Royal College of Physicians of Edinburgh response to the Scottish Mental Health Law Review - Additional Proposals.

Independent Advocacy

Introduction

Independent advocacy (IA) seeks to speak up for and stand alongside individuals or groups , to help ensure an individual's rights are recognised , respected and secured.

It can happen on a one-to-one basis where one person is supported by another. Alternatively, it can happen in groups or collectively where a group of people with a shared agenda come together to campaign and influence change.

The role of independent advocacy is to support people to understand and navigate complex systems. It helps empower people so they can have more control over their lives and ideally are able to make their own decisions (with support if needed). It addresses the imbalance of power that often exists between people who are marginalised and discriminated against and others e.g., decision makers. It facilitates good communication and helps people speak up and voice their needs, wishes and desires with the aim of enabling people to live fulfilled lives. It is more than people fulfilling their basic human rights, it is about ensuring people have access to education, employment, relationships, support networks and friendships. Independent advocates only do what they have agreed with their advocacy partner.

Non instructed advocacy

Non instructed advocacy plays an important role in safeguarding people with little or no verbal communication. Its role is to take affirmative action with or on behalf of a person who is unable to give a clear indication of their views or wishes in a specific situation. The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with consideration for the will and preferences of the individual.

What does the law say about independent advocacy?

The vision of the Millan committee was that independent advocacy should be readily available to anyone with a mental disorder who needed it . The right to independent advocacy is enshrined in the Mental Health (Care and Treatment) (Scotland) Act 2003.

What is the current landscape and how can we improve it ?

Only around 5% of people who have a right to independent advocacy actually access it. There are several reasons for this:

- the lack of knowledge amongst people about what independent advocacy is, how it can benefit them, how to access it,
- the very limited levels of funding most independent advocacy organisations (IAO) receive,
- the different 'levels' of access that each piece of legislation grants,
- the lack of awareness or understanding of IA amongst Health & Social Care staff.

There remains a 'suspicion' or mistrust of IA on the part of some staff who believe they are more 'appropriate' advocates for the person they are treating or supporting without proper regard for the conflict of interest created.

There is a lot of confusion amongst professionals about the right to independent advocacy. The Scottish Government has recognised that there are many situations in which people require additional support so as well as the Mental health legislation the following legislation also grants a right to independent advocacy:

- Social Security (Scotland) Act 2018
- The Children's Hearing (Scotland) Act (2011)
- Education (additional Support for learning) (Scotland) Act (2004)
- Guidance on Looked after Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007

- Social Care (Self Directed Support) (Scotland) Act (2013)
- The Patient Rights (Scotland) Act (2011)

This has created a situation where people have different levels of access depending on the situation. For example, a person living with mental health issues may be able to access IA for themselves but if they have a child with additional support needs it would be almost impossible for them to access IA to help secure additional support for their child because the Additional support for learning Act requires local authorities to tell parents about IA but does not place a duty to fund it.

A person could be accessing advocacy from more than one organisation for different needs. As there is no shared code of practice, principles or standards people are likely to have to repeat their stories to different organisations who work in different ways leading to confusion amongst service users .

Proposals for change

- We are proposing that the Scottish Government should consolidate and align all the different pieces of legislation and policy to ensure consistency regarding the definition of independent advocacy, the right to access it and how it is commissioned and funded.

Question

- Please give us your views on this proposal.

The Royal College of Physicians of Edinburgh considers that it is appropriate and logical for the Scottish Government to consolidate and align all the different pieces of legislation and policy to ensure consistency in this area.

Improving access to independent advocacy

There is no uniform method of procuring, commissioning or funding independent advocacy across Scotland which means there is no equity of access. There are small organisations covering large areas with very few staff. For access to improve

this needs to change.

The Rome review on learning disability and autism within mental health law recommended that there should be an opt out system so people have to actively choose not to have a support from an independent advocate. Experience has shown that once people understand the role of an independent advocate the overwhelming majority accept and want it.

