



Law Society  
of Scotland

# Consultation Response

## Scottish Mental Health Law Review- Additional Proposals

July 2022



## Introduction

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The Law Society of Scotland is the professional body for over 12,000 Scottish solicitors.

We are a regulator that sets and enforces standards for the solicitor profession which helps people in need and supports business in Scotland, the UK and overseas. We support solicitors and drive change to ensure Scotland has a strong, successful and diverse legal profession. We represent our members and wider society when speaking out on human rights and the rule of law. We also seek to influence changes to legislation and the operation of our justice system as part of our work towards a fairer and more just society.

Our Mental Health and Disability sub-committee and Criminal Law committee welcome the opportunity to consider and respond to the Scottish Mental Health Law Review's consultation on the Review's additional proposals.<sup>1</sup> We have the following comments to put forward for consideration.

In the context of our deliberations, conflicts (and what might be perceived as conflicts) affecting individual members of participating committees were the subject of declarations by those members and appropriate management in the fully cooperative processes within and between committees leading to preparation of this response.

## General Comments

We appreciate that this consultation paper will have been prepared, or at least substantially prepared, before it will have been possible to take account of responses to the preceding consultation.<sup>2</sup> Nevertheless, we would urge that our comments in response to that preceding consultation be taken as applicable to the further topics and proposals in this latest consultation.

This latest paper retains an inappropriately narrow focus on mental health law and mental health issues, thus failing to address the full breadth of the Review's remit, and all people coming within the scope of that remit. It appears to contemplate differences between provisions in different regimes where that would in our view be inappropriate not only in the context of any long-term aim to achieve fusion or alignment, but even in absence of those objectives to avoid undue public confusion where there are differences that cannot be justified and have persisted for historical reasons. Scots law is a fundamentally principle-based system, and related areas of law should be dealt with consistently, using as far as possible similar approaches and terminology, consistent with relevant principles.

<sup>1</sup> Consultation (mentalhealthlawreview.scot)

<sup>2</sup> Scottish Mental Health Law Review consultation - Scottish Government - Citizen Space

Several of our concerns can be related to the “terms used in consultation”. In anticipation that similar terminology, definitions and explanations will appear in the Final Report, we have suggested some adjustments to these for the purposes of the Final Report.

“Advance statement”: It should be made clear that this is one sub-category of advance directives. We recommend that the generally accepted definition of “advance directives” in Council of Europe Recommendation CM/Rec. (2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity be repeated. However, we also recommend that the term “advance directives” be replaced with “advance choices” (with the same definition) for the reasons explained in our recent paper referred to in our general comments on Chapter 2. In view of the importance of the distinction between “instructions given” and “wishes made” in the definition in Rec. (2009)11, we recommend that our respective terminology and definitions for these two main categories should also be adopted and repeated, and that the definition of “advance statements” should explain that advance statements in mental health legislation are a sub-category of advance statements generally. See further our paper, and also our responses to Chapter 2 of this consultation.

“Advocacy”: This definition is in our view inappropriately narrow.

“Autonomy”: This definition is in our view incorrect. The prime requirement for autonomy is to allow people to act and decide definitively for themselves, within the bounds of legality, on the same basis as others. That goes significantly further than respect for will and preferences. Also, as explained later in this response, “will” and “preferences” are different concepts with different attributes. That distinction should be preserved.

“Capacity”: This definition conflicts with the assertion on page 4 to “use the terms currently in legislation”. The distinction in this definition between “mental capacity” and “legal capacity” might be understandable in international academic discourse, but its adoption would entail major re-education of public and professionals which is not necessary. In the Adults with Incapacity (Scotland) Act 2000 (“the 2000 Act”), “capacity” is explicitly defined as equating to capability. In a Scottish context, the introduction by UN CRPD of “capacity” to mean fundamental rights and status is potentially confusing and in any event re-states a settled position. All texts describing relevant law, at least since 1984<sup>3</sup>, are predicated upon all citizens of any age and any levels of capability being able to own property, have their fundamental rights respected, and so forth. Capacity, in UN CRPD characterised as “the exercise of legal capacity”, has always been the issue, and has related to the ability to act and decide, among other things in relation to the exercise of the attributes of fundamental rights and legal status. The definition in the paper seems to confuse aspects of these distinctions, including in the narrow reference to making a decision where Scots law recognises all aspects of acting and deciding with legally valid effect (juridical acts); the reference to undertaking legally valid transactions is but one example of the question of acting and transacting; and consenting to treatment, which is a matter of capability, should not be bracketed with matters of status such as the ability

<sup>3</sup> “Scots Law and the Mentally Handicapped”, Ward, SSMH, 1984.

to own property (matters of capability being relevant to decisions about such ownership, such as acquisition, management and disposal).

