



A literature review on mental health law clients

April 2026

The Scottish Legal Aid Board

www.slab.org.uk

Contents

I. Introduction	4
Research aims and objectives	4
Research scope	4
How to approach this paper	4
II. Definitions	5
III. Key legislation	6
The Adults with Incapacity (Scotland) Act 2000 (AWI Act)	6
The Mental Health (Care and Treatment) (Scotland) Act 2003 (The 2003 Act)	10
The Mental Health (Scotland) Act 2015 (The 2015 Act)	12
IV. Scottish Mental Health Strategies	13
Delivering for Mental Health (2006)	13
Towards a Mentally Flourishing Scotland (2008 – 2011)	14
Mental Health Strategy for Scotland: 2012 – 2015	15
Mental Health Strategy for Scotland: 2017 – 2027	16
Scottish Mental Health Law Review: 2019 - 2022	16
The Mental Health and Wellbeing Strategy for Scotland (2023)	19
V. Stakeholder Mapping	20
The Scottish government	20
The Convention of Scottish Local Authorities (COSLA)	21
The Mental Welfare Commission for Scotland	21
The Mental Health Tribunal for Scotland	22
The Office of the Public Guardian (Scotland)	22
The Guardianship Court	22
The Scottish Legal Aid Board (SLAB)	23
Solicitors	23
Independent Advocates	23
NHS Scotland	24
VI. SLAB's internal data and previous studies	24
Best Value Review: Mental Health (2010)	25
SLAB's monitoring reports (2013 – 2017)	26
SLAB's annual reports on mental health (2014 – 2025)	26
SLAB's annual reports on adults with incapacity (2014 – 2025)	27

SLAB’s annual reports on power of attorney (2014 – 2025).....	27
Recent studies and reports.....	28
VII. Trends and statistics	29
In Scotland.....	29
A. The Scottish Health Survey (SHeS).....	29
B. Scottish Public Health Observatory (ScotPHO).....	30
C. The Mental Welfare Commission for Scotland (MWCS)	31
D. The Office of the Public Guardian (Scotland)	32
E. Mental Health Tribunal for Scotland (MHTS)	33
F. Public Health Scotland	33
In the UK	34
In the European Union (EU).....	35
Literature Review	36
Stigma and public attitudes.....	36
Mental Health Services in Scotland.....	37
Perceived barriers to legal services	38
VIII. Conclusion	38
End Notes	39

I. Introduction

A large proportion of cases administered annually by the Scottish Legal Aid Board (SLAB) are mental health related. They fall into three categories: (1) mental health, (2) adults with incapacity (AWI), and (3) power of attorney (POA). For mental health cases, the applicant is the patient themselves, while for AWI cases, a family member seeking guardianship is usually the applicant, instead of the adult subject of the guardianship. Lastly, for POA cases, the applicant is the adult who still has capacity to make decisions for themselves. Although these three groups are somewhat distinct with different needs and characters, in this report, they constitute what we call “mental health law clients”, and hence, the focus of this report.

Despite their importance, mental health law clients have been routinely excluded from SLAB’s civil applicant surveys due to their vulnerability and the lack of reliable means to contact them. As a result, there exists a gap in SLAB’s understanding of their needs and the requirements for service design. This paper is the first step towards addressing this gap by way of a literature review.

Research aims and objectives

The aims of this paper are two-fold:

- 1) to produce a comprehensive understanding via desk-based review of the latest data and publication about mental health, AWI and POA
- 2) to understand the limits of what we can find out via the literature review.

The specific objectives include:

- understanding the relevant legislation, national strategies, and key stakeholders involved in the Scottish legal system dealing with mental health, AWI and POA cases
- exploring the mental health law clients’ experience and journeys through the Scottish mental health legal system, i.e. the mental health tribunal
- examining data to identify current trends and existing issues with the legal aid system pertaining to mental health, AWI and POA cases
- exploring options that may improve the accessibility and availability of legally aided services for mental health law clients
- determining whether routine exclusion from general applicant surveys is justified.

Research scope

The scope of this paper includes “mental health” and “adults with incapacity” civil cases, alongside “power of attorney” cases, while excluding criminal cases where mental issues might play a role. For instance, the paper does not deal with accused or convicted persons, who have a significant mental illness or learning disability, as defined in the Criminal Procedure (Scotland) Act 1995.

How to approach this paper

The paper is intended as a comprehensive, yet concise, compilation and analysis of the latest literature and data on the subject. For internal readers, the paper serves as a “one-stop-shop”,

where colleagues can find most relevant information in one place, and hence, it can be effectively used as an easy-reading introduction or a reminder to the topic. For external readers, this paper offers insights into SLAB's internal data and shows SLAB's commitment to seeking continuous improvement in our work, which is grounded in data and evidence.

The paper is organised as follows. Section II familiarises readers with a list of definitions, which are used widely by key stakeholders in the field. Therefore, it serves as a point of departure for the discussion and analysis that follow. Section III summarises the most important legislation in Scotland pertaining to mental health, POA and AWI in chronological order. In section IV, we discuss a series of national strategies adopted in the last two decades by the Scottish Government (SG) to help tackle mental health issues amongst the population. In section V, we attempt to sketch an overview of the mental health landscape with key organisations involved, their primary functions and relationships with one another. Although this stakeholder mapping exercise is not meant to be exhaustive, we hope to provide a concise and accurate depiction of the ways the mental health system works in Scotland. Section VI deals with internal data and previous studies conducted by SLAB to help explore what is known internally on the subject. Section VII provides the latest external data on trends of mental health issues in Scotland, the UK, and around the world to help put our understanding in a wider context. In section VIII, we review literature that deals with mental health, POA and AWI within the Scottish context to examine which aspects of the subjects have been well-studied and where the gap lies. Finally, in section IX, we discuss key findings and the state of our existing knowledge.

II. Definitions

This section provides concise definitions of common terms used throughout the legal and professional field of mental health as defined by the Scottish government, Mental Welfare Commission for Scotland, and as found in key legislation. It thus serves as a point of departure and a quick reference for key terms in this report.

- **Mental health:** is a part of our overall health, alongside our physical health. It is what we experience every day, and like physical health, it ebbs and flows daily.¹
- **Mental wellbeing:** is our internal positive view that we are coping well psychologically with the everyday stresses of life and can work productively and fruitfully.¹
- **Mental illness:** is a health condition that affects emotions, thinking and behaviour, which substantially interferes with or limits our life. Mental illness is a term used to cover several conditions (e.g. depression, post-traumatic stress disorder, schizophrenia) with different symptoms and impacts for varying lengths of time for each person. Mental illnesses can range from mild through to severe illnesses that can be lifelong.¹
- **People with mental health:** as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003, people with mental health are regarded as people with 'mental disorder', covering mental illnesses, personality disorders, and learning disabilities.²

¹ [Scottish Government | Mental health and wellbeing strategy – Definitions.](#)

² [Scottish Government \(Sandra McDougall\) | Mental Health Act – what's it all about: introduction.](#)

- **Adult with Incapacity (AWI):** as defined in the Adults with Incapacity (Scotland) Act 2000, AWI is defined as people aged 16 or over who lack capacity to take some or all decisions for themselves due to a mental disorder or an inability to communicate.³
- **Mental health service users:** people who receive treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 are known as mental health service users, or shortly as service users.²
- **Named persons:** those who have been chosen to help protect the interests of people who need treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003.⁴
- **Listed persons:** those who have a limited right to apply or appeal to the Mental Health Tribunal on the service user's behalf, in case where the service user does not have a named person. Listed persons are usually the carer, nearest relative, guardian or welfare attorney of the service user.
- **Carers:** The Mental Health (Care and Treatment) (Scotland) Act 2003 says a carer is someone who gives a person care and support when they need it.⁴
- **Mental Health Officers:** A mental health officer is a social worker who has special training and experience in working with people who have a mental illness, learning disability, dementia or related condition.⁴
- **Independent advocacy:** independent advocacy supports people to speak up, to understand what is being said, and to make decisions. Advocates and advocacy workers are independent and do not work for hospitals, social work or other statutory services.⁴
- **Power of attorney (POA):** is a legal document which allows a person to plan for their future when they have the capacity to do so. It gives another person (known as the attorney) the authority to deal with their affairs, be it personal welfare or financial/ property matters. The power of attorney must be certified by a solicitor or a medical practitioner and be registered with the Office of the Public Guardian before it can take effect.⁵

III. Key legislation

Since health and social services are devolved matters, the Scottish Parliament has power to make laws on a range of issues, including mental health law.⁶ This section provides a summary of key legislation on the topics of mental health, adults with incapacity, and power of attorney.⁷

The Adults with Incapacity (Scotland) Act 2000 (AWI Act)

The AWI Act was one of the first pieces of social legislation passed by the Scottish Parliament.⁸ It introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves.⁹

³ [Scottish Government | Adults with incapacity – Social care.](#)

⁴ [Mental Welfare Commission for Scotland | Mental Health Act.](#)

⁵ [Scottish Government | Setting up power of attorney.](#)

⁶ [Scottish Parliament | Devolved and Reserved Powers.](#)

⁷ [Scottish Government | Mental health – Legislation and guidance.](#)

⁸ [Office of the Public Guardian in Scotland | Adults with Incapacity Scotland Act.](#)

⁹ [Scottish Government | Adults with Incapacity \(Scotland\) Act 2000: principles.](#)

The AWI Act defines adults with incapacity as people aged 16 and over, who are incapable of either acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memories of decisions. The reason for their incapacity can be mental disorder or physical disability, but it does not include a lack or deficiency in a faculty of communication that can be made good by human or mechanical aid.¹⁰ As a result, the AWI Act applies to people with a learning disability, dementia, a mental health condition, head injury, or physical disability that prevents them from communicating.¹¹

Five principles of the AWI Act

The AWI Act is underpinned by five principles, which anyone taking action under the Act must apply when making decisions on behalf of the adult or deciding which measure will be most suitable for meeting the need of the individual.⁹ They include:

- a) **Benefit:** Any action or decisions taken must benefit the adult and only be taken when that benefit cannot reasonably be achieved without it.
- b) **Least restrictive option:** Any action or decision taken should be the minimum necessary to achieve the purpose.
- c) **Considering the wishes of the adult:** When a decision is to be made, account should be taken of the present and past wishes and feelings of the adult.
- d) **Consultation with relevant stakeholders:** When a decision is to be made, account should be taken of the views of relevant people (such as, the nearest relative and the primary carer of the adult, the adult's named person, any relevant guardian or attorney, and so on), so far as it is reasonable and practicable to do so.
- e) **Encouraging the adult:** The adult shall be encouraged to exercise whatever skills they have concerning property, financial affairs or personal welfare, in so far as it is reasonable and practicable to do so.

Types of intervention

Where an adult is found to have incapacity, the AWI Act makes provisions for different types of intervention. Some of the key types of interventions are discussed below.

