights in Scotland. The SHRC is independent of Government. We are accountable to the people of Scotland via the Scottish Parliament.

The SHRC has heard evidence from people with lived experience that excessive restrictive practices and seclusion take place in Scotland. This reflects concerns raised by international human rights bodies, like the UN Committee on the Rights of Persons with Disabilities. The SHRC is not confident that the existing safeguards are sufficient to ensure human rights compliance.

Appropriate revisions to the Code, alongside other measures, are crucial to ensuring human rights compliance. As such, the SHRC seeks to outline the applicable human rights standards that the Code must pursue and identify international examples of good practice to help inform the appropriate development of the Code.

Human Rights Framework

The below section sets out the requirements of the human rights framework on restrictive practices to provide context to our subsequent answers to the specific consultation questions.

European Convention on Human Rights

People in mental health care benefit from several human rights protections while in medical care, including those under Article 3, Article 5, Article 8, Article 9, Article 2, and Article 14 of the European Convention on Human Rights (‘ECHR’). Caselaw of the European Court of Human Rights ('the Court') usually refers to people as 'patients' and accordingly we use this language in this submission when applying caselaw.

The prohibition of torture, inhuman and degrading treatment (Article 3 ECHR) Article 3 prohibits torture, inhuman and degrading treatment and is absolute. Article 3 can apply to any measures that reach the 'minimum threshold of severity.' Assessment of whether measures reach that threshold takes into account a number of factors including the stringency of the regime, its duration, the objective pursued and its effects on the person concerned.[2] In the mental health treatment context, the assessment of whether the minimum threshold has been reached will take account of the vulnerability of the patients and their position of 'inferiority' when compared to the staff.[3]

There is no need for the conduct to be intended to hurt or humiliate a person for the Article 3 prohibition to apply.

Therapeutic necessity

Measures which are 'therapeutically necessary' do not violate Article 3.[4] Therapeutic necessity is defined by reference to established principles of medicine, rather than a legal test. Nonetheless, the State must evidence the therapeutic necessity.[5] The European Court of Human Rights will usually require the State to produce a therapeutic plan tailored towards the needs of the individual patient to show therapeutic necessity.

Adequate safeguards

The measure must also be accompanied by adequate safeguards, which are commensurate to the severity of the measure and provide sufficient procedural protection and are 'capable of demonstrating sufficient justification that the requirements of ultimate necessity and proportionality have been complied with and that all other reasonable options have failed to satisfactorily contain the risk of harm to the patient or others'.[6]

While the Court has not identified exactly what safeguards will satisfy these criteria, a human rights complaint approach will certainly require close supervision of restrained patients and proper recording of measures used, alongside other safeguards.[7]

Equally, the Court has emphasised that when compulsory treatment is used, namely treatment which is administered without the full and free consent of the patient, 'they must be subject to rigorous oversight to prevent potential abuse and to ensure that the interference with personal autonomy is proportionate and justified'.[8] Spivak v Ukraine explains what the oversight must be capable of achieving. The Ukrainian authorities argued that Ukrainian law provided sufficient safeguards because it provided for judicial review, a complaints mechanism, and the possibility to seek external psychiatric review.

In finding these insufficient, the Court made several comments about what the legal and regulatory framework (as a whole) should achieve to comply with Article 3

1. Where the domestic framework places reliance on a complaints mechanism to achieve compliance with Article 3 rather than a

regulatory body, it must enable prompt intervention by an independent authority with the power to intervene directly in the diagnostic process or medication administration and to detect and prevent potential arbitrariness or abuse;

2. There must be evidence, that the safeguards are genuinely accessible to patients, rather than being largely theoretical[9]; and
3. The safeguards should not promote a culture of silence and fear to develop, in which patients feel unsafe to express their grievances open.[10]

Caselaw also indicates that the State should also recognise that private contact and correspondence with family and friends is a safeguard against abuse or arbitrariness because it provides a means of sending a complaint to an outside authority.[11]

Investigation of allegations

Relatedly, if someone raised an arguable claim of torture, inhuman or degrading treatment, the State also has a procedural obligation under Article 3 to investigate. Investigations must be 'effective', meaning adequate, independent, reasonably prompt, reasonably open to public scrutiny and victim and/or family participation.[12]

For an investigation to be adequate, it must be capable of establishing the material facts and cannot be based solely on reliance of the testimony of people responsible for the ill-treatment.[13]

While the investigators need not be absolutely independent from the persons investigated, the persons conducting the investigation must be practically, including institutionally and hierarchically, independent.[14] As such, external accountability mechanisms are required to achieve human rights compliance, where an arguable allegation of ill-treatment is made.