“Child and young person”: We suggest consideration, in the reference to “special attention”, of amending “special” to “age appropriate”.

“Collective advocacy”: Limitation to “a common problem” is in our view too narrow.

“Compulsion”: This should be broadened, and the terminology changed, to cover any involuntary/non-consensual intervention. It might be helpful to make a distinction between “non-consensual” where a person does not indicate opposition, but is not capable of giving informed agreement, and “non-consensual” in the sense of overriding a decision, or expressed statement of will, by an individual.

“Human rights”: Should not be stated as limited to the relationship between an individual and the state.

“Human rights-based approach”: Again, this is in our view too narrowly stated, and should extend to all aspects of provision complying with, and requiring or at least facilitating compliance with, human rights in all settings.

“Mental Welfare Commission for Scotland”: A broader statement, coinciding with the statutory definition of the Commission’s functions, might be more appropriate.

“Protected characteristics”: The items in the list are not “types of discrimination”. The protection of the Equality Act 2010 is against discrimination on grounds of the characteristics stated in the list.

“Supported decision-making”: For reasons explained in our previous response, this is in our view inappropriately narrow, particularly in the context of the development of Scots law over recent decades. It is not a term used in CRPD, which requires support for the exercise of legal capacity, a much broader concept covering all acting and deciding with legal effect (all juridical acts).

In expectation that both the extent and the timescale of implementation of the Review’s recommendations may be constrained by resources, we recommend that the Final Report should highlight where necessary reforms are most urgently needed, and where the most widespread detriment currently occurs. Of course, every significant issue that impacts someone within the wide scope of the Review’s remit is important, but there may nevertheless be need for proportionality in proposing priority of reforms. Consultations, including this one, seem to reflect a predominant concentration on (a) particular aspects of mental health legislation and (b) long-term aspirational aims, at the expense of urgent areas of major need, where reform was already seriously overdue in 2018 and, apart from re-stating issues and proposed solutions already overdue for attention then, have progressed little since then. We recommend that the Final Report should include the data available to the Review on numbers of persons at any one time affected or potentially affected by issues under each of the three main Acts. For example, the reforms leading to the 2000 Act proceeded on an assessment quoted by Scottish Executive of approximately 100,000 adults in Scotland at any one time having impairments of capacity. That figure, and the broad breakdown of it, were quoted in

the Annotations to the 2000 Act<sup>4</sup>. Any updated figure would require to include the total number of registered powers of attorney, each by an individual having taken steps under the provisions of the 2000 Act to provide for future incapacity. Further detail can be provided by the numbers of measures under each of the relevant provisions of the 2000 Act currently in force according to the Public Guardian's records, recognising however that there is no requirement for registration of when a power of attorney is brought into operation, therefore a figure for the total number of powers of attorney currently in operation is probably not available. In the case of provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), it should be possible to narrate the total numbers of measures currently in operation, and the total number of advance statements issued, to provide a suitable comparator. As regards both urgency and impact, we would suggest that the "across the board" effect of continuing failure by Scottish Government to implement its obligation to make suitable provision to regulate deprivations of liberty should be prioritised. Recent well-publicised experience demonstrates substantial numbers of potentially unlawful deprivations of liberty, including in the form of unlawful discharges from, or retentions in, hospital, both before the commencement of the pandemic, in the period following it, and continuing since then.<sup>5</sup> This has occurred despite the Mental Welfare Commission addressing such issues in 2004 (see the 2004 paper listed in our previous response); Scottish Law Commission produced a report with recommendations in 2014; and Scottish Government consultation on that report was substantially completed in 2016, though followed by further consultation partly on that issue and to a large extent on other issues in 2018.

## Chapter 1: Independent Advocacy

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### Our general comments on this chapter

We have no general comments.

### Our response to the consultation questions

#### 1.1 Please give us your views on this proposal.

We consider this to be an essential proposal, and support it. However, the alignment should not be limited to existing legislation listed in the consultation document. Provisions should be drafted to allow them to be incorporated into future legislation.

<sup>4</sup> Current Law Statutes, published by W Green, at page 4-4

<sup>5</sup> See our response to the preceding consultation, available at: [22-05-27-mhd-crim-smhrl-consultation.pdf](https://www.lawscot.org.uk/22-05-27-mhd-crim-smhrl-consultation.pdf) (lawscot.org.uk)

## **1.2 Do you think there should be an opt out system for independent advocacy?**

We agree that there should be an opt out system, but with obligations to provide explanation and support to anyone indicating an intention to opt out.