Proposals for change

If there is to be an opt out system we think the following things need to happen:

- The Scottish Government needs to set out in law what the role of an independent advocate is and the duties required to effectively commission and fund IAOs.
- IAOs need to be resourced to explain what they do and how they can help people help themselves.
- Training need to help practitioners across health and social care to understand what IAOs can do and how IA can help improve communication, relationships with patients and unpaid carers and can help secure better outcomes for patients
- There should be a public awareness raising about independent advocacy
- A wider right to independent advocacy in law,
- Strong right to access independent advocacy in human rights legislation

Questions

- Do you think there should be an opt out system for independent advocacy?
- Please give reasons for your answers
- Please give your views on our suggestions for change.

The College supports the principle of an opt out system for independent advocacy as there will of course be some cases where individuals do not believe it is appropriate or necessary for them . The suggestions for change here appear broadly correct.

Evaluation and quality assurance of independent advocacy organisations

We need a systematic way of measuring the quality of the services being delivered by IAO and the difference they are making. It is also important in the context of safeguarding the people who access IAO so we need to make sure that services are not only providing independent advocacy of the highest standards, are following the Scottish Independent Advocacy Alliance Principles, Standards & Code of Practice but also that organisations are being run ethically, effectively and efficiently and providing staff and volunteers with the right support.

The SIAA has on many occasions called on the SG to set up an independent system of evaluation of IAO for many years. Currently IAO must commission independent consultants to evaluate them using the Evaluation Framework and the Measuring Impact Toolkit. They must fund this through their reserves as they no longer receive funding for evaluations as they did in the past.

As part of their SLA or contracts most IAO already collect data on the issues, they support people with including breaches of human rights and regularly share these with their monitoring officers or commissioners and funders.

Proposals for change

- We think that an independent body should be created by the Scottish Government with a specific remit to evaluate independent advocacy organisations , or responsibility be given to an existing organisation to do this.
- Resource should be given to independent advocacy organisations to collect data in a uniform way across Scotland, so issues can be tracked at structural and strategic level.

Questions

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

The College considers there should be a system that coordinates independent

advocates and evaluates the process. This needs to be independent and with clear lines of accountability.

- 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.

Who can be an independent advocate?

Independent advocacy organisations recruit both volunteers and paid staff . All require references and disclosure checks. They provide training using the SIAA Principles, Standards and Code of Best Practice amongst other documents. However, there isn't an agreed standard of induction or training for new volunteers, staff or collective advocacy members.

The Advocacy Project in Glasgow has developed a SQA accredited qualification in independent advocacy alongside Edinburgh Napier University, which is being used by several organisations. It has not been rolled out across Scotland, due to the costs involved and to the fact that some organisations object to the development of a qualification for philosophical reasons. The Scottish Government has in the past raised the issue of independent advocates being 'registered' much like SSSC hold a register of social care staff during the passage of the Social Security Bill. This is an issue that has been discussed within the advocacy movement but remains without conclusion.

Proposals for change

- Introduce a Scotland wide qualification for paid and voluntary independent advocacy workers
- Create a national register for independent advocacy workers

Questions

- Please give us your views on our proposals for who can be an independent advocate.
- Please also let us know if you consider the qualifications and registration should be required for those who support collective advocacy groups

The College considers there is merit in developing further proposals for a Scotland wide qualification, working with carer organisations to do so.

Diversity, equality and inclusion

It is hard to identify all the groups accessing independent advocacy because not all organisations collect monitoring data, but the impression we have is that there are several groups who have a legal right to access advocacy but don't.

Also there is a lack of diversity amongst those who work or volunteer for Scottish advocacy organisations . There is an urgent need for more diverse representation. The dilemma is whether there should be specialist services that are culturally appropriate or should 'mainstream' IAO take steps to make themselves more accessible to marginalised groups. However, evidence from the Scottish Indepent Advocacy Alliance (SIAA) Advocacy Maps show that few people from those groups access these IAO and it is unclear what steps individual organisations have taken to remedy the situation. If specialist organisations are set up, then there needs to be a recognition that people should also still have a choice between accessing a specialist service or a 'mainstream' one.