- a) **Guardianship:** when an adult has already lost their capacity, a guardian may be appointed to make decisions on their behalf. A guardian must be appointed by a court, following an application for guardianship. A guardianship order made by the court is used in situations where there is a continuous need to get involved in the affairs of an adult with incapacity.¹² A guardian can be given different powers to look after the adult with incapacity's: personal welfare including medical care (a welfare guardian), property and finances (a financial guardian), or both.¹³
- b) **A power of attorney (POA):** A power of attorney is authority given by an individual with capacity, known as the granter, to other people, known as the attorney, to deal with aspects

¹⁰ [Legislation.gov.uk | Adults with Incapacity \(Scotland\) Act 2000.](https://legislation.gov.uk/ukpga/2000/57/section/1)

¹¹ [Care Information Scotland | Adults with Incapacity \(Scotland\) Act 2000.](https://www.scotland.gov.uk/topics/health-and-social-care/care-information-scotland/adults-with-incapacity-act-2000)

¹² [Scottish Parliament | SPICe Briefing – Adults with incapacity by Laura Gilman, January 2022.](https://www.scottish.parliament.uk/SPICe/Briefing/Briefing%20-%20Adults%20with%20incapacity%20by%20Laura%20Gilman,%20January%202022)

¹³ [Mental Welfare Commission for Scotland | Adults with Incapacity Act.](https://www.mentalwelfarecommission.org.uk/adults-with-incapacity-act)

of the granter's affairs.¹³ Similar to guardianship, the attorney may exercise powers over property and finances (a continuing attorney), welfare decisions (a welfare attorney), or a combination of these.¹⁴ The key difference between a POA and a guardianship is that the POA is a self-appointed choice made by the granter when they still have capacity, whereas guardianship is a court-imposed solution for people who have already lost their capacity. While POA is usually a quick and straightforward process, guardianship requires court application, which is time-consuming and expensive.¹⁵

- c) **Intervention order:** An intervention order is made by a court to appoint someone to undertake a one-off action or actions on behalf of an adult with incapacity. This can include actions such as selling a house or signing legal documents, which need to happen once only. Once the action is complete, the powers to intervene on behalf of the adult with incapacity end.¹⁶
- d) **Access to funds:** The access to funds scheme allows an individual, local authority or another organisation to apply for authority to access and manage the funds belonging to an incapable adult. The application is made directly through the Public Guardian and does not require a court order. The Public Guardian can also transfer an application to the local sheriff court.¹⁷

Latest development of the AWI Act

The AWI Act was amended in late 2007 and early 2008, after an extensive consultation exercise with stakeholders and customers had been carried out.¹⁸ The amendments to the AWI Act were brought into force as a part of the Adult Support and Protection (Scotland) Act 2007, which received Royal Assent on 22 March 2007.¹⁹ The AWI Act was amended with “a view to improving how it operates in practice”, followed a two year project monitoring the implementation of the Act. The key improvements to the practical operations of the AWI Act include:

- Applications and proceedings: the sheriff shall consider the incapable adult’s wishes and feelings, as expressed by a person providing independent advocacy services
- Clarifying orders about incapable adults nearest relatives
- The continuing power of attorney: when it is exercisable, by whom, and how it can be revoked in practice
- Accounts and funds: concerning intromission (that is, the assuming of the possession or management of someone else’s property) with the incapable adult’s funds and related

¹⁴ [Scottish Parliament | SPICe Briefing – Adults with incapacity by Laura Gilman, January 2022.](#)

¹⁵ [Burnett & Reid | Understanding the Difference Between Power of Attorney & Guardianship.](#)

¹⁶ [Scottish Parliament | SPICe Briefing – Adults with incapacity: Intervention order by Laura Gilman, January 2022.](#)

¹⁷ [Scottish Parliament | SPICe Briefing – Adults with incapacity: Access to funds by Laura Gilman, January 2022.](#)

¹⁸ [Office of the Public Guardian in Scotland | Adults with Incapacity Scotland Act.](#)

¹⁹ Since the Adult Support and Protection (Scotland) Act 2007 dealt with a much wider range of adults in need of support, including adults at risks of harm, adults with incapacity, and so on, this 2007 Act will not be explored in detail in this report. For more information see: [Adult Support and Protection \(Scotland\) Act 2007.](#)

processes for determination, suspension, termination, and renewal of the authority to intrude

- Intervention orders: adding further clarification to the section, including what happens after the death of the person who is authorised to intervene
- Guardianship orders: adding further clarification to the section, including recalling the guardianship orders, death of the guardian, and guardianship orders for children
- Power to obtain records: further clarification on Public Guardian’s power to obtain records

Most recently, SG announced a new consultation (between 25 July and 17 October 2024) seeking views from across Scotland on proposed changes to the AWI Act. Those changes were intended to “put the adult front and centre of the legislation”,²⁰ as well as addressing the recent changes in both legislation (for instance, the United Nations Convention on the Rights of Persons with Disability) and case law (for example, the Bournemouth and Cheshire West cases)²¹. This was the first step in a wider programme of work to reform mental health and incapacity law in Scotland over the next ten years, following the recommendations of the Scottish Mental Health Law Review.²² The consultation seeks views on suggestions for change to the AWI Act, which include:

- Improving access to justice for adults affected by the AWI Act
- Shifting the focus of the AWI Act on the adult
- Making it easier for adults to access rights
- Supporting adults to make and act upon their decisions as long as possible
- If the adult lacks capacity, ensuring that their will and preferences are followed as much as possible
- Making reform on authority for research.

Regarding the last point, the Chief Scientist Office has developed a few proposals, which might have significant impacts on how research on adults with incapacity might be conducted in the future.²³ The proposals are summarised as follows:

- Establishing more than one ethics committee for reviewing research proposals involving adults with incapacity in Scotland
- Permitting adults with incapacity to be included in research studies without consent for those types of research which do not require consent from adults with capacity
- Allowing adults with incapacity to participate in research on conditions other than those responsible for their incapacity
- Permitting waivers of consent in emergency situations to involve adults with incapacity, when it is not practical or realistically possible to seek consent from the individual’s guardian, welfare attorney or nearest relatives

²⁰ [Scottish Government | Adults with Incapacity Amendment Act: consultation.](#)

²¹ [House of Lords – Mental Capacity Act 2005: post-legislative scrutiny – Select Committee on the Mental Capacity Act 2005.](#)

²² [Scottish Government | Adults with Incapacity Amendment Act: consultation.](#)

²³ [Chief Scientist Office | Adults with Incapacity Amendment Act: Consultation \(Rongieras, 2024\).](#)

- Expanding the list of people permitted to provide consent for adults with incapacity to take part in research studies.

The Mental Health (Care and Treatment) (Scotland) Act 2003 (The 2003 Act)

Overview

The Mental Health Act 2003 came into force in 2005 to replace the previous 1984 Act²⁴. The 2003 Act covers a range of issues including²⁵:

- when people can be taken into hospital against their will
- when people can be given treatment against their will
- people's rights and safeguards to make sure that their rights are protected.

Amongst them, safeguarding is the overarching approach of the 2003 Act. It ensures that the law and practice for those who require compulsory care and treatment are driven by core principles, particularly minimum restriction in individual liberty with the maximum benefit for the patient.²⁶ Detention in hospitals and compulsory medical treatment on grounds of mental disorder is allowed by the 2003 Act under very strict circumstances. The 2003 Act also guarantees the rights of patients to independent advocacy, an independent Mental Health Tribunal for Scotland, and the independent Mental Welfare Commission. Key components of the 2003 Act will be explored in more detail below.

Ten principles of the 2003 Act

The 2003 Act was based on ten principles, which helped guide and any actions taken under the Act. They include:

- non-discrimination, equality, and respect for diversity principles**, which ensure that the power of the Act would be exercised equally without discrimination and have respect for the background of the service user.
- reciprocity, participation and respect for carers principles**, which lay out the roles, responsibility, and the respect required for key stakeholders involved in the treatment process, including service users, health and social care authorities, and carers.
- informal care, least restrictive alternative, and benefit principles**, which specify the types of care that should be delivered under the power of the Act, for example, informal care is preferred, with treatment and support chosen in the least invasive manner, and with a focus on producing a benefit for the service user.
- child welfare principle**, which dictates that the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the power of the Act.

²⁴ [Headway | A guide to the Mental Health Act in Scotland.](#)

²⁵ [Scottish Government \(Sandra McDougall\) | Mental Health Act – what's it all about: introduction.](#)

²⁶ [Scottish Government | Legislative framework – Mental health and wellbeing strategy.](#)

The power of the Act

There are three types of compulsory powers defined in the 2003 Act:

- 1) **Emergency detention:** allows someone to be detained in hospital for up to 72 hours in an urgent situation where hospital admission is needed to help assess the person's condition. It will only take place under a doctor's recommendation. In addition, an agreement with a mental health officer should also be obtained, unless it is not possible for this consultation to take place. There is no right of appeal to the Tribunal against an emergency detention certificate. This is because it would not be practical to organise an appeal in such a short time.²⁷
- 2) **Short-term detention:** allows someone to be detained in hospital for up to 28 days.²⁸ This only takes place if recommended by a specially trained doctor (a psychiatrist) and agreed by a mental health officer. The service user or their named person can apply to the Tribunal to have the short-term detention certificate revoked. They are entitled to legal aid (covered by advice by way of representation (ABWOR) to have a solicitor represent them at any Tribunal hearings.
- 3) **Compulsory Treatment Order (CTO):** allows someone to be detained in the hospital or in the community for the initial period of six months, with the possibility of further six-month and 12-month extensions. Only a Tribunal has the power to approve, amend or extend a CTO.

A CTO application needs to include two medical recommendations and a detailed care plan, which specifies the care and treatment proposed for the patient.

The patient, the patient's named person, and the patient's primary carer would be entitled to have their objections heard by the Tribunal. The patient and the named person would be entitled to ABWOR for the Tribunal hearing.

Conditions for the use of power under the Act

The power of the 2003 Act is exercised under strict conditions, which include:

- the person has a mental disorder
- available medical treatment could stop their condition getting worse or help treat some of their symptoms
- significant risks to the person or to others if medical treatment was not provided
- the person's ability to make decisions about medical treatment is significantly impaired due to their mental disorder
- it is necessary to use compulsory orders.

²⁷ [Scottish Government | Mental Health Act – emergency and short-term powers: guide.](#)

²⁸ Under the Mental Health Act (2008 version), it is possible for the certificate to be extended beyond the 28-day period. For instance, if your condition got worse, you can be detained for a further three days to allow time to prepare an application for a CTO. Where an application for a CTO has been submitted to the Tribunal, you can be detained in the hospital for further five days under the short-term detention certificate. Further information [here](#).

In addition to those conditions, the 2003 Act also specified the roles and responsibilities of health and care authorities, such as the Mental Health Tribunal for Scotland, to help safeguard the rights of mental health service users. Detail discussion of the key stakeholders involved in the provision of mental health care and services in Scotland is provided below.

The Mental Health (Scotland) Act 2015 (The 2015 Act)

The Mental Health (Scotland) Act 2015 received Royal Assent on 4 August 2015.²⁹ The 2015 Act introduced several amendments to the 2003 Act, which allowed mental health service users to gain access to treatment quickly and easily, as well as measures around named persons, advance statements and advocacy. In particular, the 2015 Act specified the following key provisions on:³⁰

- **Excessive security:** the 2015 Act allowed regulations to extend the right of appeal against being detained in an excessive level of security to qualifying patients in qualifying hospitals - namely the Orchard Clinic, Rowanbank Clinic and the medium secure service at Rohallion Clinic.
- **Named persons:** the 2015 Act removed provisions for the appointment of named persons by default, so that adult patients only have a named person if they choose to have one, although this does not apply to patients under 16. In cases where the service user had no named person, the 2015 Act introduced a limited right for listed person to apply or appeal to the Mental Health Tribunal on the patient's behalf. The 2015 Act also removed the power of the Tribunal to appoint or substitute a named person for adult patients and required named persons to agree to taking on the role in writing.
- **Advance statements:** the 2015 Act required NHS Boards to keep a copy of any advance statements received with the patient's records and to provide information about them to the Mental Welfare Commission, so that the information can be held on a register of information.
- **Independent advocacy:** the 2015 Act required local and healthcare authorities to provide information to the Mental Welfare Commission about how they are meeting their duties to provide independent advocacy services, at least every two years.
- **Suspension of detention:** the 2015 Act made amendments to provisions on detention. For example, the maximum detention time allowed was amended to 200 days in any 12 month period, excluding any period of less than eight hours.
- **Cross-border transfers and absconding patients:** the 2015 Act included a right of appeal against the transfer for the named person or listed person, as well as setting out provisions governing medical treatment to patients, who have absconded to Scotland from elsewhere.