Failure to provide adequate care can also be a standalone violation of Article 3, rather than only evidence that a certain use of force or restriction was not therapeutically necessary.[15]

The Court will actively review the treatment provided for 'adequacy' based on the medical records available, requiring proper treatment for the problem diagnosed. States must ensure that medical supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's

health, rather than addressing problems on a symptomatic basis.[16] The therapeutic plan should also pave the way towards achieving the particular person's release and reintegration into the community.

The 'manner in which' an intervention is carried out can also amount to a violation of Article 3 if it is excessively painful, degrading, or punishing.[17]

The right to liberty (Article 5 ECHR)

A person can be lawfully detained under Article 5 if they are of 'unsound mind' and, verified by medical evidence, their condition is such that it warrants compulsory treatment and their disorder persists throughout the period of their detention.[18] To be lawful, a deprivation of liberty must also have a clear legal basis, which identifies when a patient may be deprived of their liberty. Where a person is detained, they have the right to access certain procedural safeguards, such as the opportunity to challenge the lawfulness of their detention before a court or tribunal.

Further Deprivations of Liberty

Even where the patient is detained within a mental health treatment facility lawfully, they retain a residual liberty. Placing them in seclusion within that facility may amount to a further deprivation of liberty and thus require the implementation of procedural safeguards. Whether this is the case will depend on the type, duration and manner of implementation of the measure. [19] In determining whether someone has been deprived of his liberty, the starting point must be the applicant’s concrete situation and account must be taken of a whole range of criteria, such as the type, duration, effects and manner of implementation of the measure in question. The criteria must apply with greater force when the person is already detained. [20]

The right to private and family life (Article 8 ECHR)

Article 8 protects a wide range of interests, including autonomy, family and other relationships and identity. Most of the restrictions in psychiatric hospitals or mental healthcare are likely to engage Article 8. Restrictions that do not meet the Article 3 threshold of necessity will nonetheless engage Article 8.

As such, clinicians do not have unrestricted freedom to restrain or control the patients’ choices because they think it may be convenient. Instead, measures that interfere with Article 8 must be prescribed by law, pursue a legitimate aim and be necessary and proportionate to the aim pursued.

The assessment of necessity and proportionality will always be highly fact-specific, but the Court has identified some factors in previously cases that are likely to be relevant. In Calvi v Italy, the applicant was placed in almost complete isolation for about three years in a social care facility, unable to see family and friends.[21] His phone calls and correspondence were screened. The Court found these measures disproportionate, highlighting a number of factors, including the lack of effective safeguards to prevent abuses, as they are 'particularly important in determining whether the respondent State has remained within the limits of its margin of appreciation'.[22]

As such, the Court will require clinicians to assess the patients' circumstances as a whole and impose appropriate safeguards to protect the patients' rights before they impose a restriction.

The right to freedom of thought, conscience and religion (Article 9 ECHR)

Article 9 protects freedom of thought, conscience and religion. This includes the freedom to manifest a belief, like by wearing a religious symbol, praying or participating in religious events. As with Article 8, any interference with this Article will need to be prescribed by law, pursue a legitimate aim and be necessary and proportionate to the aim pursued.

As such, medical staff cannot impose blanket policies that restrict the patients' ability to manifest their belief by dress or conduct without a full assessment of whether the restriction is justified and proportionate.