Proposals for change

- Those commissioning independent advocacy services to require collection and sharing of monitoring data
- Resource provided for diversity and equality training for all independent advocacy workers
- Support for independent advocacy organisations to have dedicated staff to work with specific groups they share a background with, and to work with groups facing particular barriers in Scottish society

Question

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

The College welcomes plans to improve diversity, equality and inclusion in independent advocacy and understands the need for resource in order to help achieve this. The College emphasises the importance of EDI training across the sector.

Funding and commissioning of independent advocacy

At present local authorities and NHS boards have a legal duty to ensure access to independent advocacy. This creates a conflict of interest especially when service issues arise. And there are significant inconsistencies regarding access to advocacy across Scotland.

Funding models also differ hugely and there is limited transparency in way funding is awarded. Funding models need to consider the diverse range of needs of people accessing independent advocacy. For example, the time required to support a person with learning disability who will often require support from the same person over a long period of time is very different to someone needing one off support for a single issue. There is also the need to bear in mind people in high and medium secure facilities, including young people in secure units, and people in prison with mental health issues who also have the right to access independent advocacy.

Proposals for change

- We suggest the following should be considered around funding and commissioning
- A national fund to be created for the provision of independent advocacy which would cover the different areas of work –e.g. mental health, children's advocacy, social security and remove unequal levels of access across Scotland.

Question

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

The College considers that there is merit in setting up a national fund to ensure equity in support for independent advocacy across the country.

The role of independent advocacy in supported decision making

Supported decision making (SDM) is support that helps a person to form a view about what they want to happen and how to make that happen so that it has legal effect. It includes support for the person to put those decisions into effect and can include support to challenge barriers that disable the person. IA is about empowering and supporting people to make their own decisions. The amount of support provided will depend on the needs of the person.

Supported Decision Making is an integral part of the work of IAO, however some independent advocates may not be familiar with the term or use the language of SDM. Also, there needs to be recognition that some people will need a great deal of support to make significant and 'everyday' decisions. This would place a significant demand on IAO and is probably unrealistic under current funding models. Therefore, we suggest that independent advocacy should be part of the wider SDM landscape where SDM is delivered by:

- Specialist SDM practitioners
- Independent advocacy organisations
- Peer support
- Unpaid carers/family/friends
- Professionals

The 'unique selling point' of independent advocacy is the lack of conflicts of interest and so it might be more appropriate for independent advocacy organisations to be involved in SDM for significant decisions where others might have a potential conflict of interest. For SDM to be effective good quality relationships are essential and the person receiving the support for decision making must be able to trust their supporter and so the involvement of IAO needs to also allow for time for the person to establish a relationship with their independent advocate.

Proposals for change

The Scottish Government should -

- commission a training programme on Human Rights and SDM to all independent advocacy organisations and :
- commission a training programme and awareness raising for the public and other relevant groups on SDM

Question

- Please give us your views on the proposals for training and your reasons for these.

The College considers that both of these training proposals would be positive initiatives which could improve the capacity of independent advocacy organisations and other groups in relation to these issues.

Scrutiny and accountability of independent advocacy organisations

There is a need for robust scrutiny of independent advocacy organisations. This would be the equivalent of the Care Inspectorate inspecting services.

The Mental Welfare Commission was given additional duties around scrutinising local strategic planning for independent advocacy in 2015, however this has not produced the desired results for several reasons including the lack of identified independent advocacy leads in each NHS and LA area.

Proposal for change

- Scottish Government should appoint an agency to scrutinise independent advocacy organisations regularly. Such an agency might need to be overtly human-rights based. For independent advocacy to promote and protect human rights effectively, the scrutinising agency would have to have a thorough understanding of human rights law and its application in practice.