Apart from these key provisions, the 2015 Act made several minor amendments to the 2003 Act with regards to supporting patients in certain circumstances (such as mothers with

²⁹ [Mental Health Law Online | Mental Health \(Scotland\) Act 2015.](#)

³⁰ [Scottish Government | Mental Health Scotland Act 2015: key provisions.](#)

postnatal depression), deaths of patients in hospital for treatment, and technical changes to operations of orders and certificates.³¹

The 2015 Act also introduced a Victim Notification Scheme for victims of mentally disordered offenders³² and made some changes to the Criminal Procedure (Scotland) Act 1995 in relation to mental health disposals in criminal cases.

IV. Scottish Mental Health Strategies

Improving mental health, as well as preventing and treating mental illness, has been a priority for the Scottish Government (SG) for the past two decades.³³ This section is dedicated to examining a series of strategies championed by SG to help address mental health issues in Scotland.

Delivering for Mental Health (2006)

Delivering for Mental Health is the first “national Mental Health Delivery Plan” devised by SG after the enactment of the 2003 Mental Health law.³⁴ This strategy mainly focused on the delivery of mental health services in NHS settings, but it also touched on early detection, prevention and intervention of mental health issues in local and community settings. It sets three targets for Scotland to achieve:

- **Target 1:** Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009-10
- **Target 2:** Reduce suicides in Scotland by 20% by 2013 (compared with existing target)
- **Target 3:** Reduce the number of readmissions (within one year) for those that have had a hospital admission of over seven days by 10% by the end of December 2009.

To achieve the three targets, SG had pledged to:

- a) develop tools and standards to help better assess patients and provide them with appropriate therapies and treatments
- b) implement new training or improving existing ones for key mental health services staff and support workers
- c) promote effective care in local and community settings for mental health patients to avoid inappropriate admissions to the hospital. Nevertheless, evidence suggests that these approaches were largely unsuccessful in meeting SG’s targets.ⁱ

³¹ For more information, see [Mental Health \(Scotland\) Act 2015 – Explanatory Notes](#).

³² Scheme became operational in September 2017. It is a statutory scheme which makes sure victims of a mentally disordered offender can be made aware of information about that offender and can make representations before decisions are taken about that offender. For more information: [Offenders with a Mental Disorder – Guidance for Victims Eligibility and Registration](#).

³³ [Scottish Government | Mental Health Strategy: documents and progress reports](#).

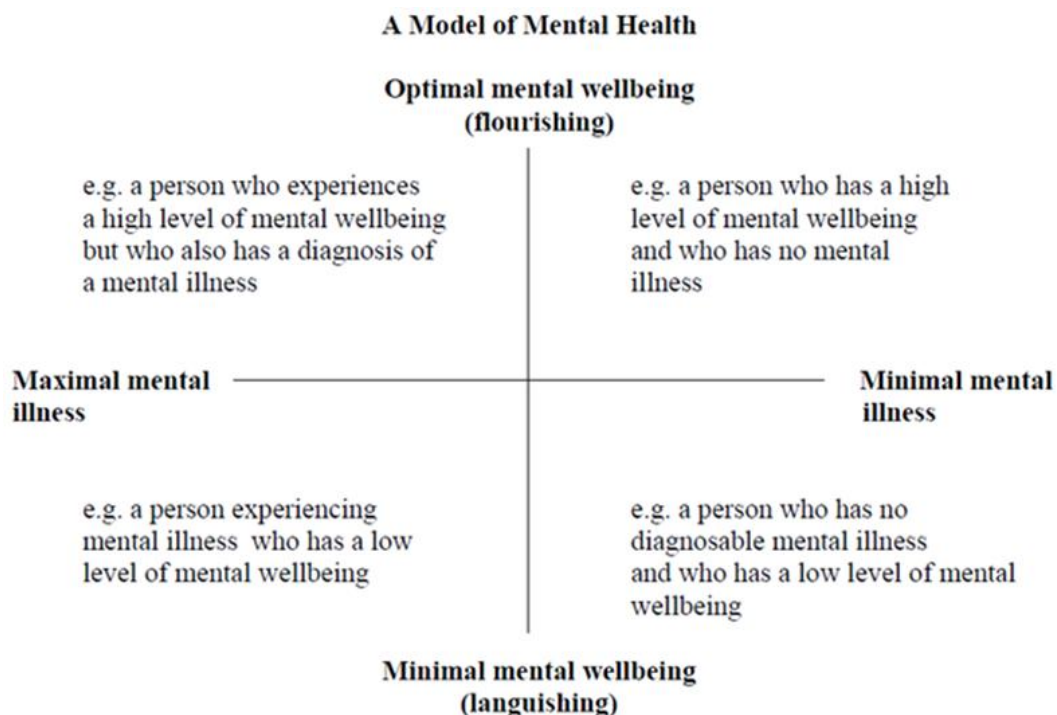
³⁴ [Scottish Government | Delivering for Mental Health: plan](#).

Towards a Mentally Flourishing Scotland (2008–2011)

In October 2007, SG began consultation on a new national programme, titled “Towards a Mentally Flourishing Scotland”, with a scheduled implementation of the action plan between April 2008 and March 2011.³⁵

In this strategy, SG’s vision of what a mentally flourishing Scotland would look like was “there is no health without good mental health” and “people have a capacity for change [to improve their own mental wellbeing]”.³⁵ It was the job of national and local government and other agencies to help set the context, conditions and opportunities for this change to happen. In addition, the strategy also came with a set of formally defined terms and concepts, including:

- **Mental wellbeing:** refers to three dimensions – emotional, social, and psychological wellbeing. Mental wellbeing consists of a continuum ranging from high or flourishing mental health at one end to poor or languishing mental health at the other end.
- **Mental health problems:** refer to having difficulties with mental health which affect how people go about their everyday lives.
- **Mental illness:** refers to clinically identifiable illnesses or conditions that affect our cognitive function. Mental illness can also be described as a continuum from high to low levels of mental illness.
- **Dual continua model of mental health:** as mental wellbeing and mental illness exist in two different continua, it is possible for one to have high levels of mental wellbeing while being low in mental illness, and vice versa (See Figure 1 below).



SG proposed to take forward the action plan through three main themes:

³⁵ [Scottish Government | Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-2011.](#)

- 1) promotion of mental health, focusing on increasing key protective factors and reducing key risk factors
- 2) prevention of common mental illnesses, such as depression and anxiety, and focus on the interaction between mental illness and other health conditions
- 3) supporting the improvement in quality of life, addressing stigma and discrimination and promoting equality of opportunity for people with mental health problems.

The strategy also emphasised the need to “targeting efforts at those who need it most”, since mental health problems were not randomly distributed across populations.³⁵

Mental Health Strategy for Scotland: 2012–2015

The 2012-15 Mental Health Strategy for Scotland was the direct successor to the Delivering for Mental Health and Towards a Mentally Flourishing Scotland strategies. It was built on a vision that “by 2020 everyone is able to live longer healthier lives at home, or in a homely setting”.³⁶ As a result, the healthcare system in Scotland was envisioned to have integrated health and social care with “a focus on prevention, anticipation and supported-self management”. This meant that when hospital treatment was required, day care treatment would be the norm, and people would get back to their home or community environment as soon as appropriate.

The 2012-15 mental health strategy fully adopted the following three qualities:

- 1) **person-centred:** representing the mutually beneficial partnerships between patients, their families and those delivering healthcare services.
- 2) **safe:** meaning no avoidable injury or harm to people from the treatment they receive, and safe environment for always delivering healthcare services
- 3) **effective:** referring to the provision of the most appropriate treatments, interventions, support and services at the right time to everyone who might benefit, while eradicating wasteful or harmful variation.

In addition, the strategy focused on four key areas of change:

- a) **Child and adolescent mental health:** SG identified this as the most vulnerable group, as well as “a critical opportunity to intervene to break cycles of poor outcomes”.
- b) **Common mental health problems:** SG promised more readily available therapies, as well as a wider range of responses from social prescribing to self-help, to tackle common mental health problems, such as depression and anxiety.
- c) **Integrated mental health services:** SG envisioned that a well-functioning mental health system had a range of community, inpatient and crisis mental health services, with “the broad direction of change towards developing more services based in the community”.
- d) **Other services and population:** with a focus on improving services to other population groups, such as women, veterans, and people with neurodevelopmental disorders.

³⁶ [Scottish Government | Policy Context - Mental Health Strategy for Scotland: 2012-2015.](#)

Mental Health Strategy for Scotland: 2017–2027

In 2016, SG legislated to bring together health and social care into an integrated system. The integration was aimed at improving the care and support for service users, their families and carers by “joining up services and focusing on anticipatory and preventative care.”³⁷

Consequently, a new ten-year national strategy for integrated health and social care was developed by SG and announced in March 2017.³⁸

In this strategy, the government pledged to “prevent and treat mental health problems with the same commitment, passion and drive as... physical health problems” and that “you should only have to ask once to get help fast”.³⁸ The main focus of the strategy was to address the inequality which caused mental health problems to be more prevalent and severe in some groups compared to others. In particular, the strategy’s actions were aimed at:

- **Prevention and early intervention:** improve support and training for people who handle the mental health and wellbeing of children and young people in educational settings, children with conduct disorders, and those in the justice system
- **Access to treatment and joined-up accessible services:** increase the mental health workforce, improve the quality of therapy services, develop more accessible self-help resources, and improve arrangements for dual diagnosis for people with problem substance use
- **Rights, information use and planning:** review the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 to ensure it fulfils the needs of people with learning disability and autism, and reform Adults with Incapacity (AWI) legislation
- **Data and measurement:** develop a quality indicator consisted of six dimensions:
 - i. person-centred
 - ii. safe
 - iii. effective
 - iv. efficient
 - v. equitable
 - vi. timely.

A full progress review was planned to be carried out in 2022, the halfway point of the strategy, to ensure that lessons were learned from the actions taken. Nonetheless, an independent report published by Audit Scotland in September 2023 found that progress against commitments in the 2017-27 Mental Health Strategy was “mixed” and despite further financial, operational and workforce commitments, SG was not on track to achieve them.³⁹

Scottish Mental Health Law Review: 2019 - 2022

The Scottish Mental Health Law Review was commissioned by SG in 2019⁴⁰ to ensure mental health and incapacity legislation in Scotland was more aligned with recent human rights

³⁷ [Scottish Government | Health and social care integration - Social care.](#)

³⁸ [Scottish Government | Our Vision - Mental Health Strategy 2017-2027.](#)

³⁹ [Audit Scotland | Adult mental health \(September 2023\).](#)

⁴⁰ [BBC News | Scottish mental health legislation to be reviewed \(March 2019\).](#)

developments. The Review brought together a wide range of stakeholders, including academics, professionals, people with lived experience, unpaid carers, and other third-party organisations, with an aim of improving the rights and protections of people with incapacity, mental health disorder, and intellectual disabilities.⁴¹ The outcome of this three-year consultation was a 944-page report with over 200 recommendations, published in September 2022.⁴²

In this report,⁴³ the authors recommended going beyond changes to the law to improve the rights and protections of people who were subjected to mental health, incapacity or adult support and protection legislation. Their recommendations included:

- 1) improving awareness for the public and practitioners,
- 2) participation of people with relevant lived experience,
- 3) dissemination of good practice and improved shared vocabulary,
- 4) changing the laws.