## **1.3 Please give reasons for your answers.**

Based on our experience, there is a danger that when people feel overloaded with requirements, particularly when they are in crisis, they react negatively to anything that is proposed. They may do so to shield themselves from such demands, without – in the case of advocacy – understanding the meaning and value of what is proposed. They need to be given sufficient time, information and support to make a truly informed decision. It might be sensible for the opt out to be recorded in writing, signed (or counter-signed) by the person who has given this support.

## **1.4 Please give your views on our suggestions for change.**

The proposed statutory definition should be clear as to overall purpose and functioning, but inclusive rather than exclusive in stating particular functions, to allow for future development of the concept without need for amendment of statutory provisions. Except for our specific comments in these responses, we support the suggestions for change.

## **1.5 Please give us your views on the proposals for evaluation and quality assurance of independent advocacy organisations.**

We support these proposals. Evaluation and quality assurance should in particular target initial and ongoing training of advocates, monitoring, support, and complaints handling. Requirements should be presented in such a way as to acknowledge that a culture of rigorous self-criticism is preferred to records designed to show that “everything is fine”.

## **1.6 In particular if you consider the role of evaluation should be given to an existing body, we would welcome suggestions as to which body might take on that role.**

We have no comments.

## **1.7 Please give us your views on our proposals for who can be an independent advocate.**

Various purposes require to be identified and balanced, as they are not always easy to reconcile. Being too prescriptive about requirements might deter people who would in fact make excellent advocates. People able to “tick all the boxes” may still perform poorly, often because of the nature of their underlying motivation. The contribution of a good advocate, of course, will tell the maximum about the client and nothing at all about the advocate’s personal views and preferences. Our view is that recruitment should be broadly based on personal characteristics; that pre-recruitment requirements should be limited to those which are essential, namely those proposed in the consultation document; and that there should be clear standards of induction and training that should be mandatory and stated as minimum requirements, with further requirements for ongoing training, and shared learning arrangements in which less experienced advocates can learn from those with greater experience. The dangers of persons failing to understand the role, or failing to apply that understanding, and of persons acting inappropriately, are such that there should be minimum evaluation standards and, on balance, if possible a requirement for registration. There should be further research and assessment as to whether proposed requirements would have an undue deterrent effect; but on the other hand there does need to be a way of “tracking” people who use the role inappropriately in any way (including promoting personal agendas), perhaps moving from organisation to organisation when found to be unsatisfactory.

There are of course many people who act as effective advocates for one individual only (usually a relative or friend) who are not offering a service in a general sense. They should be recognised as supporters, rather than advocates. Some might contemplate applying the experience to others in the future, for example following the death of the supported relative. While such an intention should be welcomed, it should be seen as a step from one role to another, notwithstanding the value of past experience for the new role, which should be distinguished (among other things) by the training and other requirements.

Given the crucial role of independent advocacy in supporting people to understand and navigate complex systems, independent advocates should have access to opportunities for professional development and career progression to encourage them to remain in the independent advocacy sector. We are aware, anecdotally, that it is not uncommon for independent advocates to choose to move on to other related careers to access better pay, conditions and opportunities.

## **1.8 Please also let us know if you consider the qualifications and registration should be required for those who support collective advocacy groups.**

The key point here is the distinction between support and advocacy. Anyone providing support but not acting in an advocacy role should not come within advocacy regimes, but if that person acts as advocate and not just simply a supporter of self-advocacy, then that person should come within the regime. While some acting in such ways, in the best of faith, might find the distinction difficult, it is important that they should understand it.

## **1.9 Please give us your view on our proposals for improving diversity ,equality and inclusion in independent advocacy**

We support these proposals provided that they address fully and in a balanced way each of the requirements for diversity, equality and inclusion, with the principal emphasis upon inclusion, to ensure that “tick box” requirements in relation to diversity and equality do not limit the widest possible recruitment of people – however they might be personally categorised, and however unusual their personal backgrounds – who have the potential to become good and effective advocates, and are motivated to do so.

## **1.10 Do you think there should be a national fund for the provision of independent advocacy in Scotland ? Please give reasons for your answers.**

Yes. The proposals that we support cannot be achieved with sufficient minimum effectiveness across the country without some carefully targeted financial support.

## **1.11 Please give us your views on the proposals for training and your reasons for these.**

We reiterate the point that support (meaning “support for the exercise of legal capacity” in the broadest sense, in terms of the requirements of UN CRPD) and advocacy are separate functions, not necessarily performed for the same individual by different persons, and indeed in many situations performed by the same person. However, the common theme for training such as is proposed should not be either the provision of support or the provision of advocacy, but an understanding of the separate concepts of rights, will and preferences and the requirement to respect each of them. There must be separate understanding of each element: often “will and preferences” are treated as if they were one combined entity, when they are not. Support and advocacy are two means by which respect for rights, will and preferences might be achieved, but those distinctions (including the five categories listed on page 23 of the consultation document), and the related standards and requirements (where applicable, for example in relation to particular categories of professionals) should be seen as separate steps beyond the unifying core training focusing on respect for rights, will and preferences. There will require to be implementation arrangements addressing the outcome of the Review in a coordinated way, to include both appropriate training for identified roles and also general public education and awareness. As we have previously urged, this could usefully be based on the experience gained by the work of the implementation steering group in relation to the 2000 Act.