To ensure human rights compliance, medical staff must be aware of this responsibility. Equally, bearing in mind that patients in mental health treatment centres are often 'under effective control of the psychiatrists' and the vulnerability of patients, medical staff must:

1. be wary not to pry into the patients' beliefs; or
2. attempt to 'correct' them by disparaging or insulting the belief and encouraging the patient to adopt a critical attitude towards their pre-existing beliefs.

unless there clear and imminent risk that such beliefs will manifest in actions dangerous to the patient or others.[23]

Comments by staff within mental health treatment settings aimed to discourage the patients from practising their beliefs etc are likely sufficient to interfere with human rights.

The right to life (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.[24] 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.

The right to protection from discrimination (Article 14 ECHR)

Article 14 protects people from discrimination in the enjoyment of their rights under the other ECHR Articles.

This means people who have different characteristics, such as ethnic minorities or people with particular diagnoses, must not be disproportionately adversely affected by any policies or restrictions, unless this treatment can be objectively and reasonably justified.

Article 14 also regulates the types of procedural safeguards and processes the State must have in place. For example, to comply with the Article 3 duty to investigate described above, together with Article 14, the State cannot allow any diagnosed disability of the complainant's to illegitimately impact the investigation into any allegations made by them.

In Clipea v Moldova, the applicants alleged that the State had failed to properly investigate their allegations of ill-treatment because they had intellectual disabilities. The Moldovan authorities relied on the applicants' diagnosis in order to defend discontinuing the investigation, stating that the applicants were "persons with limited legal capacity, [who] in these circumstances, ... [were] not always able to fully and correctly understand the things that happen[ed] in certain circumstances".[25]

The Court was concerned by this negative stereotyping. Any dismissal of a complaint must be based on an objective analysis of all the evidence obtained as part of an

effective investigation, rather than any mere assumption that the account by the complainant cannot be relied on.

International Human Rights Instruments

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

Users of any new Code must also be aware of the rights protected by the UN Convention on the Rights of People with Disabilities (CRPD), which Scottish duty bearers are bound by international law to uphold. CRPD aims to ensure that disabled people are treated on an equal basis with others.

CRPD protects a number of relevant rights, including:

- 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 & 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; and
- 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 CRPD Committee highlights the "deep pain and trauma" resulting from forced treatment.[26]

CRPD adds a layer of stringency for the use of restrictive interventions on top of ECHR obligations. It requires the elimination of coercive practices, including in mental health detention and, specifically, "eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanical restraints."[27] The Committee has found that those practices are not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment of persons with disabilities. While the ECHR does continue to permit therapeutically necessary restrictions, this emphasis from CRPD places greater focus on the need to work towards elimination of coercive practices.

The Committee also requires that, where a person's rights have not been upheld, they are entitled to "appropriate redress and reparation".[28]

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment's (CPT) standards

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment's (CPT) sets out standards[29] which provide more detailed guidance about how to put in place adequate safeguards to ensure that restriction is only used in a rights-complaint manner.

The CPT has stressed that "the ultimate goal should always be to prevent the use of means of restraint by limiting as far as possible their frequency and duration".

The standards make clear that:

1. Means of restraint should always be applied in accordance with the principles of legality, necessity, proportionality and accountability;
2. Staff must be appropriately trained;
3. Restraint should only be a last resort, only for a period during which is it absolutely necessary;
4. Every psychiatric establishment should have a comprehensive, carefully developed policy on restraint;
5. Blanket authorisation of restraint is not permissible. Instead, it can only be approved by a doctor following an individualised assessment;
6. Restrained or secluded patients should be under constant supervision;
7. All instances of restraint and seclusion should be recorded; and
8. Effective complaints procedures must be in place, as they are basic safeguards against ill-treatment in all psychiatric establishments.

Response to consultation questions

The following responses to the formal consultation questions are informed by the human rights safeguards and instruments referenced above.

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

The SHRC is concerned about the clarity of the terms ‘restrictive interventions’ versus ‘restraint and seclusion.' These have different meanings but are used interchangeably throughout the consultation. Human rights standards are concerned with the whole area of restrictive practice, within which restraint and seclusion are only two forms. The general principles suggest that restrictive intervention involves a physical restriction of movement, whether physically, mechanically or chemically induced. Restrictive practices used in mental health care are much wider than this, and their improper use will violate human rights. As such, staff require guidance within the Code of Practice about when restrictive practices can be appropriate and how they must be minimised and regulated.