It was argued that the primary focus of the existing Scottish legislation was on “authorising and regulating actions which encroach on an individual’s autonomy” and “generally not concerned with ensuring that wider human rights are met” (p.11).⁴³ Therefore, the report proposed a human rights approach, in which all the human rights of people under the legislation should be respected, protected and fulfilled.

The authors also criticised existing laws for being predicated largely on the concept of ‘mental disorder’, which was regarded as “a stigmatising and offensive term”. They argued that the diagnostic criterion of mental disorder violated the UNCRPD⁴⁴ anti-discrimination requirements regarding the right to exercise legal capacity (Article 12) and the right to liberty (Article 14). Therefore, they proposed reforming Scottish mental health and incapacity laws as a supportive piece of legislation and based on non-discriminatory grounds. The new legislation, argued the authors, should use a more inclusive definition, which applied to “anyone who needs support arising from any aspect of their mental health or cognitive functioning.” (p. 12).⁴³

In the long-term, the authors envisioned unifying the mental health and incapacity laws into a single Act, while excluding adult support and protection law in the unified legislation. They argued that mental health and incapacity legislation could be made to align incrementally, with harmonised language, a shared definition of who the law applied to, and information sharing as the biggest benefit coming from the alignment. The authors argued that, in principle, future legislation should “be more about helping people with a mental or intellectual disability to live well and enjoy their lives without stigma or prejudice” (p.15).⁴³

The proposed principles are summarised in the table below.

⁴¹ [Edinburgh Napier University Innovation Hub | Scottish Mental Health Law Review.](#)

⁴² [BBC News | Review calls for major overhaul of Scotland's mental health laws \(September 2022\).](#)

⁴³ [Mental Welfare Commission for Scotland | Scottish Mental Health Law Review – Final Report: Executive summary and recommendations \(2022\).](#)

⁴⁴ [United Nations | Convention on the Rights of Persons with Disabilities \(CRPD\).](#)

No.	Principles	Description
1	Dignity	Respecting the inherent dignity of any individual who may seek or be offered support for a mental or intellectual disability.
2	Inclusion	Facilitating full and effective participation and inclusion of people with a mental or intellectual disability in society and in all decisions affecting them individually and collectively.
3	Autonomy	Respect for the individual autonomy of people with a mental or intellectual disability, and their will and preferences including past and present wishes.
4	Equality	Respect for difference, and acceptance of people with a mental or intellectual disability as part of human diversity and humanity who retain the same rights and entitlements as those with other health needs.
5	Non-discrimination	Avoid discrimination based on disability or any other characteristic.
6	Respect for carers	Consider the needs of anyone who is a carer and provide them with information that may assist them to care for the individual.
7	Respect for the rights of the child	Any interventions concerning a person aged under 18 shall respect the rights of that person under the UNCRC and UNCRPD.
8	Benefit	The intervention must provide benefit to the person which could not reasonably be otherwise provided, and which can be justified with respect to the human rights of the person overall.
9	Least restrictive alternative	The intervention is the least restrictive alternative of the options likely to fulfil the aims of the intervention.
10	Reciprocity	Where an individual is required under the legislation to comply with a programme of treatment and care, there shall be a parallel obligation on health and social care authorities to provide suitable care and support, including, but not restricted to, after compulsion.

Table of Principles of the future unified legislation on mental health and incapacity.

While the legislative reforms might take years to develop, it was recommended that a reform of the Adult with Incapacity (AWI) Act would be urgently needed. Evidence from the 2018 AWI consultation suggested that “many of the processes within the legislation had become overly cumbersome and were no longer fit for purpose” (p.105).⁴³ As a result, the authors made a number of recommendations to reform the AWI legislation, some of which include:

- 1) ensuring the will and preferences of the adult are prioritised
- 2) amending powers of attorney (POA) which includes increasing uptake

- 3) developing further support, training and guidance for attorneys
- 4) increasing awareness of the importance of a POA
- 5) developing a new decision-making model to replace guardianship.

The Mental Health and Wellbeing Strategy for Scotland (2023)

Taking the proposals of the Scottish Mental Health Law Review into consideration, SG and the Convention of Scottish Local Authorities (COSLA) launched the Mental Health and Wellbeing Strategy for Scotland in July 2023.⁴⁵ The strategy laid out the long-term vision and approach to develop “a highly effective and well-functioning mental health system” in Scotland.⁴⁶ The strategy acknowledged that mental health was more than just mental illness but also included other “severe and enduring mental health conditions”.⁴⁶ Consequently, the strategy’s emphasis is placed upon early intervention and prevention, as well as promoting good mental health and wellbeing for all. They are known as the three pillars of “Promote, Prevent, Provide”:

- promoting positive mental health and wellbeing
- preventing mental health issues occurring or escalating while tackling underlying causes
- providing mental health and wellbeing support and care.

The strategy reflects views from more than 18 months of consultation, with a particular focus on the voices of lived experience and the role of inequalities. The strategy highlights:

- 1) the quality of services that people can expect
- 2) the importance of having services available locally whenever possible
- 3) the crucial role of specialist services in a high-functioning mental health system.⁴⁷

The Scottish Government also reported a significant increase in its investment on mental health over the years.⁴⁸ In particular, spending on mental health by NHS Scotland reached £1.3 billion in 2021-22, compared to £1.1 billion in 2019-20 and £0.7 billion in 2007-08. This represents an increase in the proportion spent on mental health to 8.8% of total spending by NHS Boards. SG's direct budget for mental health has more than doubled during the lifetime of the current Parliament, and the government aims to increase spending on mental health services to 10% of the total frontline NHS spending.⁴⁹

The government considers this as a good economic investment to help tackle the £8.8 billion loss to the Scottish economy each year due to the lost productivity of people living with mental health conditions, as well as costs incurred by unpaid informal carers.⁵⁰

⁴⁵ [Scottish Independent Advocacy Alliance | New Scottish Government Mental Health and Wellbeing Strategy Launched \(July 2023\)](#).

⁴⁶ [Scottish Government | Introduction - Mental health and wellbeing strategy](#).

⁴⁷ [Scottish Government | Improving mental health and wellbeing – New strategy for Scotland \(June 2023\)](#).

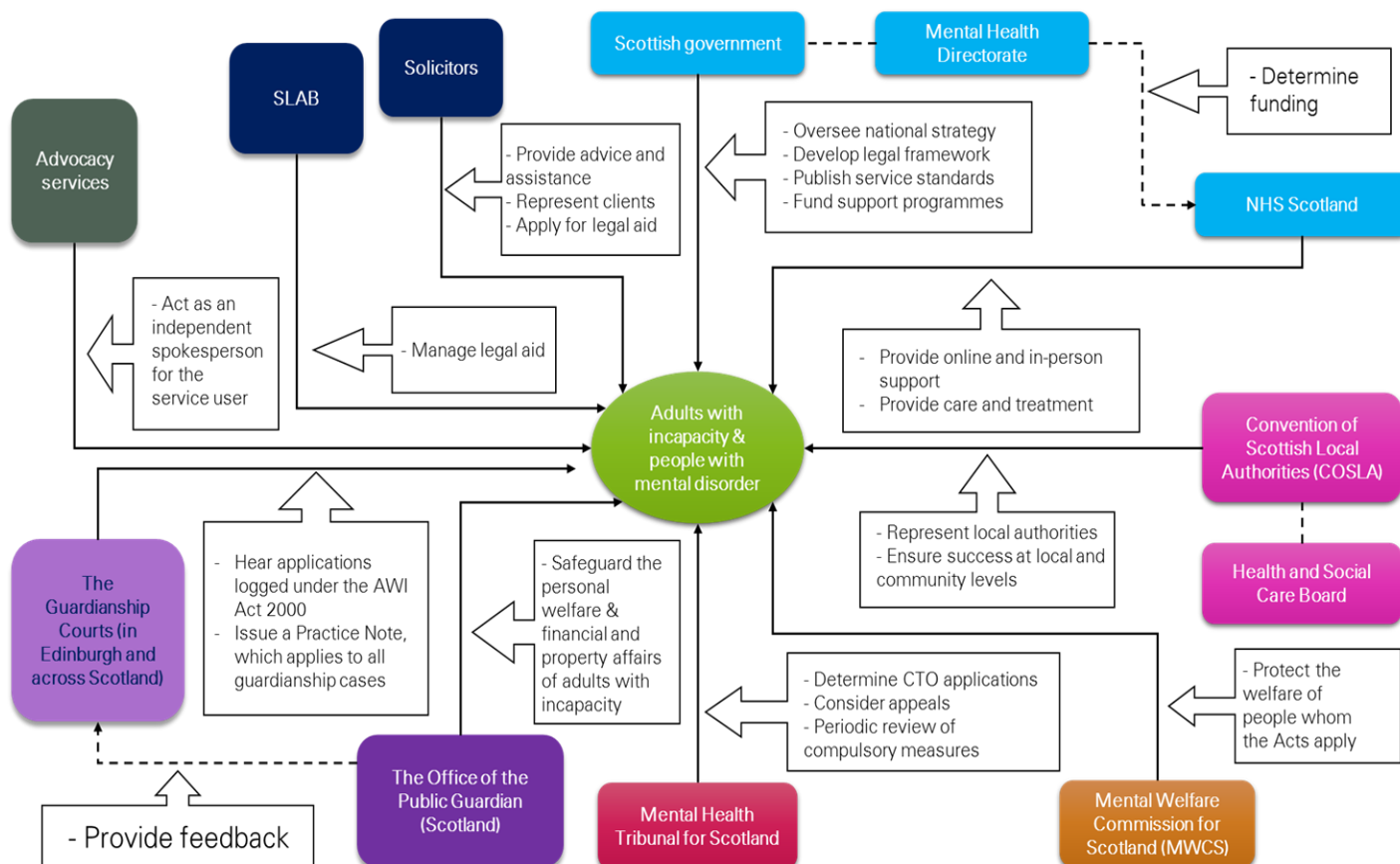
⁴⁸ [Scottish Government | Financial framework - Mental health and wellbeing strategy](#).

⁴⁹ [Scottish Parliament | Website Meeting of the Parliament: 22/05/2024](#).

⁵⁰ [Mental Health Foundation | The economic case for investing in the prevention of mental health conditions in the UK \(2022\)](#).

V. Stakeholder Mapping

This section is dedicated to mapping and outlining key stakeholders and their roles in designing, managing, delivering, and monitoring services for adults with incapacity, power of attorney, and people with mental disorder in Scotland (see Figure 2 below).



The Scottish government

The Scottish government is responsible for steering the national strategy on mental health.⁵¹ The government establishes the legal framework, under which mental health services operate, by developing bills and passing them into legislations. It also publishes policies and standards for mental health services and psychological therapies, as well as rolling out a wide range of support programmes for people in need.⁵²

Mental Health Directorate

The Mental Health Directorate leads on mental health policy and on the delivery of the mental health aspects for the Scottish government, the Mental Health Transition and Recovery Plan, the co-operation agreement with other political parties, and other key commitments. The key

⁵¹ A new Mental Health and Wellbeing Leadership Board was set up in 2024 to support and oversee the delivery of the strategy on behalf of Scottish Government. For more information, see [Leadership Board - terms of reference](#).

⁵² [Scottish Government | Mental health policy](#).

role of the directorate is to help the government manage policy around mental health, including overall policy direction, mental health services, mental health law, mental health care standards, and so on.⁵³

The Convention of Scottish Local Authorities (COSLA)

Alongside the Scottish government, COSLA is co-author and jointly responsible for the delivery of the new strategy for mental health and wellbeing in Scotland. Representing the voices of local governments, COSLA plays a key role in ensuring the success of the strategy, the quality of mental health services, and the availability of support programme for a wide range of people in need at local and community levels.