## 1.12 Please give us your views on our proposals for scrutiny of independent advocacy organisations.

While supporting the concept of an appropriate agency, the emphasis and culture should be not upon scrutinising alone, but on scrutinising and supporting advocacy organisations. We have not considered whether such a function could be provided by an existing organisation. While we would not propose the Office of the Public Guardian for this role, the ethos of that Office of combining scrutiny (if necessary, rigorous) with availability of advice and support could usefully be transferred to the functioning of the suggested agency.

It is also essential that the cost of appointing a scrutiny agency and creating supervisory structures is not at the expense of appropriate funding for frontline advocacy organisations.

## 1.13 Please give use your views on the proposal for support for unpaid carers.

In our experience, the needs of unpaid carers can often be greater, yet more neglected, than those of the persons cared for. Here again, however, the distinction between support and advocacy is important. If the proposal is intended to cover both, we support it.

## Chapter 2: Advance Statements

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### Our general comments on this chapter

Throughout this response, we adopt and adhere to the scope and terminology set out in our paper *Advance choices, and medical decision-making in intensive care situations*.<sup>6</sup> We adopt the term “advance choices” as a more accurate term for what are sometimes otherwise described as advance directives. We have referred to our paper throughout this chapter of our response.

This chapter is in our view too narrowly focused on healthcare matters, and principally even more narrowly on mental health matters, rather than addressing the Review’s full remit; and it is too narrowly focused on the sub-category of advance choices that records “wishes and feelings”, rather than the broader purposes of advance choices (according with the Council of Europe definition of advance directives)<sup>7</sup>. The Review’s recommendations on this and other topics need as far as possible to be “future-proofed” to take account of predictable developments over the minimum period of two decades which has hitherto separated comprehensive reforms of this area of law.

<sup>6</sup> [22-05-19-adwg-report-final.pdf \(lawscot.org.uk\)](https://www.lawscot.org.uk/22-05-19-adwg-report-final.pdf)

<sup>7</sup> See our General Comments on the whole paper, above.

## **Our response to the consultation questions**

### **2.1 What are your views on the proposed system, any significant omissions and on other steps that might be taken to strengthen advance planning as part of the supported decision making framework in our wider proposals?**

We adhere to our proposals in our recent paper (see above), under which mental health advance statements are seen as one sub-category of advance choices.

### **2.2 What do you think of the general approach to a ‘statement of will and preference’ (SWAP)?**

This proposal confusingly conflates the two distinct concepts of “will” and “preferences”. “Will” represents a settled decision or determination on a matter, at the time when it is expressed. At any one time there can only be one expression of will on the same matter. “Preferences” indicate a range of considerations, in varying degrees persuasive, which often include conflicts which require to be resolved in order to arrive at a statement of will, but which are nevertheless all relevant to understanding the personality and views of an individual, particularly in situations where it is necessary to try to construct a best interpretation of the adult’s will. If the concept of a “statement of will and preferences” (which in any event should be plural, rather than the singular “preference” in the consultation paper), then it will be necessary for accompanying material to explain the difference, paralleled with an explanation of the difference between advance instructions and advance statements (as defined in our paper).

### **2.3 What are your views on the application of the ‘statement of will and preference’ (SWAP) to treatment under Mental Health Law, other medical treatment and other welfare issues?**

It is welcome that this question extends beyond mental health law, but unclear why it is still limited to “other medical treatment and other welfare issues”, rather than the full potential scope of advance choices. In the limited situation of mental health law, the starting-point should be to address what should be the permitted outcomes of an advance choice, and in particular the extent to which they should be binding, the circumstances in which they may be disapplied, and the extent to which they should be treated as persuasive and indicative only (and non-binding).

## **2.4 What do you think of the possibility that a SWAP could give advance consent for something the person might refuse when they are unwell?**

In principle, this should be fitted within the proposals in our paper, including in particular as to the status of different categories of advance choices and (in the case of advance instructions) the criteria for disapplication.

## **2.5 What are your thoughts on the process for making a SWAP and the requirements for its validity?**

These should be as proposed in our paper.

## **2.6 What do you think of the proposals as to who can decide if a SWAP should not be followed?**

The overall regime for disapplication should be as proposed in our paper. That would not exclude any special provisions for the purpose of mental health advance statements only, but they should clearly be identified as particular requirements for one sub-category of advance choices.