The general principles should clearly define the term ‘restrictive interventions’ or practices separately from restraint and seclusion to make this clear.

The SHRC is concerned that the general principles suggest that the Code will have too narrow a field of application to achieve full human rights compliance. This concern in addressed in more detail in our response on definitions below.

The SHRC notes the importance of the principles statement that emphasis must always be on preventing or minimising the use of restrictive interventions, including early identification of distress, de-escalation, and anticipatory planning, so that restraint and seclusion are avoided wherever possible.

This statement is crucial to ensure the Code is compliant with the ECHR’s requirements as set out above. It is also in line with the CPT's guidance and is therefore welcome.

However, the general principles appear to accept the ongoing use of restraint and seclusion.

The Code must also acknowledge the requirement of CRPD to eliminate the use of restraint and seclusion or, at the very least, work towards it with a reduction over time.

The SHRC encourages the Scottish Government to consider the example of legislation in Victoria, Australia, which stipulates a long-term goal to eliminate restrictive interventions within ten years.[30] It should also consider adding the

principle adopted by that legislation that "Restrictive interventions offer no inherent therapeutic benefit to a person". [31]

The SHRC is concerned that the general principles may fail to sufficiently emphasise the importance of safeguards and define the scope of the Code's application too narrowly to ensure human rights compliance.

First, in relation to safeguards, for an intervention capable of engaging Article 3 to be lawful, it must be accompanied by commensurate safeguards. Even if the intervention does not engage Article 3, the Court may find that it violates Article 8 or 9 because the lack of sufficient procedural suggests the intervention was a disproportionate interference with the patient's rights.

As such, a human rights-compliant approach must include an emphasis on ensuring any intervention or restriction is accompanied by strong safeguards. Human rights compliance cannot be achieved without adequate safeguards.

Currently, the 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.

If the revision of the Code is to make a substantial change to staff's ability to ensure rights compliance, the Code must detail specific safeguards that staff must put in place.

Currently, the consultation paper does make reference to important safeguards, like monitoring, health checks, reviews of the incident and staff training. However, given the seriousness of the violations the safeguards need to protect against, we would expect them to be more robust.

In our view, ECHR compliance requires that treatment provided to staff be subject to independent oversight by persons with the power to intervene directly in the diagnostic process or medication administration and to detect and prevent potential arbitrariness or abuse. Investigations must also be conducted by independent people. Given this, the availability of an independent regulator and/or accessible, effective complaints management body would be best practice. While the Mental Welfare Commission has a monitoring role, it is not a regulator. Scotland still lacks a system of effective enforcement powers that can require action when human rights concerns are identified.

In England, Baroness Hollins produced a report about the use of solitary confinement for people with learning disabilities and people with autism. This report

provides examples of the measures the Code could promote to support patients' families in keeping those caring for the patients accountable.[32] We would encourage the Scottish Government to consider these examples.

Baroness Hollins recommended that family, friends and legal representatives should also be included in oversight where they are involved.[33] Family and support networks should be provided with information about how to raise a safeguarding concern.[34]

The consultation paper does not suggest that the Code will help family and the patient's other support networks to become an accountability mechanism. It does not emphasise the need to upskill family members. The SHRC urges the Scottish Government to consider the inclusion of this in the Code, to ensure it contains the strongest possible safeguards in line with the requirements of the human rights framework.

The Code also has insufficient emphasis on ensuring that the patient has as much skill, knowledge and support as possible to hold the staff caring for them accountable when the patient experiences abuse or arbitrariness. While the consultation does make reference to supporting patients to understand and access advocacy and explaining complaints processes in an accessible, age appropriate way,[35] this must be extended to all patients, not only children, to achieve a human rights complaint approach. In particular, the right to be treated equally before the law under Article 12 CRPD requires that support for decision-making be provided. CRPD also requires accessibility in all matters for disabled people.