The Health and Social Care Board

The Health and Social Care Board leads on all aspects of policy development and political lobbying relating to health and adult social care on behalf of COSLA. Its central objective is to ensure that health and social care services are high-quality, sustainable, accessible, and personalised.⁵⁴

The Mental Welfare Commission for Scotland

The Mental Welfare Commission for Scotland (MWC) was originally set up in 1960 under the Mental Health Act.⁵⁵ Its duties were set out in the current legislation on adults with incapacity and mental health and wellbeing, which mainly seeks to protect the welfare of persons to whom the Acts apply. As a result, the Commission is also referred to as the mental health “watch dog”.⁵⁵

The Commission focuses on five main areas of work:

- 1) **Visiting people:** to visit people in the settings where they are receiving care and treatment to ensure the quality of care and treatment meets the user’s needs.
- 2) **Monitoring legislation:** the Commission monitors the 2003 Act, including the amendments introduced by the 2015 Act, and the welfare parts of the AWI Act.
- 3) **Investigations:** to investigate when someone with a mental disorder or learning disability is not getting the right care and treatment. If the case might be valuable for similar cases across Scotland, the Commission can undertake in-depth investigation and publish results and recommendations from the study.
- 4) **Information and advice:** the Commission gives advice and information about rights and best practice in relation to the AWI Act and the 2003 Act. The Commission can also refer people to other relevant organisations when they cannot help directly.
- 5) **Influencing and challenging:** to improve policy to help in safeguarding people and preventing things going wrong.

⁵³ [Scottish Government | Mental Health Directorate.](#)

⁵⁴ [COSLA | Health and Social Care.](#)

⁵⁵ [Mental Welfare Commission for Scotland | Who we are and what we do.](#)

The Mental Health Tribunal for Scotland

The Mental Health Tribunal for Scotland (MHTS) was created on 5 October 2005 by virtue of section 21 of the 2003 Act.⁵⁶ The Tribunal discharges its functions through panels consisting of three members: (1) a legal member (who acts as Convener), (2) a medical member and (3) a general member.

The primary role of the Tribunal is to:

- consider and determine applications for compulsory treatment orders (CTOs) under the 2003 Act
- operate in an appellate role to consider appeals against compulsory measures made under the 2003 Act
- play a monitoring role by periodic review of compulsory measures.

The Office of the Public Guardian (Scotland)

The Office of the Public Guardian (Scotland) (OPG) was created when the AWI Act received Royal Assent in May 2000.⁵⁷ The Office's key functions are to safeguard the rights, welfare, and financial and property affairs of adults with incapacity. They include:

- maintaining a public register of powers of attorney, guardianship, intervention orders, and authorisations granted under the access to funds scheme
- registering powers of attorney that are to begin or continue in the event of incapacity
- supervising people appointed to manage the financial and property affairs of adults with incapacity
- investigating circumstances where the property or finances belonging to an incapable adult appear to be at risk.

The Guardianship Court

There is no single guardianship court in Scotland, but rather, guardianship orders are granted by the local Sheriff Court.⁵⁸ For example, in Edinburgh, the guardianship court was established at Edinburgh Sheriff Court to hear summary applications lodged under the Adults with Incapacity (Scotland) Act 2000.⁵⁹

In addition, the Sheriff Principal is responsible for issuing Practice Notes, which apply to all applications for guardianship orders and intervention orders, minutes for renewal and/ or variation of guardianship orders, appointment of additional or replacement guardians, as well as all appeals to the sheriff lodged under the 2000 Act at Edinburgh Sheriff Court.

The latest Practice Note was issued in January 2024.⁶⁰

⁵⁶ [The Mental Health Tribunal for Scotland | About the Tribunal.](#)

⁵⁷ [Office of the Public Guardian in Scotland | What we do.](#)

⁵⁸ [Care Information Scotland | How guardianship is set up.](#)

⁵⁹ [Scottish Courts and Tribunals Service | Edinburgh, Lothian and Borders Guardianship Court.](#)

⁶⁰ [Sheriffdom of Lothian and Borders | Practice Notice No 1 of 2024.](#)

The Scottish Legal Aid Board (SLAB)

SLAB, as a non-departmental public body, was set up in 1987 to manage and administer legal aid in Scotland.⁶¹ In terms of legal aid for people with mental disorder, adults with incapacity, and power of attorney, SLAB's role includes:

- assisting people in finding solicitors by [referring them to SLAB's find-a-solicitor tool](#)
- assessing and managing legal aid applications
- monitoring legal aid funding for those cases
- providing advice and assistance and/or representation for clients through the Civil Legal Assistance Office (CLAO).

Solicitors

Solicitors play an important role in mental health, AWI and POA cases. For mental health cases, the main role of solicitors is to represent and safeguard the patients' interests at Mental Health Tribunals and other hearings.⁶² For POA and AWI cases, the solicitor's main function is either to provide expert legal advice and to assist others to have a power of attorney in place, or to have them granted a guardianship order, or to contest an existing guardianship order.

Independent Advocates

Advocates are people who speak on others' behalf.⁶³ In particular, what an advocate does includes:⁶⁴

- listening to people and standing alongside those who are at risk of being pushed to the margins of society
- helping people have a stronger voice and have as much control as possible over their own lives
- getting people the information that they need to make decisions about their circumstances
- speaking on behalf of people who are unable to do so for themselves.

People covered by the Mental Health (Care and Treatment) (Scotland) Act 2003 have a legal right to independent advocacy. This also includes people with mental health issues, learning disability, autism and dementia.⁶⁵ Advocacy organisations are independent, and therefore, they are separate from Mental Health Services.

The Scottish Independent Advocacy Alliance (SIAA) is a national alliance of independent advocacy organisations, whose objectives are to promote, support and advocate for independent advocacy. SIAA helps people find advocates via their network of member organisations.⁶⁶

⁶¹ [Scottish Legal Aid Board | Corporate information.](#)

⁶² [Mental Health Law Online | The role of the mental health lawyer \(2023\).](#)

⁶³ [Scottish Government | Advocacy – someone to speak on your behalf.](#)

⁶⁴ [NHS Greater Glasgow and Clyde | Advocacy Information.](#)

⁶⁵ [Care Information Scotland | Advocacy.](#)

⁶⁶ [Scottish Independent Advocacy Alliance | About us.](#)

NHS Scotland

NHS Scotland consists of 14 territorial NHS Boards, seven Special NHS Boards and one public health body.⁶⁷ Each territorial NHS Board is responsible for the population's health in its territory and for the delivery of frontline healthcare services. Special NHS Boards, as the name implies, support the regional NHS Boards by providing a range of specialist and national services. Amongst them, the State Hospital Board for Scotland provides assessment, treatment and care for people with mental disorder in conditions of special security because of their dangerous, violent or criminal propensities.⁶⁸

Mental health care in Scotland is composed of primary and secondary care services. Primary care is all services, which are usually delivered by or linked to a GP practice, that provide health care in a local area.⁶⁹ Each board area in Scotland has devised and developed their own initiatives in relation to mental health carers, resulting in diversified models of primary mental health care across Scotland.⁷⁰ Secondary care, on the other hand, comprises all services to meet the need of individuals who have longer term or complex psychological or mental health conditions that cannot be met by their GP or other primary care services. Secondary mental health services are thus made up of community mental health teams and adult in-patient mental health wards. Currently, there are no national standards for adult secondary mental health services in Scotland.⁷¹

In Scotland, the demand for mental health care is continuing to rise and adding much pressure on an adult mental health system already under significant strain.⁷² Furthermore, there are only 48 specialist hospital beds provided within the NHS in Scotland for children and young people (aged 12 to 18) with mental health problems. There are three in-patient units – Edinburgh, Glasgow and Dundee – with no provision north of Dundee. There is a further six-place unit for those aged five to 12 in the Royal Hospital for Sick Children in Glasgow.⁷³

VI. SLAB's internal data and previous studies

This section is dedicated to examining previous studies and internal data held by SLAB on mental health, AWI and POA cases. Before delving further into those studies, it is also important to note the existing position on means testing such cases: POA cases are mean tested, while there is currently no means test for most mental health and AWI cases.

The only exceptions are advice and assistance (A&A) for AWI cases and a few mental health cases regarding general rights, which are currently means tested.

⁶⁷ [NHS Scotland | About NHS Scotland.](#)

⁶⁸ [NHS Scotland | Organisations.](#)

⁶⁹ [Scottish Government | Adult secondary mental health services - quality standards: consultation.](#)

⁷⁰ [Scottish Government | Primary Care Mental Health Models in Scotland \(2022\).](#)

⁷¹ [Scottish Government | Adult secondary mental health services – quality standards: consultation \(2022\).](#)

⁷² [Scottish Parliament | Committee Report on Adult Mental Health \(2024\).](#)

⁷³ [Scottish Children's Services Coalition | Mental Health.](#)

Best Value Review: Mental Health (2010)

SLAB conducted the Best Value Review for Mental Health cases amidst increases in spending on those cases, standing at £4.2 million in 2010. The purpose of the review was to establish whether the current system offered appropriate access to legal advice, assistance and representation in a manner which represented best value for the legal aid fund.

Expenditure

It was found that expenditure had increased 230% from £1.8 million in 2006 to £4.2 million in 2010. The average case cost had grown in the same period from £918 to £1,272. In total, 131 firms received payments from the fund, amongst which only 14 firms earned more than £10,000. The top two firms earned between them £2.2 million pounds.

Supplies of services

Most firms were found to be in or near the central belt or big cities, with little local provisions in certain areas, particularly the Highlands and Islands, or Dumfries and Galloway. Firms in the central belt did extensive travelling to represent clients across Scotland, which created barriers for local firms to gain work.⁷⁴

Most importantly, cost of cases was much higher for distant firms compared to local firms, due to the significant costs of travel. Firms which travelled would travel extensively across Scotland even in areas well-served by local firms. This resulted in cost inefficiency, and a high chance of diary conflicts due to multiple tribunal callings in different locations across Scotland.

Quality of services

Although most practitioners were found to deliver high quality services, there existed anecdotal evidence of practice which did not benefit clients yet caused costs and inconvenience to the legal aid fund, the tribunal, and the health services. There was also evidence of unnecessary or premature applications, as well as cases being processed in inefficient ways.

Proposals for changes

The 2010 best value review made a few proposals for changes. Most importantly, the review proposed reducing cost of travels and encouraging local supply of solicitors' services for mental health cases by:

- 1) reducing the time-based fee payment for travel
- 2) promoting solicitors' best practice
- 3) introducing fixed fee structure for such cases.

In addition, solicitors employed by CLAO would provide services for mental health cases.

⁷⁴ More recent interviews with SLAB colleagues revealed that, for mental health ABWOR, there were currently only a handful of firms that handle most of the work but for AWI cases, the work appeared to be spread more widely and evenly amongst firms.

SLAB’s monitoring reports (2013–2017)

From time to time, SLAB assessed the extent to which legal services were accessible and available to people in Scotland via the monitoring reports. In the 2013 monitoring report to the Scottish government, it was found that there were wide variations in the proportion of tribunal cases where a solicitor was listed as a contact.

It was found that most cases from which solicitors undertook work in relation to mental health laws was ABWOR. The number of hearings at the Tribunal remained static between 2008-09 and 2011-12 (a reduction by three percentage points). A&A intimations for mental health law work had fallen over the period by 9%, partially because of the changes implemented following the Board’s Best Value Review of Mental Health.⁷⁵

There were eight types of application which accounted for 90% of all applications heard by the Tribunal. Amongst them, applications for Compulsory Treatment Orders (CTOs) accounted for 46% of total hearings in 2011-12.

Finally, it was noted that there was low level representation in three areas, namely Clackmannanshire, Stirling and West Dunbartonshire. This observation was reconfirmed in subsequent monitoring reports in 2014, 2015, 2016 and 2017. It was concluded that there was high probability of a systemic problem of low solicitor representation in mental health law in the three aforementioned areas for several years.