## **2.7 S243 of the Mental Health (Scotland) Act 2003 allows for treatment to be given to prevent serious deterioration in a patient's condition. We have not included this as it may prove too broad a justification for many psychiatric treatments which a patient might reasonably refuse. What are your views on this?**

This should be approached in accordance with the analysis of relevant law in relation to medical decision-making offered in our paper.

## **2.8 We would like to know your views on the overruling process proposed and if there are any others you think might be authorised to review certain decisions.**

Again, the framework proposed in our paper should apply to questions of disapplication of advance instructions. The consultation paper (though not the consultation questions) raises the distinct, important and novel issue of whether patients should be able to demand a particular treatment. Under existing law they cannot. They may accept or reject treatment offered, or make a choice among alternative treatments that are offered. A right to demand treatment, even a qualified one, would be novel, and this should be made clear in any legislative proposals, and in consultation upon them. It is noted that the "right to demand" would be based on the assertion that human rights principles could be violated if the requested

treatment were not to be provided. We consider that this approach has merit, on the basis that refusing such treatment should be approached in the same manner as our paper proposes for disapplication. It should be recognised that this would create an element of reversal of onus: the medical practitioner would have to justify not offering a particular treatment and not proceeding with it if the offer were accepted, with an onus upon the medical practitioner to justify not having offered it. We anticipate, however, that the principles for disapplication proposed in our paper would still be applicable.

## 2.9 What do you think about the proposals for dealing with conflict?

If these proposals are to be stated in the Review's Final Report, they should be accompanied by statistics for use and outcomes of the existing procedures referred to. For example, in relation to procedure under section 50 of the 2000 Act, our understanding from information available to us is that this procedure has rarely been initiated, never carried through to a final determination by a nominated practitioner, and has never been taken further to a decision by the Court of Session. That does not mean that these procedures are not valuable: the fact of their existence may have the beneficial effect of encouraging parties to find an agreed solution, though with the danger that an agreed solution may reflect the wishes of the parties to a dispute rather than a best interpretation of the rights, will and preferences of the patient. Accordingly, the safeguards in Article 12.4 of CRPD should be robustly applied to any such procedure.

## Chapter 3: Forensic Proposals

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### Our general comments on this chapter

The views expressed in our previous response on the status of "mental disorder" apply also in the forensic sphere. To an extent, it could be argued that over time Scottish criminal law (or at least the way in which it is characterised) has taken a "wrong turning" away from underlying principles. Even in accordance with existing fundamental principles, there should be no differentiation "solely on grounds of mental disability" or on grounds of "mental disorder". As regards guilt or innocence, the fundamental question, if the act alleged is proved to have occurred, is whether there was or was not *mens rea* (criminal intent). If *mens rea* is absent, that, not the reasons for its absence, is the determinative factor. The reasons may be a mental disorder, or other reasons. The principle is the same.

On the issues of risk to others, including to their safety and risk of serious harm, existing provisions are wrong in principle in that they start with the presence of a mental disorder, rather than the presence of risk. At present, terrorists known to continue to present a high level of risk are nevertheless released upon completion of their sentences. Where necessary, we understand that security personnel are detailed to follow them constantly. See the examples given on page 182 of "Mental health, legal capacity, and human rights" (Stein and others, editors), Cambridge, 2021. If people are to be deprived of their liberty, or have their freedoms limited, because they present a risk, there should be a uniform regime for that which is non-discriminatory. The present situation of differentiation of people with mental disorders in the controls

applied to them, compared with others (such as convicted terrorists) presenting equal or even greater risk, is potentially discriminatory and may amount to a violation of human rights obligations undertaken by the United Kingdom.

As with application of the principle of *mens rea*, there should be no fundamental discrimination in relation to the application of the principles of mitigation. In the case of diminished responsibility, the focus should be upon the degree of diminished responsibility. The presence of a mental disorder should be secondary to that: the mental disorder may support an assertion of diminished responsibility, but should not of itself be the sole reason for such a finding.

Similar principles of non-discrimination should apply to any link between mental health provisions and criminal disposals. If criteria for treating a mental disorder exist, the court may direct that treatment be offered, but beyond that the right of the patient to refuse treatment that is offered, and the availability of provisions to override that refusal, should be the same as under civil procedure. The level of punishment, if any, should likewise be unified with the other provisions of criminal law, whether exoneration by reason of lack of *mens rea*, or mitigation or adjustment of punishment by reason of mitigating factors derived from a mental disorder. In no circumstances should a disposal based on the commission or alleged commission of an offence be more restrictive of liberty or freedom than where similar lack of *mens rea* or mitigating factors arise from reasons other than mental disorder. If measures relating solely to the mental disorder are appropriate, they should be shown to be appropriate by the same criteria as for people who have not reached that point through the criminal justice system.