Safeguards provided for by the Code should ensure as much external and robust accountability to prevent abuse or arbitrariness so as to approximate, as far as the confines of what a Code can achieve, the scrutiny a regulator would provide. To achieve this, the Code should include measures like:

- Duties to support family members and friends of patients to help them keep the staff accountable;

- Duties to support patients to access accountability mechanisms;

- Duties to facilitate patient access to independent advocacy and peer support;

- Rules that encourage Boards to ensure that only staff with established relationships work with patients;

- Rules creating accessible and effective complaints and redress mechanisms; and

- Staff training that will enable staff not only to act in a human rights complaint way but also hold each other accountable and support mutual development.

Clinicians should be required to support patients in complaining or seeking review of their care and ensuring that any information and support they provide is accessible to the patient with whom they are working. The Code should make clear that general information leaflets or statements will not be sufficient to satisfy this duty.

This could be done, for example, by expanding the proposed mandatory debriefs that are to follow restrictive interventions (as described on pages (p.15, 18, 19 of the Consultation paper) to include supporting the patients to raise complaints or seek redress, where an allegation of ill-treatment or breach of rights is raised.

Assigned intermediaries would also be good practice in this regard. In Sweden, for example, potential victims of ill-treatment are assigned contact persons for support, and persons receiving compulsory psychiatric care or forensic psychiatric care are entitled to a support person, a representative or counsel.[36] These help support the patient and provide a reliable mechanism to help the patient contact external agencies. Trusts could individually implement such a measure by assigning staff members, who are not normally involved in the care of a particular patient, as the intermediaries.

Patients should also generally have access to digital technologies to enable contact with others. This could be an effective safeguard by providing a means of supporting the patient and allowing the patient to communicate with outside agencies to seek assistance where needed.

Do you agree with our definitions of restraint and seclusion?

We are concerned that the Code, as outlined in the Consultation Paper, will define seclusion too narrowly and unduly limit the scope of application of the Code by failing to define, limit and regulate restrictive practices.

The Code defines seclusion on p.10 of the Consultation paper as ‘the supervised confinement and isolation of a patient away from other patients in a room, area or other space from which the patient is prevented from leaving’. The SHRC considers this definition to be too narrow, as it would not capture situations in which the patient is not confined within a single physical space but is nonetheless forcibly prevented from having meaningful contact with other people.

The risk, from the perspective of human rights compliance, of adopting the definition proposed is that a patient may suffer all the psychological harms associated with seclusion because they are unable to have meaningful contact with others without having access to the safeguards and support that patients would normally benefit from because they are not technically confined within a single space.

The Scottish Government should consider the approach developed by Baroness Hollins and the IC(E)TR Oversight Panel which defines seclusion practices as those which isolate people from meaningful human contact. In particular, "meaningful human contact does not include being with staff in institutions or talking to people through medical necessity."[37] These components should be added to the definition proposed.

More broadly, we are concerned that the Code does not apply to restrictive practices used in mental health treatment settings that do not involve the physical restriction of a person's movement. The Code focuses on restraint, which it defines as preventing someone from physically moving freely by various means.

However, as outlined above, human rights protections also regulate conduct capable of restricting the patient's freedom beyond physical prevention of movement. As the ECHR has recognised, patients in mental health treatment are vulnerable compared to staff and often are within the effective control of the staff at the treatment setting. This is why the ECHR has recognised that patients must be protected and have safeguards against restrictions like disproportionate or arbitrary policies on family contact, visits, access to technology, surveillance or other measures that affect the patient's rights. Equally, comments by staff within mental health treatment settings aimed to discourage the patients from practising their beliefs etc are likely sufficient to interfere with human rights.

Given this, staff within mental health treatment settings require clear guidance about the kind of conduct that could restrict a patient in a way that may risk human rights violations. The Code must also prescribe safeguards to prevent such human rights violations.