Question

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

The College has no specific comments on this question.

Independent advocacy for carers

Unpaid carers have spoken of their need for independent advocacy. Sometimes they are able to access independent advocacy for their own mental health needs for example but not as an unpaid carer because the organisation might not be funded to work with unpaid carers. Also, organisations report it is not appropriate for unpaid carers and the person they care for to be supported by the same organisation so the carer will go unsupported .

Proposal for change

- Independent advocacy organisations are resourced by the Scottish Government to recruit dedicated staff and volunteers specifically to support unpaid carers.

Question

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

The College considers that unpaid carers should be able to access independent advocacy where this is required and therefore would support more work being undertaken on this proposal.

Advance Statements

Introduction

Advance statement has the meaning given in the Mental Health (Care and Treatment) (Scotland) Act 2003 by which a patient may set out the way in which they wish to be treated, or treatment they do not want, for their mental health condition. In our extant consultation recently concluded, we proposed that it should be made easier to make an advance statement and that they should be integrated with other forms of advance planning.

The Rome Review recommended that a statement of rights, will and preference should replace the advance statement in the 2003 Act for persons with learning disabilities or autistic persons. We believe this should apply to all persons who wish to make provision for their futures involving mental health or incapacity legislation.

As a comparison to our proposals, we looked at approaches of the Mental Capacity Act, The Scottish Law Commission, the propose reforms to the English and Welsh Mental Health Act and the recent Law Society of Scotland review.

Questions

- 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?
  Fellows of the Royal College of Physicians of Edinburgh consider that the uptake and awareness of advance planning is greatly reduced at present by a multiplicity of methods and templates and a lack of robust access and communication. The RCPE considers this proposal is an opportunity to address this issue and secure a legislative underpinning for advance refusal of treatment within Scotland.
  In addition the College considers that there is a continuing requirement for better public education around the importance of Power of Attorney and early conversations about health choices and wishes in various scenarios.

- What do you think of the general approach to a ‘statement of will and

preference' (SWAP)?

The College welcomes the principle that 'there should be consistency between advance decision making in relation to treatment for mental disorders and other medical decisions." Some Fellows urged caution in relation to the introduction of yet another new model, warning that another acronym will not solve the misunderstanding and the lack of accessibility of information on the subject and could potentially even worsen the problem. The College considers that the SWAP model proposed is, in effect, an anticipatory care plan (ACP) and as such that model is very well established and yet poorly used in Scotland's health and social care system. Some Fellows emphasised that ACP should and already do include the ability to document wishes and preferences around care and treatment for those with a mental health disorder; they voiced some concerns that this consultation does not recommend building on and strengthening what is already established or call for a national consistency of approach in ACP process but rather calls for an entirely new model.

- 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?

  The College agrees that any such statement should apply across all of these health and care domains. We have concerns that the proposed process does not address the issues of awareness, national consistency and accessibility of information that prevent existing advance decision-making from being accessed and appropriately used when it matters to the individual. Furthermore, we have concerns that while the communication and education needs of staff supporting any such process are well understood, they are not addressed in this proposal. This must be a key recommendation for any possibility of success in embedding such a process.

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

The College agrees with the concept and considers that reviewing the legal basis for advance decision to refuse treatment or to clearly define treatments where consent can be assumed in a person-centred way would be a welcome aspect of any proposal. The College would want to see this embedded clearly in the proposed model as it would want to avoid confusion over the legality of advance wishes and preferences continuing to create challenges for health and social care staff .

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

  The College considers that this is very similar to the process for establishing an advance directive in Scotland but is concerned that the current proposal does not add clarity to the legal power of advance decision-making. We believe the proposed process needs to make clear what is the legal request and what may add weight to clinical and social care decision-making but is not legally binding.