No new regime following upon the Review should start life in breach of international human rights obligations. It should be based on the above principles. That approach informs our responses to consultation questions below.

## **Our response to the consultation questions**

### **3.1. Do you agree that we should introduce intermediaries to support people who need them in criminal proceedings? (Section 1)**

Yes. There could be real benefits to having an intermediary with specific training to support people who require it in criminal proceedings. Communicating with the accused is typically reserved to the defence solicitor however and so careful consideration would have to be given as to how the two roles would interact, and also to practical issues such as appropriate training for intermediaries and whether intermediaries could be called as witnesses. Consideration could be given to extending the role of specialist independent advocacy workers.

### **3.2. What do you think about courts being given the power to require that appropriate medical provision is found for any remanded prisoner? (Section 2)**

In principle, yes. This should cover both medical provision and placement. Mentally disordered accused persons are often remanded to prison simply because a psychiatric bed cannot be found and they cannot be safely bailed. Courts are often reluctant to bail people to hospital addresses even if beds are available. It is not always possible to make a hospital based order in the absence of supporting reports. However, the scope of the proposal and how it would work in practice are not clear. Does this mean that the Court should have the power to direct that a bed in a hospital must be found in order to prevent someone being remanded (if the remand is only on the basis a psychiatric bed can't be found and they can't be safely cared for elsewhere)? If so, who is the direction to be issued to? At what stage is this to take place- first appearance, or later in the process? If so, how is this to be communicated and by whom? Will a 'short term holding power' power be required i.e. the person must be transferred to the relevant hospital within 72 hours? Should the Scottish Ministers be involved? The focus of any new power should be on ensuring that there is an attributable duty to ensure that remand prisoners are able to access appropriate medical provision. In some cases, this may lead to such prisoners being appropriately diverted from the criminal justice system at an early stage.

### **3.3. What are your views about whether supervision and treatment orders continue to be needed or not? (Section 3)**

Supervision and treatment orders should remain in force. These are not used widely however there are limited options available to the Court upon disposal of a case whereby an accused has been found not criminally responsible or unfit for trial. Supervision and treatment orders essentially allow for an ongoing level of monitoring by trained professionals in the community where the criteria for a compulsion order is not met. This is a less restrictive outcome than a compulsion order in many ways but allows a level of support and supervision that would not be available to the Sheriff if the Court makes no order. There is no provision for the social worker who is the supervising officer to have any specialist qualifications. A mental health officer may be more appropriate where ongoing treatment for a mental disorder is part of the disposal.

### **3.4. Do you think there are specific legal changes that could support more appropriate diversion of offenders into the mental health system? (Section 4)**

There should be specific provision within the legislation to ensure that diversion by way of treatment under the civil mental health procedures has been considered before a person is prosecuted/convicted. There should be an obligation on the Crown to explore this, and the Court to consider it. There should be a requirement for Sheriffs, and defence and prosecution agents to undergo mandatory training if they deal with cases involving mentally disordered offenders/accused persons.

### **3.5. What do we need to be aware of from a forensic mental health point of view when considering the continued use of ‘mental disorder’ within our mental health and incapacity law more generally? (Section 4.1)**

See introductory comments to this section.

### **3.6. What are your views on whether or not a SIDMA test (or a similar requirement like ADM) should be added to the criteria for forensic orders? (Section 4.2)**

A SIDMA test or similar should be added for forensic orders. The same criterion should be applied as in cases for ‘civil’ patients.

### **3.7. Do you feel that risk to the health, safety or welfare of the offenders (‘harm to self’) should continue to a criterion for forensic orders? (Section 4.3)**

Yes, but the same criterion, applied similarly, as for “civil” patients. This is a very sensitive issue. Whilst appreciating an individual’s right to autonomy and independence, and acknowledging the criminal law does not often intervene to prevent individuals from harming themselves, there is an argument that given the individual is within the confines of the criminal justice system and the risk has been brought to the attention of the state, then the state has a duty of care to that individual. The criminal law may not be best suited to supporting these individuals. However if they are receiving no care or support from other sectors then is there not a responsibility on the state to take action and provide that support, from whatever source, rather than allow these people to potentially fall through the gap?

### **3.8. Do you think forensic orders should only be allowed if the offence is punishable by imprisonment? (Section 4.4)**

No, provided that the principles in our general comments on this chapter are applied. We would agree that on the face of it there appears to be unfairness in that someone can be accused of having committed a crime and, even if convicted, that conviction could not lead to imprisonment however if they are acquitted, on the basis they are unfit for trial or not criminally responsible, they may have their liberty restricted. We can see the merit in suggesting supervision and treatment orders as an alternative. However, the forensic order is not intended as a punishment but as a means of providing the effective medical treatment and support the individual requires. If an order which restricts the person of their liberty is considered to be the most appropriate measure to take to provide the most suitable treatment for them, then that order should be available to the court.