The English NHS guidance on restraint and restrictive practice provides a model of good practice in this regard. It identifies eight types of restrictive practice. Aside from covering physical restrictions of movement through mechanical, chemical and physical means like the Code, it describes other means of restriction, like cultural restraint, psychological restraint, environmental restraint, blanket restriction and surveillance.[38]

This guidance recognises that these practices must be reduced and that 'preventative measures to reduce the use of restrictive practices in mental health services can only be effectively designed and implemented if all types of restrictive practice and their contributing factors are identified and reported'.[39]

Crucially, the guidance recognises that most staff within mental health treatment settings will recognise that restraint, seclusion and segregation are restrictive practices, but they may be less aware of the other practice described. The SHRC welcomes this approach which highlights the necessity of description and regulation in the Code.

We encourage the Scottish Government to expand the scope of the Code's application to the include the restrictive practices identified in the English guidance to maximise rights compliance.

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

We welcome the clear statement within the proposed code that restraint and seclusion require a clear legal basis and must only be used where it is strictly necessary, proportionate, and for the minimum time required to prevent immediate and significant harm. This is consistent with the human rights approach.

However, we recommend that this section of the Code should make more explicitly clear that practitioners have a duty to consider all alternative interventions before they resort to seclusion or restraint. It should also make clear that it is the obligation of clinicians to develop a plan for ending seclusion as soon as it commences, rather than criteria the patient has to satisfy.

We are encouraged by the Code's recognition that 'certain procedural safeguards require to be followed' and it notes that the list of safeguards identified is 'not exhaustive'. However, as above, we are concerned that the safeguards suggested are insufficient. The safeguards identified, like monitoring, health checks and documentation, are important to ensuring a human rights-based approach but they are insufficient. Human rights compliance, in our view, requires external accountability mechanisms, like an independent complaints body or independent regulator.

The Code must, therefore, at least attempt to approximate the scrutiny such bodies would provide. Aside from supporting and family and the patient to be

competent to challenge abuse or arbitrariness, as outlined above, we recommend that the following safeguards could help maximise compliance:

- Automatic review by clinicians independent of the case;

- A robust, accessible complaints process directly to the Health Board for patients and family; and

- Individual staff should be encouraged to self and peer report failures to comply with the Code to the Mental Welfare Commission or Health Board. Staff could be encouraged to do this by training (the SHRC's recommendations are outlined below).

The Code should also emphasise that clinicians must consider the manner in which the restraint or seclusion is carried out. The staff who carry out restraint must be mindful to choose the least restrictive and stressful means of restricting the patient. The Code must make that clear.

The potential for seclusion to amount to a deprivation of liberty requiring procedural safeguards provides welcome clarity. Staff must understand from the Code that just because someone is detained within an institution lawfully does not mean that they do not retain a residual liberty protected by Article 5. Indeed, the requirement for scrutiny of the measures clinicians choose to employ applies with 'greater force' in these circumstances.

Do you agree with our recommendations around future care planning?

The SHRC welcomes the emphasis on advanced planning and the emphasis on taking into account the views of the patient.

It is crucial that the Code emphasises this for two key reasons. First, a failure to have a therapeutic plan that is capable of treating the condition of a detained patient will likely amount to a violation of the prohibition of torture, inhuman and degrading treatment.

Second, a failure to spot warning signals, to de-escalate and treat appropriately before the patient reaches a crisis would likely undermine a claim that a subsequent restraint is necessary. Future planning would help prevent the escalation arising. However, the Code should make this clear to clinicians.

We recommend that the 'future care planning' section of the Code should make explicit reference to the prohibition of torture, inhuman and degrading treatment to make clear the importance of future planning to avoiding violations of absolute obligations.

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

The SHRC welcomes the principles identified in the section. We are encouraged by the recognition in the Code that the 'presence of autism or learning disability should not be treated as an indicator for the need for restraint' and the requirement that 'their care should be person centred and trauma informed, to prevent escalation to the use of restraint or seclusion where possible'.