  The College would wish to highlight that this proposal also mentions using the SWAP to communicate advance decisions regarding emergency but does not reference the existing systems in Scotland for doing that. Currently the Key Information Summary communicates such information where it exists across all emergency health care services while very soon the digital realisation of the ReSPECT process (Recommended Summary Plan for Emergency Care and Treatment) will provide the ability for this information to be communicated across all health and social care settings and with patient access and role based read and write access via the National Digital Platform. It is essential that any proposals for advance decision-making for emergency care relating to individuals with mental health disorders align with the existing national work which is progressing. The ReSPECT digital process could give robust and immediate access to any digitally held ACP or SWAP data set in an emergency situation.

Deficiencies of advance statements

There have been a number of deficiencies noted under the current advance statement model. These are:

- They are not used a lot.
- There is a lack of awareness of them.
- They have legal status but may not be regarded as having sufficient weight.
- They can be overridden by a doctor or Mental Health Tribunal. Reasons for doing so must be recorded.

- The Act does not specify the grounds it would be reasonable to override an advance statement.
- It is a relatively formal process to draw one up having to be signed and witnessed by a qualified person who certifies that the signed had capacity to make the statement.
- It is limited in its application only operating in respect of treatment under the 2003 Act.
- It does not apply to treatment as an informal patient, treatment under the Adults with Incapacity (Scotland) Act 2000 or wider issues someone might want to make provision for.
- Mental health professions are perceived to respond to the quality of the advance statement.
- People may be anxious that past wishes expressed may overrule current wishes.

A revised model will need to remedy these.

The Adults with Incapacity (Scotland) Act 2000 makes no reference to advance statements. This has left considerable uncertainty in the law. There is mixed opinion as to whether an advance directive in relation to medical treatment has legal effect in Scotland. There has been no case law to confirm the position.

Although focus of discussion is primarily medical treatment, advance choices are relevant in relation to other welfare issues. The 2009 document by the Council of Europe states ‘Advance directives may apply to health, welfare and other person matters, to economic and financial matters, and to the choice of a guardian, should one be appointed. The Law Society of Scotland have recently reviewed the law in this area and concluded the Scottish Parliament should make ‘clear and comprehensive legislative provision’ in respect of advance choices.

When looking at advance planning, Anticipatory Care Planning is long established in healthcare and increasingly encouraged with toolkits promoted by Healthcare Improvement Scotland and others. Anticipatory Care Plans will commonly include statements as to what medical interventions a person would or would not wish. The legal status of such Anticipatory Care Plans is not totally clear. It is a useful tool to assist doctors but less obvious as to what should happen if the patient is refusing something in an Anticipatory Care Plan.

There has been a slow increase of capable people making a ‘statement of wishes’ perhaps as part of a power of attorney. This is helpful to support an Attorney and when challenges arise. This can be appended to a power of attorney which is then registered with the Office of the Public Guardian, Scotland. Registering the statement with the power of attorney sets it in stone when it is preferable that the statement should be a living document.

Proposals for change

- We propose that advance statements be replaced by a ‘Statement of Will and Preference’ (SWAP). This should not be a rebadging but a new model to address the inadequacies of the current system.
- We believe that Scotland should address the gaps in incapacity law in respect of advance decision making, as part of an integrated system. In principal we believe there should be consistency between advance decision making in relation to treatment for mental disorder and other medical decisions and the proposed SWAP could extend to all forms of advance choice. The wider issue of advance directives in medical care is a complex and sensitive one, and

further detailed consultation would be needed before adopting a final model for all forms of advance choice.

- A SWAP could have a wider application than medical treatment. It could apply to any support, care or treatment the person may need across all areas of their life.

- There could be variations in the extent to which advance choices are intended to be binding. One model suggested by the Law Society of Scotland includes both advance instructions (intended normally to be binding) and advance statements (non-binding expressions of the wishes of the individual). We believe this could be a helpful distinction.