A prison sentence, and a restriction of liberty as a result of a forensic order, are not directly comparable. They don’t seek to achieve exactly the same aims.

The imposition of a restriction order is a different matter. This is an order which is potentially lifelong, and is without limit of time. There is little scope for review. If a person has been convicted of a crime, or are acquitted of a crime, that they would not have been imprisoned for had they not been suffering from a mental disorder then it does not seem equitable, and indeed seems potentially discriminatory, to allow them to be made subject to an order of such gravity. Arguably, if the offence was not so serious that a person who is not suffering from a mental disorder cannot be deprived of their liberty, then an order further restricting a persons liberty without limit of time should not be available to the Court.

### **3.9. Do you have any suggestions for updating the criteria for imposing a restriction order? (Section 5)**

Whilst the approach set out in section 59 of the 1995 Act is robust and remains appropriate, it is agreed that the wording originating in the 1960 Act (and now replicated in the 1995 Act) is potentially outdated and ambiguous, and could be updated and clarified. It is not clear whether the test is to be considered in the context of a person having been released with no support, or a person having been released and subject to a compulsion order- this should be clarified.

### **3.10. What do you think about the differences between the tests and procedures for imposing an Order of Lifelong Restriction (OLR) and those for a compulsion order and restriction order (CORO)? What should we do about this? (Section 5)**

It is not necessary for the tests to mirror each other, nor would it necessarily be appropriate for them to do so. The two orders are intended to serve distinct (albeit, to some extents, similar) purposes.

Protection of the public is at the heart of both tests. However, in respect of the CORO an additional outcome is sought. The individual has been made subject to the order because they have a mental disorder and medical professionals have identified there is treatment available which would alleviate the symptoms or stop the disorder from worsening. As such, whilst public protection is a major contributing factor in determining whether to impose the order, so too is the health and welfare of the individual.

In respect of an OLR there is no suggestion the risk to the public can be mitigated or extinguished by the offender receiving treatment. However, for mental illness to be part of the criteria for such an order would potentially contravene UN CRPD, and may be unlawful if CRPD is incorporated into Scots law in accordance with the intentions of Scottish Government. It would only be non-discriminatory if arising from an assessment of risk equally applicable where risk arises from mental illness or from other causes. See our general comments on this chapter, as regards the example of convicted terrorists predicted to resume previous dangerous conduct upon release.



### **3.11. What do you think about our proposals for time limiting compulsion orders, with or without restriction orders? (Section 6)**

One concern in applying time related options for additional restrictions “in the same way that is applied for criminal sentences” is the attempt to compare the forensic orders to a criminal sentence. One of the considerations of the court when imposing a sentence is punishment, as is deterrence. A forensic order is not intended to punish an individual nor is its imposition designed to act as a deterrent to others. A forensic order is not directly comparable to other sentencing options.

In addition it is noted “we have heard that a form of limiting term was used in the past in Scotland, but there were problems accessing the appropriate resources to sustain it”. There is no elaboration on what the problems were. It is therefore difficult to determine whether these problems could now be overcome.

### **3.12. What do you think about our suggestions to either remove or significantly restrict the ‘serious harm’ test introduced in 1999? (Section 7)**

See our general comments on this chapter. The serious harm test was essentially introduced to remedy legal challenges which could lead to perceived unsafe discharges. This has created a situation whereby the risk of serious harm is one of the primary considerations in forensic mental health orders. The detention of a person with a mental disorder without consideration as to whether the person can benefit from treatment is not consistent with the principles of the Mental Health Act. The serious harm test is often misunderstood, particularly in the context of their being a separate test for the imposition of a restriction order, and there being a separate criterion for risk to others. The serious harm test should not negate the need for beneficial treatment under the Mental Health Act.

### **3.13. Do you think the current roles that Scottish Ministers have in the management of restricted patients should be reduced, and to what extent? (Section 8)**

The role of the Scottish Ministers can cause delay to rehabilitation and discharge in some cases. In many ways there can be administrative barriers and delays. RMOs should be given a higher level of discretion in care planning with restricted patients. It is assumed that Ministers require to give the same level of permission and input in every restricted patient case. This should not be assumed and assessment should be made on a case to case basis with RMOs taking more control over planned outings and rehabilitative activities when the risk is carefully managed, and with lower risk patients, as they do with ‘civil’ patients. Consideration should also be given to the fairness of MAPPAs procedures. There is no transparency or right to challenge decisions, access information in respect of how decisions are made, or indeed in some cases what decisions have been made. MAPPA decisions influence care plans that impact upon the length of time a person spend in hospital, or on forensic orders. The inability to challenge these decisions or access information may not be ECHR compliant. The Scottish Minister currently have a 21 day period to appeal any conditional discharge, even if it was not opposed by them. This delays a persons discharge until the

appeal period has expired. There should be an option for Ministers to opt out, or formally intimate that they do not attend to appeal, to allow the immediate discharge of the patient as again is the case in civil cases where discharge is granted.