However, the SHRC believes that the provisions outlined by Baroness Hollins' final report should be given serious consideration. They follow a sustained programme of review of seclusion of people with learning disability and/or autistic people which identified a number of concerns and, as such, provide a robust framework designed to avoid similar concerns arising in Scotland. In particular, the report states that

"Solitary confinement for people with a learning disability and/or autistic people should become 'never events' in the following instances where it lasts for longer than 15 days. If solitary confinement is used as a 'never event' it must trigger:

- A serious investigation as stipulated in NHS England's never event policy (this could be applicable in Scotland as a critical incident review);

- Private company directors and senior trust management must be held to account for failing to provide a safe and therapeutic environment;

The use of other restrictive interventions should be closely monitored to ensure that there is not an increase in their use because of the reduction in solitary confinement".[40]

However, we emphasise that the principles must also be applied to the safeguards designed to protect people with autism and people with learning disabilities from ill-treatment.

We also recommend that this section of the Code be expanded to include rules concerning the appropriate treatment of allegations of ill-treatment made by

autistic people and people with learning disabilities. As the ECHR requires, someone's disability must not be used to justify the dismissal of an allegation made by them without an effective investigation. The Code must make this clear and provide the guidance needed to enforce this. Our recommendations made on the general principle of ensuring accessible complaints mechanisms apply particularly for autistic people and people with learning disabilities. There should be active support for patients to understand and access advocacy services and complaints processes.

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

We agree with the principles articulated. However, we recommend that the Code should make two matters clearer than the consultation currently suggests.

- First, the Code must emphasise that clinicians should seek to encourage the patient to eat voluntarily and this must be the focus of the measures taken. As such, for example, building good relationships with patients must be prioritised. The patients should not be separated, unless absolutely necessary, from their support network, which might cause distress and discourage the patient from eating normally.

- Second, the Code should emphasise that the manner in which the nasogastric tube feeding may be determinative of whether it was human rights compliant. Even if the nasogastric tube feeding was necessary, if it is conducted in manner that is unduly distressing or restrictive, it may amount to a violation of Article or Article 8 of the Convention.

To determine whether the nasogastric tube feeding was conducted in a manner that was unduly restrictive or distressing, the individual characteristics of the patient must be taken into account. This is because the threshold of severity for the application of Article 3 is affected by the characteristics of the patient. The effect on the patient will also be relevant to the proportionality of the measures adopted, when assessed under Article 8.

As such, when using restraint for nasogastric tube feeding, the staff involved must be mindful of the patient's expressed preferences and characteristics. For example, female patients who have said that they are distressed by being restrained by male staff should not generally be restrained by male staff unless this is absolutely

necessary. The Code must make this clear. We also recommend that the prohibition of torture, inhuman or degrading treatment is explicitly mentioned in this regard in the Code to illustrate the importance of ensuring that the intervention be conducted an appropriate manner.

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

We welcome the guidance to Health Boards about gathering data. This is a positive step for human rights compliance, and it complies with the recommendations made by the CPT and the comments by the ECHR.

Monitoring can help identify which Health Boards may be engaging in poor practice and the types of restraint that are most often resorted to. This is an important step towards compliance. However, monitoring and data gathering is not itself sufficient to improve practice without enforcement and regulatory systems. As explained above, therefore, more robust safeguards are required to complement the proposed monitoring and recording of the use of restraint.

Relatedly, the Code places significant duties to ensure that the monitoring and data gathering is properly conducted. However, the Code does not make clear how the Health Boards will be held accountable.

We recommend that the final draft of the Code provides for clear enforcement mechanisms for the new duties for Health Boards.

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

While the general principles articulated appear compliant with human rights, as above, we would like to emphasise the need for effective enforcement mechanisms to ensure that Health Boards comply with the Code as intended.

Without a national regulatory body, there is a risk that Health Boards will adopt inconsistent or significantly varying policies.

While commending the emphasis on ensuring staff are trained to ensure de-escalation, minimise the use of restraint and use any intervention safely, we recommend that the training also includes identifying warning signs of ill-treatment.

It is essential that staff are aware of the possible signs of ill-treatment or inappropriate use of restriction to ensure a human rights compliant approach. Staff peer to peer support and reporting ensures that human rights compliant practice is maintained consistently, not just where a family member or patient is capable of challenging poor practice.