SLAB’s annual reports on mental health (2014–2025)

A review of SLAB’s annual reports between 2014-15 and 2024-25 has yielded the following statistics about mental health cases over the years.

Civil A&A and ABWOR	Intimations	Number of cases paid	Total paid (£000)	Average case cost (£)
2014-2015	3,069	3,194	2,968	929
2015-2016	3,383	3,164	3,000	948
2016-2017	3,560	3,472	3,155	909
2017-2018	3,341	3,336	2,877	863
2018-2019	3,325	3,293	2,839	862
2019-2020	3,438	3,326	2,866	862
2020-2021	3,654	3,518	3,001	853
2021-2022	3,618	3,275	3,308	1,010
2022-2023	3,734	3,445	3,889	1,129
2023-2024	3,797	3,394	3,775	1,112
2024-2025	3,814	3,882	4,387	1,130

Table of the changes in mental health cases between 2014 and 2024.

Between 2014-15 and 2024-25, the number of intimations of mental health cases has increased 24%, while the number of cases paid in the financial year increased by 22%. In terms

⁷⁵ For more details, see p.34 of the 2013 monitoring report. Available on request.

of money paid, the total paid amount has increased 48%, while the average case cost has increased approximately 22%.

SLAB's annual reports on adults with incapacity (2014–2025)

A review of SLAB's annual reports between 2014-15 and 2024-25 has yielded the following statistics about adults with incapacity cases over the years.

	Intimations (of Civil A&A and ABWOR)	Civil legal aid grants	Number of cases paid (A&A plus civil legal aid)	Total gross cost (£000)	Average case cost (£)
2014-2015	2,113	3,587	4,592	3,080	671
2015-2016	2,182	4,083	5,156	3,389	657
2016-2017	2,338	4,385	5,215	3,471	666
2017-2018	2,206	4,603	5,544	3,803	686
2018-2019	2,492	4,802	6,037	3,670	608
2019-2020	2,446	5,123	6,167	4,148	673
2020-2021	1,824	3,965	4,088	3,082	754
2021-2022	2,270	5,257	5,090	3,906	767
2022-2023	2,471	5,809	5,595	4,775	853
2023-2024	2,592	6,546	6,539	5,809	888
2024-2025	2,409	6,439	7,088	6,705	946

Table of the changes in adults with incapacity cases between 2014 and 2024.

Between 2014-15 and 2024-25, the number of intimations of AWI cases has increased 14%, while the number of civil legal aid grants and cases paid in the financial year has witnessed a significant increase of 80% and 54% respectively. In the same period, the total gross cost has more than doubled, while the average case cost has increased 41%.

SLAB's annual reports on power of attorney (2014–2025)

A review of SLAB's annual reports between 2014-15 and 2024-25 has yielded the following statistics about power of attorney cases over the years.

Civil A&A and ABWOR	Intimations	Number of cases paid	Total paid (£000)	Average case cost (£)
2014-2015	1,386	1,089	217	199
2015-2016	1,580	1,453	303	208
2016-2017	1,716	1,275	274	215
2017-2018	1,551	1,646	339	206
2018-2019	1,624	1,306	270	207
2019-2020	1,523	1,384	311	224
2020-2021	793	636	141	222
2021-2022	909	798	207	260
2022-2023	841	745	198	266
2023-2024	1,040	714	194	272
2024-2025	1,023	807	242	300

Between 2014-15 and 2024-25, there has been a significant change in the number of intimations of power of attorney cases. While the number of intimations stayed around 1,500 for the most part between 2014-15 and 2019-20, this number suddenly dropped to below 800 in 2020-21 before gradually increasing to 1,023 in 2024-25. A similar pattern can be observed in the number of cases paid within the same period.

In terms of money paid, the total paid amount has witnessed a similar fluctuation with a significant drop recorded in 2020-21 (55% drop in the total paid amount). On the other hand, the average case cost has gradually increased by 51% throughout the period. Despite this, expenditure on POA as a proportion of the total spent on POA and AWI has fallen from between 7% and 8% in the pre-pandemic years to 3% in the most recent two years, suggesting a shift away from preventative spend at a time of increasing demand.

Recent studies and reports

There are a few recent reports published by SLAB which are worth mentioning.

SLAB's work on the Legal Aid Payment Advisory Panel⁷⁶ showed that, in 2018-19, mental health and AWI accounted for 5% and 7% of the total value of paid civil work respectively. Most of the mental health work was handled by practitioners in three councils: Fife, Glasgow, and Edinburgh. Practitioners in rural areas, however, were found to receive very little to no income from mental health work. For AWI cases, there was still high concentration of work in Glasgow and Edinburgh, but the work was perceived to spread more evenly amongst practitioners across the councils.⁷⁷ A more recent analysis⁷⁸ of the supply of legal aid by solicitor firms in Scotland showed a similar picture. For the supply of mental health work (including A&A and ABWOR) in 2023, there was still a high degree of concentration of work in terms of firms and geography. 85% of mental health cases were granted to 12 firms, with the top two firms handling 51% of the total cases. On the other hand, there were 12 council areas which had no local firm branches getting grants for mental health cases.

Most recently, in May 2025, SLAB published a geographic trend analysis on civil legal aid data between 2014 and 2024.⁷⁹ It was found that AWI grants⁸⁰ were almost doubled (increasing 82%) compared to 2014-15 and were the main driver behind the rise in civil legal aid grants. The analysis also revealed a general decline in the number of firm branches delivering civil legal aid, especially in more rural and remote areas and those furthest from the Central Belt. Interestingly, the overall volumes of work in rural and island areas were found to have significantly increased between 2014-15 and 2023-24, despite the decline in local branches.

⁷⁶ [Scottish Government | Legal Aid Payment Advisory Panel.](#)

⁷⁷ [Scottish Government | Legal Aid Payment Advisory Panel minutes: November 2019.](#)

⁷⁸ SLAB | The Supply of Legal Aid by Solicitor Firms in Scotland (2023) – internal report, available on request.

⁷⁹ [SLAB | Civil legal aid: Geographic trends analysis \(May 2025\).](#)

⁸⁰ AWI legal aid applications are made by individuals seeking, opposing or renewing guardianship orders in relation to another person. In many cases, they are needed where an individual becomes unable to make decisions about their life but has not put in place a POA, and the court must make orders about who can make decisions about their life. **See discussion on POA vs. Guardianship on page 8.**

Shetland Islands witnessed the largest increase in case volumes (67%), followed by Perth & Kinross (53%). Within the AWI subject, there was a slight reduction in the number of active practitioners (a decrease of 17%) but a significant increase in the concentration of AWI cases. Practitioners with 17 cases or more were responsible for 76% of all AWI cases in 2024, as compared to 48% in 2014.

To sum up, these reports disclosed uneven supply of legal aid for mental health and AWI cases by firm branches, which were primarily located near the Central Belt, and the high concentration of cases into only a handful of firms and practitioners. This could potentially cause issues in terms of availability and accessibility for mental health law clients. This was particularly true for those who reside in rural or remote areas, although it remains the case that mental health specialist firms provide their services over a wide geographic area.

VII. Trends and statistics

In Scotland

This section is dedicated to exploring several sources which provide publicly available data with regards to mental health, adults with incapacity, and power of attorney in Scotland.

A. The Scottish Health Survey (SHeS)

The Scottish Health Survey (SHeS), commissioned by the Scottish Government Health Directorates, has been carried out annually since 2008 to provide regular information on aspects of the public's health and factors related to health which cannot be obtained from other sources. The SHeS 2022 showed that:⁸¹

- Measured by mean Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)⁸², **average levels of mental wellbeing decreased between 2021 and 2022** (down from 48.6 to 47.0), which was outside of the range previously observed between 2008 and 2019 (between 49.4 and 50.0)
- In 2022, older adults (65 years old or older) reported to have higher wellbeing scores (above 49.3) compared to younger adults (16-54 years old), whose scores were between 45.5 and 46.5
- **In 2022, 27% of adults had symptoms indicating possible psychiatric disorder**, which is a significant increase compared to 2021 (22%) and previous time series, 2003–2019 (between 14% and 19%), and the percentage was found to be significantly higher for women than for men (31% and 22% respectively)
- In 2022, the percentage of adults who felt lonely “most” or “all of the time” increased to 11%, compared to 8% as reported in 2021
- **Young adults (aged between 16 and 24) were more likely to have mental health issues**, and they were the most likely age group to report feeling lonely “most” or “all of the time”

⁸¹ [Scottish Government | Scottish Health Survey 2022 Main Report](#).

⁸² The [Warwick-Edinburgh Mental Wellbeing Scale](#) measures respondents' based on their answers to 14 questions with a five-point Likert scale. The scores range from 14 (the lowest level of positive mental health) to 70 (the highest).

(17%). They were also the group with highest prevalence of two or more symptoms of anxiety (25-26%). Differences by sex in terms of having two or more symptoms of anxiety were also greatest amongst this age group (13% for men and 33% for women)

- In 2022, 30% of children were found to live with a parent who had symptoms indicative of a possible psychiatric disorder.

B. Scottish Public Health Observatory (ScotPHO)

Another source of data on mental health in Scotland is provided by the ScotPHO.⁸³ The most recent ScotPHO's profiles showed various statistics and recent trends of mental health outcomes in Scotland between 2008 and 2021.

In particular:

- **Adults deliberately self-harming in past year:** the percentage of adults conceding to self-harming increased from 2.5% in 2008 to 9.6% in 2021. Amongst them, women were found to be more likely to harm themselves compared to men (10.6% compared to 8.5%).
- **Anxiety symptoms in past week:** more people were found to have anxiety symptoms in the past week (an increase from 8.7% in 2008 to 14.4% in 2021). Women were found to be more likely to have anxiety symptoms than men (17.8% compared to 10%).
- **Attempted suicide in past year:** the percentage has increased from 0.5% in 2009 to 1.2% in 2021. Men were found to be more likely to attempt suicide compared to women (1.9% compared to 0.6%)
- **Deaths from suicide (16+ years):** there has been a slight decrease in the number of deaths from suicide amongst people aged 16 years old or older. The age-standardised mortality rate⁸⁴ (per 100,000 people) in 2002-06 was 18.9, compared to 17.5 in 2018-22. Men were more likely to be dead from suicide compared to women (26.1 compared to 8.8).
- **Depression symptoms in past week:** there has been a slight increase of people conceding to have depression symptoms in past week (from 8.4% in 2008 to 10.8% in 2021). Men were more likely to have depression symptoms than women (11.6% compared to 10.2%)
- **Mental wellbeing score (WEMWBS):** the mean score for adults in Scotland aged 16+ years in 2022 was 47, which was the lowest mean score recorded in the time series between 2008 and 2022. Male mental wellbeing scores were slightly higher than female scores (47.7 compared to 46.5).
- **Symptoms of common mental health problems in past few weeks:** there has been a large increase in the percentage of people reporting to have symptoms of common mental health problems in past few weeks (from 15% in 2012-2015 to 25% in 2018-2022). Women were more likely to have symptoms of common mental health problems than men (31% compared with 22%).

⁸³ [ScotPHO | Profiles.](#)

⁸⁴ The age-standardised mortality rate is a weighted average of the age-specific mortality rates per 100,000 persons, where the weights are the proportions of persons in the corresponding age groups of the World Health Organisation standard population. For more information, see [Noncommunicable disease \(NCD\) mortality rate and suicide rates.](#)

C. The Mental Welfare Commission for Scotland (MWCS)

The third source of statistics is published by the MWCS, which produced separate monitoring reports for both the Mental Health Act and the AWI Act over the years.⁸⁵

The statistics from the monitoring reports in the last five years are summarised in the two tables below.