- The proposals we make for SWAPs are closer to an advance instruction in this approach to a non-binding expression of wishes which could be developed alongside other forms of advance planning.

- A key element of our proposed reforms is that SWAPs should have 'more teeth' than advance statements currently do. We don't believe an advance statement can be simply followed in every case. The key questions that would need addressed are:

    - What are the justifications for *not* following an advance statement?
    - Who should decide if one of those justifications has been made out?

  In answering these questions we are mindful that situations can be complex. We therefore believe that there needs to be a degree of discretion afforded to the decision maker. The decision maker needs to be informed by the principles of law and the person's human rights. It should not be the case that the clinician's view on what is best for the patient is the most important factor.

- Under the 2003 Mental Health Act a patient subject to short term detention or compulsory treatment order does not have the right to refuse treatment for mental disorder, even if they have capacity at the time. In principle we do not believe a SWAP can be more legally binding than a competent refusal at the time which triggers safeguards in Part 16 of the Act. We are developing proposals to strengthen the rights of patients in Part 16 and looking at how

our Human Rights Enablement and Autonomous Decision Making proposals should apply here. We will consider how to ensure the two different situations are treated equitably.

- We understand that an advance statement can be made by a child who is sufficiently mature to make a medical decision in terms of the Age of Legal Capacity (Scotland) Act 1991. We propose the same for a SWAP in relation to medical treatment. If extended to other decisions, they would have legal effect to the same extent.

Proposals for how a 'statement of will and preference' (SWAP) will operate

- Take account of the health and social care system and how decisions are made therein. Stakeholders are involved in developing a revised SWAP mechanism.
- For a SWAP to have legal status, it should be signed or otherwise authenticated and witnessed by someone appropriately qualified to certify that the person was able to make an autonomous decision in respect of the SWAP.
- For the Mental Welfare Commission to retain a register of the SWAP, not including retention of the actual document.
- For the Mental Welfare Commission to have general monitoring and reporting duties.
- The SWAP should be developed with care and time.
- To be able to get help and support to complete a SWAP from people such as advocacy workers, lawyers, peer support workers etc.
- For unpaid carers, clinicians, family and trusted people to have an input to the SWAP, should the person give them authority to do so.
- To be treated as a living document and get regularly updated. For review dates to be logged on the SWAP.

- To have more than one SWAP for different aspects of your life should you wish it.
- To be able to video, audio record or use visual statements to record a SWAP, not just by written statement.
- For a person who has completed an episode of compulsory treatment, at an appropriate time, to consider making or reviewing their SWAP.
- Stored accessibly so they can be located quickly with a copy being held by the individual for emergency situations.
- For style formats to be considered and made available, without prescribing the content.
- If there is no SWAP, the rights of the person to have their views heard are still to be respected. There may be evidence from past wishes, choices or behaviours which could be considered for their will and preference on this occasion. The model of support for decision making and autonomous decision making test both speak about the process of best interpretation.
- Encourage people to have a SWAP to ensure views are heard and not based on assumption or interpretation.

Questions

- What do you think of the proposals as to who can decide if a SWAP should not be followed?
  The College considers that these are reasonable and in line with current capacity legislation and thinking around person-centred care and shared decision-making. Fellows wish to emphasise the importance of awareness and education for those health and care staff who may come across this process infrequently. Any new model would need to be supported to help it achieve a significant profile and there must be clarity of process guidance for staff outwith mental health care.

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 onthis?

The College considers that this should continue to be addressed separately.

When could a 'statement of will and preference' (SWAP) not be followed?