We recommend that elements of training outlined in the English Mental Health Units (Use of Force) Act 2018 be added to the Code. These include:

- how to involve patients in the planning, development and delivery of care and treatment in the mental health unit

- showing respect for patients' past and present wishes and feelings

- showing respect for diversity generally

- avoiding unlawful discrimination, harassment and victimisation

- the risks associated with the use of force

- the impact of any use of force on a patient's mental and physical health

- the impact of any use of force on a patient's development.

Conclusion

The SHRC welcomes the clarity provided by the proposals on the proper use of restraint and seclusion. However, we have identified a number of gaps where the Code should provide further clarity of the limits of proper use and the obligation to work towards reduction and, ultimately, eradication of these practices. We have also recommended the addition of a number of safeguards required to support human rights-based practice.

The SHRC remains concerned that significant gaps remain in relation to other forms of restrictive practice and structures to support accountability for improper use. The Code provides a crucial opportunity to make progress to the greatest extent possible pending further law reform.

Endnotes

[1] Department of Health and Social Care, Baroness Hollins' final report: My heart breaks - solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people (Department of Health and Social Care)

[2] [2] V. I v Republic of Moldova no. 38963/18 (ECtHR, 26th of March 2025), para 96

[3] Kaganovskyy v Ukraine no. 2809/18 (ECtHR, 15th September 2022), para 122

[4] V. I v Republic of Moldova no. 38963/18 (ECtHR, 26th of March 2025), para 95

[5] Ibid, para 95

[6] Makki v Denmark no 10297/23 (ECtHR, 31st March 2026), para 91-92

[7] Ibid, para 93

[8] Spivak v Ukraine, no 21180/15 (ECtHR, 5th of June 2025), para 176

[9] For example, the Court noted that "the Government have not provided any examples of a successful complaint having ever been successfully lodged by an inmate of a psychiatric hospital about his or her psychiatric treatment or any other issue." Ibid at para 187

[10] Ibid at paras 178 - 189

[11] Ibid, para 186

[12] M and Others v Italy and Bulgaria, no 40020/03 (31st July 2012)

[13] MS v Croatia no.75450/12 (ECtHR, 19th May 2015), para 75-76

[14] Bouyid v Belgium, no 23380/09 (28th of September 2015), para 118

[15] Rooman v Belgium, no 18052/11 (31st January 2019), para 147

[16] Ibid

[17] Ciorap v Moldova, no 12066/02 (19th June 2007), para 84

[18] Ilnseher v Germany, no 10211/12 27505/14 (ECtHR, 4th December 2018)

[19] Munjaz v United Kingdom, no 2913/06 (ECtHR, 17th July 2012), para 64

[20] Ibid at para 67

[21] Calvi v Italy, no 46412/21 (06th July 2023)

[22] Ibid at para 89

[23] Mockute v Lithuania, no 66490/09 (27th February 2018), para 125

[24] V v Czech Republic, no 26074/18 (ECtHR, 7th of December 2023).

[25] Clipea and Grosu v Moldova, no 39468/17 (19th November 2024), paras 90-93

[26] General comment no.1 at para. 42

[27] Committee on the Rights of Persons with Disabilities, Guidelines on the right to liberty and security of persons with disabilities at para. 12

[28] Ibid at para 24

[29] CPT 'Means of restraint in psychiatric establishments for adults (Revised CPT standards)' (2017)

[30] Mental Health and Wellbeing Act 2022; Restrictive interventions | health.vic.gov.au

[31] Decision-making principles for treatment and interventions | health.vic.gov.au

[32] Department of Health and Social Care, *Baroness Hollins' final report: My heart breaks - solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people* (Department of Health and Social Care).

[33] Ibid.

[34] Ibid, recommendation 8

[35] p.9 of the Consultation Paper

[36] European Union Agency for Fundamental Rights, Places of Care = Places of safety? Violence against Persons with Disabilities in Institutions (2025).

[37] Department of Health and Social Care, Oversight Panel's solitary confinement code of practice framework (2023)

[38] NHS England, Identifying restrictive practice (2025).

[39] Ibid

[40] Department of Health and Social Care, Baroness Hollins' final report: My heart breaks - solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people (Department of Health and Social Care).