Monitoring reports on Mental Health

Statistics	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Detention episodes	N/A	6,699	6,569	6,713	7,109
Rate of detention orders	N/A	Female: 59.0 per 100,000. Male: 60.8 per 100,000.	Female: 58.1 per 100,000. Male: 60.5 per 100,000.	Female: 58.8 per 100,000. Male: 61.4 per 100,000.	N/A
The proportion of individuals from an ethnic minority group	N/A	4% of the general population	4% of the general population	4% of the general population	N/A
Detentions under section 299 (nurses' power to detain pending medical examination)	N/A	155	171	143	208
Section 297 (place of safety) orders	N/A	1,125	1,255	1,345	1,276
Extant orders	N/A	3,751	3,950	4,061	4,022
Detention orders under the Criminal Procedure Act	N/A	341	361	333	316
T2 certificates	N/A	830	928	954	922
T3 certificates	N/A	2,031	2,366	2,573	2,626
T4 certificates	N/A	452	530	498	553

⁸⁵ [Mental Welfare Commission for Scotland | Publications.](#)

Monitoring reports on AWI

Statistics	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Individuals on a guardianship order	15,973	16,033	17,101	17,849	19,078
Granted guardianship orders	3,199 (78% new)	2,194 (91% new)	3,371 (94% new)	3,501 (94.7%new)	4,009 (91.7% new)
Overall rate of guardianship orders	70.4 per 100,000 population	48.2 per 100,000 population	N/A	N/A	N/A
The most common primary diagnosis	Learning disability (49%)	Learning disability (47%)	Learning disability (46%)	Learning disability (46%)	Learning disability (48.8%)
Second most common	Dementia/ Alzheimer's Disease (36%)	Dementia (38%)	Dementia (39%)	Dementia 36.7%	Dementia (35.20%)

D. The Office of the Public Guardian (Scotland)

The fourth source of data can be found on the Office of the Public Guardian (Scotland)'s website in the form of yearly comparisons.⁸⁶

Below are summaries of trend data on POA registered, Intervention Orders registered, and Guardianship Orders registered.

Power of Attorney registered

Year	Financial	Welfare	Both	Total
2019-2020	577	484	63,105	64,166
2020-2021	312	238	37,449	37,999
2021-2022	377	298	57,144	57,819
2022-2023	363	250	60,177	60,790
2023-2024	425	256	76,760	77,441
2024-2025	340	251	67,178	67,769

The number of POA registered has slightly increased (around 6%) in the past six years.

However, it is interesting to note that there have been significant decreases in the number of POA registered under Financial and Welfare (41% and 48% respectively), while the number of POA registered under Both categories has been the main driver behind the increase in the total number of POA registered.

⁸⁶ Office of the Public Guardian (Scotland) (ca. 2026) "Yearly comparisons by type" <link>

Intervention Orders registered

Year	Financial	Welfare	Both	Total
2019-2020	472	2	0	474
2020-2021	370	7	2	379
2021-2022	483	5	2	490
2022-2023	545	0	0	545
2023-2024	548	2	1	551
2024-2025	590	2	3	595

The majority of Intervention Orders have been registered under the Financial category, which accounted for approximately 99% of total intervention orders. The total intervention orders have increased by 25% since 2019-20.

Guardianship Orders registered

Year	Financial	Welfare	Both	Total
2019-2020	145	1,254	1,379	2,778
2020-2021	106	808	998	1,912
2021-2022	133	1,112	1,518	2,763
2022-2023	118	1,171	1,603	2,892
2023-2024	150	1,276	1,809	3,235
2024-2025	134	1,280	1,818	3,232

The total number of guardianship orders has increased 16% since 2019-20. Amongst them, the guardianship orders under Both categories witnessed the largest increase (32%), while the Welfare category was staying relatively stable. There was a slight decrease (8%) in the number of guardianship orders registered under the Financial category.

E. Mental Health Tribunal for Scotland (MHTS)

Annual reports on tribunal activities in Scotland can be found on the MHTS' website.⁸⁷ The 2024-25 Annual Report showed the number of applications received by MHTS has steadily increased in the last ten years to reach over 5,700 applications received in 2024-25. Amongst them, applications for compulsory treatment orders constitute the largest percentage of applications received (44%), followed by application for revocation of short-term detention or extension certificate (17%). In terms of hearings, a total of 6,300 hearings were held in 2024-25 and 72% of cases were determined at their first calling. In 96% of cases, the final decision paper work was issued to parties to Tribunal proceedings within 10 working days of the final hearing.

F. Public Health Scotland

In November 2022, Public Health Scotland published a report, which focused on forecasting the future burden of disease in Scotland over the next 20 years.⁸⁸ In this report, mental health disorders were ranked fourth in 2019 in the leading causes of disease and injury groups in

⁸⁷ [Mental Health Tribunal for Scotland | Annual Reports.](#)

⁸⁸ [Public Health Scotland | Scottish Burden of Disease Forecasting Briefing \(2022\).](#)

Scotland. It was also predicted that, in 2043, mental health disorders would remain in fourth place in Scotland as one of the leading causes of disease and injury.

In the UK

There are two key surveys conducted in the UK to gather data about people with mental health issues: the Adult Psychiatric Morbidity Survey⁸⁹ and a survey of children and young people's mental health⁹⁰. The latest statistics on mental health in England was published by the House of Commons Library in March 2024.⁹¹ Key findings from this report include:

- **Common mental disorders (CMD)** include conditions such as depression, anxiety, panic disorder, phobias, and obsessive-compulsive disorder. In 2014, one in six people aged 16+ was reported to have symptoms of CMD in the week before being surveyed. Across all ages, women were more likely to experience CMD compared to men. The differences were most profound in the 16-24 age group, where women were nearly three-times as likely to experience CMD. People, who were economically inactive or unemployed, were more than twice as likely to experience CMD compared to those who were employed.
- **Post-traumatic stress disorder (PTSD):** in the 2014 Adult Psychiatric Morbidity Survey, 3.7% of men and 5.1% of women screened positive for PTSD. Women aged 16-24 were most likely to screen positive (12.6%).
- **Bipolar disorder** involves swings between episodes of depression and mania. Around 2% of adults screened positive for bipolar disorder in the 2014 survey. The differences between men and women were small across age groups, although the rates were slightly higher among men. The highest rate of bipolar disorder was found among women aged 16-24 (3.7%).
- **Suicidal thoughts and self-harm:** in 2014, 5.4% of people surveyed reported having suicidal thoughts past year, an increase from 3.8% in 2000. The percentage of people reported self-harm also increased from 2.4% in 2000 to 6.4% in 2014. Among women, suicidal thoughts in the past year were most common among those aged 16 to 24 (10%). Among men, rates were highest in 16 to 24-year-olds and 25 to 34-year-olds (6% and 7% respectively). Similarly, women aged 16 to 24 were much more likely to report having self-harmed than any other age groups, with almost 20% reporting self-harm. Among men, those aged 25 to 34 were most likely to report self-harm (10%).
- **Children and young people's mental health:** The 2023 survey of this group found that 20% of children aged 8 to 16 had a probable mental disorder, up from 12% in 2017. The biggest rise was among those aged 17 to 19 (from 10% in 2017 to 23% in 2023). Among children aged 8 to 10, boys were more likely than girls to have a probable mental disorder in 2023 (20% of boys compared with 14% of girls). This gap reversed in older age groups, with girls

⁸⁹ The [Adult Psychiatric Morbidity Survey \(APMS\)](#), conducted in 1993, 2000, 2007, and 2014, measured how common mental health disorders are, both treated and untreated, among adults aged 16 and over in England.

⁹⁰ The [Mental Health of Children and Young People Surveys](#), carried out between 2017 and 2023, looked at the mental health of people aged eight to 25 in England.

⁹¹ [House of Commons Library | Mental health statistics: prevalence, services and funding in England by Carl Baker & Esme Kirk-Wade \(2024\)](#).

aged 17 to 19 more likely (32%) to have a probable mental disorder than boys (15%). More than half (57%) of children aged 6 to 16 with special educational needs and disabilities (SEND) had a probable mental health disorder in 2021, compared with 13% of those without SEND.

In the European Union (EU)

In 2004, the European Commission published a comprehensive report, titled “The State of Mental Health in the European Union”.⁹² The aims of the report were to find out more about mental health and its determinants, to enable comparisons between Member States, and to stimulate further projects on mental health in Europe. Below are key findings from the report with a strong focus on the comparative position of the UK compared to other EU countries.

- **Total health spending:** measured by per capita spending per year as purchasing power parity, the UK was ranked eleventh with expenditure of around \$1,800, while Germany, Norway and Luxembourg were the highest spenders (spending \$2,600 or more).
- **Psychological distress:** Netherlands and the UK were the lowest in terms of psychological distress, while France and Italy claimed the highest places in this category.
- **Suicide:** In the UK, the yearly rate was seven per 100,000 people, compared to the lowest rate in Greece at three per 100,000 and the highest rate in Finland at 24 per 100,000. There was an overall trend of decreasing suicide rates across the countries. The decreased trend was stronger for females than for males. It was also found that the elderly had the highest suicide rates in the population.
- **Gender & mental health:** The UK psychiatric morbidity survey showed that the mental health scores of women was much lower than men (3.5 compared to 5.73 respectively). While men were found to be more at risk from violent death than women, women were more likely to attempt suicide than men.
- **Age & mental health:** in the UK, younger people were found to have a better mental health score than adults. In addition, the older adults were found to have higher mental health scores compared to those of the adult population (elderly people in the UK had the highest score in the comparison at 6.4).
- **Marital status and living arrangements:** it was consistently found that being married or living with someone is associated with better mental health than being divorced, widowed, or single. Results from the UK showed that the divorced, separated and widowed had higher level of distress compared to those living in a couple.
- **Social factors – poverty unemployment, and deprivation:** the common mental disorders were significantly more frequent in socially disadvantaged populations. In the UK, the mental health scores of the employed and unemployed were 5.45 and 2.98 respectively.
- **Rural-urban differences in mental health:** most European studies showed a higher risk for mental health problems in urban areas. In the UK, the mental health scores were 5.8 in rural areas, compared to 4.49 in urban areas.

⁹² [European Commission | The State of Mental Health in the European Union \(2004\).](#)

- In a more recent Eurobarometer survey on mental health in October 2023, it was revealed that 46% of European population experiencing psychological problems, such as depression or anxiety, in the past twelve months.⁹³ Another study estimated that the total costs of mental health problems could be €600 billion across the 27 EU countries.⁹⁴ To tackle the increasing mental health problems, the EU have introduced initiatives and allocated funding to finance activities that directly or indirectly promote mental health between 2021 and 2027.⁹⁵ Across the globe, the prevalence and severity of mental health problem was re-confirmed by the Global Burden of Disease (GBD) study, which reported 14% of the world’s population experiencing mental disorders and a staggering economic burden estimated at around 5 trillion USD.ⁱⁱ

Literature Review

This section is dedicated to examining literature on mental health services and their service users within the Scottish context. We are looking at:

- stigma and public attitudes toward mental health conditions
- operations of the mental health services in Scotland
- perceived barriers to legal services/representation in relation to mental health and AWI.

Stigma and public attitudes

The Scottish Social Attitudes (SSA), carried out by the Scottish Centre for Social Research since 1999, is the longest running of study of public attitudes in Scotland.⁹⁶ In 2013, a dedicated report on the topic of Scottish attitudes to mental health was compiled using SSA data and data collected from earlier surveys.⁹⁷

It was found that, although nine out of ten people in Scotland (89%) disagreed that “people with mental health problems are largely to blame for their own conditions”, almost half (47%) conceded that they would not want people to know if they were suffering from mental health problems. Furthermore, around one in five people (19%) agreed that “people with mental health problems are often dangerous”, and over a quarter (28%) agreed that “the public should be better protected from people with mental health problems”. Over one third of the people with mental health problems (37%) reported experiencing at least one negative social impact due to their conditions.⁹⁸ These findings reflected the prevalence of stigma associated with mental health that still existed within Scotland’s public attitudes.