Proposal

- When a person has the ability to make their own decision at that time.
- If a SWAP exists but the person is not able to make their own decision, the SWAP should be respected. It should have the same status in law as of that taken by a competent adult unless one of the following reasons justify it not being followed:
    - The person has acted in a way which is inconsistent with their SWAP.
    - The person's will and preference seems to be more pertinent than those expressed in an earlier SWAP.
    - A position on the person's will and preference on a given matter cannot reasonably be concluded from matters included in the SWAP.
    - There are reasonable grounds for believing that the person did not anticipate the circumstances at the time of making the SWAP which could have affected their decision.
    - There is evidence the person's autonomous decision making was compromised when they made the SWAP.
    - Treatment which is inconsistent with the SWAP is necessary to save the patient's life or to prevent serious suffering on their part. This is drawn from s243 of the 2003 Act.
- The SWAP remains valid even if an attorney is appointed with relevant powers. The granter of the SWAP or the Court may give the attorney express power to act in ways which may contradict the SWAP where they believe that to do so would better protect the person's human rights overall.
- Any overruling only applies to that specific matter and for such time as required.
- If the model is extended to physical conditions, it will be necessary to decide if there are any kind of treatments which cannot be refused in advance.

Drawing on the Mental Capacity Act and the Scottish Law Commission models we suggest:

- It should not be possible to reuse normal hygiene, nutrition, hydration or relief of severe pain
- An advance statement is not applicable to life-sustaining treatment unless it makes clear that this is intended.

- The Mental Capacity Act and Scottish Law Commission models only consider advance refusal of treatment . We believe a SWAP should include treatment a person actively wants to receive.
- A SWAP could not require a treatment to be offered if it isn't available or clinically justified, however it should be given significant weight as failure to make a treatment available could constitute a breach of human rights.
- A more complex questions is whether a SWAP can give advance consent to a treatment the patient may have refused at the time? The concept of advance consent has been advocated for people with conditions such as bipolar disorder, who may have an idea when they are becoming ill and would want early intervention to prevent their condition deteriorating.
- We do not propose that an advance consent in a SWAP be legally binding but should be regarded as significant evidence which may support a decision that a person's stated wishes at the time of treatment do not reflect a fully autonomous decision and might be overruled.

Questions

- 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.

  The College considers that the process is generally appropriate.

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

  The College has no specific comments on this.

Overruling a statement of will and preference (SWAP)?

We propose a model which builds on the system for dispute resolution finally adopted at s50 of the Adults with Incapacity (Scotland) Act 2000 and the role of the

Mental Welfare Commission overseeing advance statements and medical treatment under Part 16 of the Mental Health Act.

A clinician who wishes to overrule a SWAP would refer this to the Mental Welfare Commission who would appoint an independent clinician (in relation to treatment for mental illness, a Designated Medical Practitioner) to assess whether there is justification to overrule the SWAP. Their decision would be final, subject to an application by any interested party to a judicial body. We suggest the Mental Health Tribunal could take on this role, depending on wider decisions about the future forum for mental health and incapacity law.

In complex or contentious cases the Mental Welfare Commission would have the power to refer the matter directly to a judicial body either before or after the appointment of an independent clinician.

In urgent cases, it would be possible for a doctor not to follow a SWAP if they conclude that at least one ground for overriding the SWAP applies and one of the grounds set out in s243 of the current Act for administering urgent medical treatment applies. This would only be for necessary treatment and until such time as it can be reviewed by the Mental Welfare Commission appointed clinician.

Conflict

It is accepted that there will be a range of potential conflicts as grounds for not following a SWAP. For example:

- People may disagree with the interpretation in terms of a SWAP.
- Partial revocation of a SWAP when a new one has been drawn up and not know what is valid.
- By respecting the SWAP it may disrespect a third party such as an unpaid carer.
- Demands on services make it impossible for them to comply with a SWAP.

More detail will be offered in guidance but we propose that such conflicts may be reported to the Mental Welfare Commission who will have the power to offer

guidance or, if the matter is sufficiently serious enough to refer it to a court or tribunal. This would be the equivalent of a Section 3 referral for direction under the Adults with Incapacity (Scotland) Act 2000.