**3.14. What do you think about the additional powers we are suggesting for the Mental Health Tribunal around the discharge and recall of restricted patients? (i.e. that they have a role in the recall, a power to vary conditions and a power to discharge to conditions that amount to deprivation of liberty)? (Sections 8, 8.1 and 8.2).**

We agree, subject to the general points in our introductory comments to this chapter. There should be a mechanism, post conditional discharge, to apply to the Tribunal to vary or remove conditions of discharge. There should be an automatic review by the Tribunal upon recall within a set period of time.

**3.15. Are there any issues with respect to cross-border transfers which are relevant for how the law might be changed? (Section 9)**

Cross border transfers should only be permitted in exceptional circumstances. It has been identified that in Scotland provision for some groups, and females in particular, is not adequate. There are no high secure female beds in Scotland. Female patients may be inappropriately placed in prison or medium secure facilities due to this lack of provision. Cross border transfer has the potential to breach the rights of those transferred from their home area, and may be discriminatory insofar as they are required to travel cross border for appropriate medical treatment. Specific criteria for a cross border transfer may be considered, to ensure that all alternatives have been considered and made available.

**3.16. Do you agree that there should be an enforceable duty on Scottish Ministers to ensure that prisoners with significant mental health needs are accommodated safely and appropriately? (Section 10)**

Yes. This duty should apply in reference comments made at 3.4, and should also apply to remand prisoners. Currently there is no provision in prisons for remand prisoners to receive longer term therapeutic mental health interventions in prison.

**3.17. Do you agree recorded matters should be allowed for forensic orders? (Section 11)**

Yes, again this should be in line with 'civil' orders.

### **3.18. Do you agree that the current right to appeal against conditions of excessive security (excessive security appeals) should be extended to all people subject to compulsion? (Section 12)**

Yes, where there is deprivation of liberty appeal rights should be equal to all detained patients.

### **3.19. What do you think about removing the need for excessive security appeals to be supported by a medical report by an approved medical practitioner? (Section 12)**

This requirement should be removed. There is no such requirement for any other appeal. There are barriers in instructing and receiving such reports. There is a small pool of forensic psychiatrists in Scotland. There are often conflicts with psychiatrists unable to do 'independent reports' due to conflict of interest where they have previously treated the patient or work in the receiving hospital. There are also restraints on legal aid funding for such expert reports, which can be costly. Some RMOs will not provide these reports for various reasons. Where deprivation of liberty is at the heart of an appeal, there should be minimal restrictions on the appeal right. It is for parties to present all available evidence to the Tribunal and for the Tribunal to make a judgment on the merit of the appeal.

### **3.20. What do you think about giving voting rights to people in the forensic mental health system? (Section 13)**

There should be no differentiation from other persons in the criminal justice system.

### **3.21. Do you have additional proposals for change?**

1. We would suggest that those on Compulsion orders with restriction orders should have a review tribunal after 6 months, in line with those patients only on compulsion orders alone.
2. The Tribunal should have the ability to vary a Compulsion Order when an application is made under s149 as a first extension. Presently the Tribunal can only extend, refuse, or refuse and revoke the Compulsion Order. At present the Tribunal cannot vary any of the measures.
3. Where an application for a Compulsory Treatment Order is made upon the expiry of a Transfer for Treatment or Hospital direction, when a prisoners sentence is due to end, there should be a mechanism for the Tribunal to make an interim order. Presently, only a full CTO can be granted. This does not allow for the patient or any other party to seek an interim order if further investigations require to be made. This is governed by Schedule 3 of the Act which allows for these patients to be treated separately from those patients who are subject to a s63 application under civil circumstances.

4. The use of Treatment Orders should be reviewed. These are often, in error, given as a final disposal by the Courts. The use of Treatments Orders post conviction should not continue. Interim Compulsion Orders allow for more frequent reviews and also permit treatment. This would avoid the use of Treatment Orders as final disposals which allow for no review at all and cause a procedural irregularity and can cause people to be discharged prematurely due to the incompetence of the order, or be detained disproportionately if this is not identified. A specific procedure manual for use with mentally disordered offenders/accused would also be beneficial.

5. Appeals in respect of the Mental Health Act for Restricted patients must go to the Court of session. This is a cumbersome and lengthy process which denies patients on forensic orders the right to an effective appeal process.



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