The report also found that a quarter of the people (26%) experienced a mental health problem at some point in their life. Depression was the most common mental health problem (21%),

⁹³ [European Union | Mental health Eurobarometer survey \(October 2023\)](#).

⁹⁴ [European Data Journalism Network | Mental illness costs Europe 600 billion euro \(2018\)](#).

⁹⁵ [European Parliament | Mental health: What is the EU doing for mental health? \(October 2024\)](#).

⁹⁶ [National Centre for Social Research | Scottish Social Attitudes](#).

⁹⁷ [Scottish Government | Attitudes to Mental Health in Scotland: Scottish Social Attitudes Survey 2013 - Research Findings](#).

⁹⁸ Examples include being discouraged from attending social events, refused a job, or subjected to physical or verbal abuse.

followed by panic attacks (9%) and anxiety disorders (8%). It was also found that mental health problems were more prevalent in certain social groups. For example, they were more prevalent in women (36%) compared to men (27%), in lowest income group (41%) compared to highest income group (25%), and in young people compared to people over 55 years of age.

For those who experienced mental health problems, they were most likely to have told family and friends (more than four out of five) compared to telling their managers (one in five) and telling their colleagues (one in six). Nevertheless, there was a sharp decline in the proportion of people choosing “family or friends” or “having belief in myself” as factors supporting their individual recovery. Instead, “other forms of treatment/ therapy” and “finding more about mental health” were on the rise as supporting factors for people’s recovery. These changes are summarised in the table below.

Shift in factors supporting individual recovery	2008	2013
Family or friends	62%	41%
Having belief in myself	31%	15%
Other forms of treatment/ therapy	19%	27%
Finding more about mental health	8%	19%

Mental Health Services in Scotland

Mental health services in Scotland are divided into services for adults and services for children and young people. On the one hand, mental health services for children and young people were described as “limited” in terms of early intervention and prevention, with a strong emphasis on specialist care and responding to crisis.⁹⁹ On the other hand, mental health services for adults were described as “fragmented and complex” with services being delivered by multiple stakeholders.¹⁰⁰

In these reports, services at the final tier – specialist inpatient services – are where legal services are most likely to be engaged, as shown by the data from MWC and MHTS. It was also found that demand for mental health services for children and young people was rising, and people were waiting longer for treatment. While demand for adult mental health care had increased since the pandemic, accessing these services remained slow and complicated for many people (with six out of ten reported facing challenges). The mental health workforce was under pressure, with high rates of vacancies and turnover.

In terms of equality, accessing adult mental health care was more difficult for ethnic minorities, people living in rural areas and people living in poverty. For example, access to specialist services in sign language was found to be limited. Similarly, access to services for people from ethnic minorities was hindered by language and cultural barriers. Mental health inequality was found to be a long-standing problem, and measures to address this had been slow.

⁹⁹ [Audit Scotland | Publication: Children and young people’s mental health \(2018\)](#).

¹⁰⁰ [Audit Scotland | Publication: Adult mental health \(2023\)](#).

Audit Scotland’s accounts of the mental health services for adults and children and young people share some commonalities. First, both systems are regarded as complex and fragmented, which makes it more difficult for service users to gain access to services that they need. Second, there is raising demand from service users to use mental health services, which are increasingly put under pressure due to lack of resources. As a result, service users must wait longer to receive support, if at all. All of which suggests pressure is likely to continue for specialist mental health services, where legal services are most likely to be engaged.

Perceived barriers to legal services

In 2019, the Mental Welfare Commission for Scotland conducted a consultation to seek people’s views on things which they perceived as barriers to the legal system, especially legal representation.¹⁰¹ A summary of the perceived barriers to the legal system is presented below.

First, most people agreed that the biggest barrier to the legal system was their own mental health conditions. People reported to have been so caught by their delusions or distress that the relevance or need for legal help became irrelevant. Distress could also make people unable to organise or understand or engage with the legal system. Similarly, the biggest barrier that people faced in getting legal representation was their impairments, which could “affect ability to interact, understand, instruct, participate, engage or even see the need for representation” (p.7).¹⁰¹

Second, lack of information was cited as another key barrier to the legal system. This was reflected in the lack of reliable and easy-to-read information around specialist solicitors for mental health cases, legal representation and people’s rights to legal representation. This problem was exacerbated by the ignorance of service users regarding cost and their rights to representation. This led to the widely held belief that it was getting harder to afford legal representation, either through legal aid or paying from people’s own pockets. It was also alleged that staff in the legal system did not always have sufficient knowledge about people with mental health issues and/or mental health laws.

Third, there was perceived to be inequality in people’s access to the legal system. The lack of solicitors’ presence in rural areas, the limited access to solicitors in out-of-hours services, and language barrier were often cited as examples. People with mental health problems had different needs, such as the need of safe and quiet places at courts or home visit by solicitors, which often was said to go unmet by the legal system. They described experience of being stigmatised by the legal staff, and some solicitors refused to take on their cases which were regarded as complicated and not worth the solicitors’ time.

VIII. Conclusion

This report provides a concise, yet comprehensive, account of the mental health law clients within the Scottish legal aid context. It also helps disclose several trends and existing issues in relation to mental health, AWI, and POA cases handled by SLAB. In particular:

¹⁰¹ [Mental Welfare Commission for Scotland | The views of people with experience of mental ill health on the barriers that they face in getting legal representation \(2019\).](#)

- **Increasing expenditure:** SLAB’s expenditure on mental health, AWI, and POA cases have witnessed general increases over the years in terms of number of cases paid, total money paid, and average case costs. This is especially true for AWI cases, which saw 54% increase in the number of cases paid, 41% increase in the average case cost, and the total gross cost had more than doubled between 2014-15 and 2024-25.
- **Uneven distribution of civil legal aid services:** the supply of legal aid by solicitor firms was found to be skewed towards the Central Belt, while appearing to be lacking in rural and remote areas. Furthermore, there was an increasing concentration of work on a handful of firms and practitioners, when the number of firm branches and active practitioners were generally in decline over the years. This could potentially lead to issues regarding accessibility to legal aid services for mental health law clients, most notably those residing in rural and remote areas.
- **Quality of service:** the Best Value Review conducted by SLAB in 2010 found that most practitioners delivered high quality services, yet there was still anecdotal evidence of bad practice causing costs and inconvenience to the legal aid fund without benefiting the mental health clients. However, there have been no further studies or reports in recent years on this subject.
- **Different types of applications:** there were interesting statistics and trends when it came to different types of applications. The Office of the Public Guardian (Scotland)’s yearly comparisons highlighted the significant decreases in the number of POA registered under “Finance” and “Welfare” and the notable increase in POA registered under the “Both” category. Mental Health Tribunal for Scotland’s annual reports showed a steady increase of the number of applications they received, as well as the dominance of applications for compulsory treatment orders. These trends could have some consequences for future applications received by SLAB.
- **Inequality amongst mental health clients:** the literature review clearly showed the significant differences between different groups of people based on their protected characteristics (sex, age, ethnicity and disability). These could have critical consequences in terms of designing legally aided services to meet their needs.
- **Other barriers to accessing support and legal services:** the review disclosed how complex and fragmented the mental health systems were for both children and adult patients. In addition, lack of information was cited as another key barrier to receiving support and accessing legal services. It would be beneficial to conduct further study on how well informed our clients are regarding the AWI and mental health laws and the roles of SLAB in supporting them.

End Notes

ⁱ Delivering for Mental Health (2006) set out to achieve three targets:

- 1) reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009-10
- 2) reduce suicides in Scotland by 20% by 2013 (compared with existing target)

-
- 3) reduce the number of readmissions (within one year) for those that have had a hospital admission of over seven days by 10% by the end of December 2009.

Nonetheless, evidence showed that none of these targets were achieved by SG. In particular:

- Target 1: antidepressant usage was found to be raising over the years. It was reported that the rate of increase of prescriptions for antidepressants in Scotland rose from 7.6% in 2009-10 to 8.1% in 2010-11. The situation was getting worse during the ten-year period between 2010-11 and 2019-2020, witnessing 43% increase in the number of patients and 80% increase in the defined daily doses of antidepressant drug.
- Target 2: data released by National Records of Scotland (NRS) showed that the rate of probable suicides was 14.9 deaths per 100,000 population in 2013, an increase from 14.7 deaths per 100,000 population recorded in 2006. The average annual probable suicide rate over the period between 2011 and 2021 was 14.8 per 100,000 population. Data also showed that, in Scotland, male's suicide rate was 2.9 times higher than female's suicide rate between 2011 and 2021.
- Target 3: there was no clear evidence to confirm whether this target had been achieved. However, a study of data on patient admissions for mental health in Scotland between 1997 and 2021 showed an increase in demand coinciding with decreasing hospital capacity for mental health patients in Scotland. The study showed that:
 - 1) the number of mental health patient admissions was declining, despite the increase in waiting time for mental health services and the steep increase in referrals (from 2,000 referrals per month in 2014 to 14,000 per month in 2021)
 - 2) the decline in number of admissions was driven by adult patients, while in-patient numbers for children and adolescents remained steady
 - 3) people from deprived areas were more likely to be hospitalised due to ill mental health compared to their counterparts from less deprived backgrounds
 - 4) the average in-patient stay length was decreasing with a great jump in the number of stays lasting for less than a day
 - 5) short-term readmission numbers fell from 1997 to 2011 and increased from 2011 to 2021. Long-term readmission, on the other hand, fell to 2011 and then levelled off between 2011 and 2021.

ⁱⁱ The Institute for Health Metrics and Evaluation (IHME) conducts one of the largest scientific collaborations in the world, namely the Global Burden of Disease (GBD), to study health trends worldwide. IHME reported that 13.9% of the world's population experienced mental disorders in 2021. Furthermore, 18% more people experienced depressive disorders, and 15% more people experienced anxiety disorders because of the Covid-19 pandemic in 2020 compared to 2019. 17.2% of the total years lived with disability in the world were due to mental disorders in 2021. Mental disorders were found to be most common in Portugal, Iran and Lebanon. High prevalence of mental disorders was also found in Australia, Western Europe, and parts of the Americas, including the US and Brazil. In contrast, mental disorders were less common in part of Asia, such as Vietnam, Taiwan, and Brunei.

To study the prevalence of mental disorders and their impacts on people's lives globally, the GBD reports employ Disability-adjusted life years (DALYs) as the unit for measurement. DALYs refer to "Years of healthy life lost to premature death and disability". DALYs are the sum of years of life lost (YLLs), and years lived with disability (YLDs).

The GBD 2019 estimated that mental disorders resulted in 125 million global DALYs in 2019. While considering sexes, females were accounted for 68.5 million DALYs (55%), males were accounted for 56.9 DALYs (45%). Amongst other level two causes for global deaths, mental disorders ranked seventh in terms of DALYs, a jump from its thirteenth place in 1990. A systematic analysis of the GBD's data between 1990 and 2019 revealed that mental disorders remained among the top ten leading causes of burden worldwide, with no evidence of global reduction in the burden since 1990.

In later research, it was estimated that 418 million DALYs could be attributable to mental disorders in 2019 (16% of global DALYs). This was over three times the conventional estimation provided by the GBD 2019, with a staggering economic burden estimated at around five trillion USD. It was thus suggested that the burden of mental illness in terms of both health and economic losses may be much higher than previously assessed.