Forensic Proposals

Introduction

The Scottish Mental Health Law Review ran a consultation on a number of its proposals for change from March to May 2022. We are working on the basis that the intended benefits of these proposals should apply equally to people in the forensic system. However, the consultation document did not have any specific proposals on the forensic aspects within the Review's remit. So, here we now outline where we think change may be needed in this important area of mental health law and the ideas we have.

We commissioned specific work on where criminal and mental health legislation meet, and what changes may be needed from a human rights perspective. This work was commissioned from David Leighton, an Advocate specialising in mental health law. We have also taken account of the other evidence gathered by the Review on forensic aspects of mental health law, including the findings of the Rome and Barron Reviews.

We want to hear your feedback on the need for these changes and alternatives to what is proposed. We also want to hear about any unintended consequences of our proposals and about anything else you think needs changed.

We are aware that the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) sets out an expectation that people with disabilities 'enjoy legal capacity on an equal basis with others in all aspects of life' (Article 12). Some commentators have proposed that this requires the abolition of criminal defences which are based solely on the grounds of mental disability. In our discussion with international experts, it has been conceded that this is an area that is underdeveloped in human rights law. We think it remains appropriate and justifiable to keep the option of a different judicial route with different disposals for those who have offended who have a mental disorder, if the consequences of that disorder have implications for either the person's culpability or the appropriate disposal.

It seems to us then that implementation of the UNCRPD should aim to make sure that any limitations imposed on people within this separate system result in equal treatment, having regard also to the State's duty of reasonable accommodation (CRPD Article 5). The proposals discussed here look at the forensic orders and their criteria from this perspective. By 'forensic orders' we mean orders imposed by criminal courts that relate to those with mental disorders who have offended or the transfer of prisoners from prison to the mental health estate.

Proposals

Where no proposal or ideas are suggested for any specific order or criterion, we are not presently considering any change. Therefore, as well as any comments on the proposals and ideas below, we welcome any comments on additional areas for change.

Pre-trial/at trial

1. Intermediaries for accused

The UNCRPD Committee has issued guidelines on Article 14 of the Convention. Article 14 is the right to liberty and security of persons with disabilities. These guidelines say that criminal defences based solely on the grounds of mental disability breach Article 14. The Committee states that this is because they deprive the accused of equal right to due process. We know from the Rome and Barron Reviews that some people in the forensic system who had been found unfit to plead, felt they could have participated in a trial if they had had better support.

At the moment, a person with a mental disorder is entitled to an appropriate adult on being interviewed by the police, but there is no formal scheme of support beyond this. We are committed to the development of support for decision making across all the areas where people's rights may be affected.

As part of this, we want to see the introduction of intermediaries for the accused and witnesses in criminal proceedings, as can already happen in England and Northern Ireland. This would support people who have communication difficulties. This lines

up with the conclusions of the Rome and Barron reviews.

We appreciate that intermediaries are not yet used at all in our justice system although they have been the subject of discussion. We think these discussions should be accelerated and should certainly include provision for accused persons.

Pre-sentence

2. Changes to the pre-sentencing orders

The court can enquire into the mental state of an accused person through assessment or treatment orders before the court process is brought to an end (e.g. by conviction or acquittal).

The court can similarly make investigations after conviction by remanding the accused for further enquiry or through an interim compulsion order.

We are concerned to hear of people being remanded to prison while waiting for appropriate mental health provision. The judge may feel they have no option but to remand the person, if they cannot be safely cared for otherwise, and no psychiatric bed is available. However, prison can be hugely traumatic for a person who is mentally unwell, and often lacks suitable support. It is also not possible to administer psychiatric medication without consent in prison.

We think remanding a mentally unwell person to prison should be seen as a failure to respect their human rights. We proposed a range of remedies in Chapters 2 and 8 our earlier consultation document which could apply here. These could include a power for the court to require that appropriate medical provision is found for any remanded prisoner. Also, if the issue is caused by a lack of appropriate provision to meet the human rights obligations of the State, there should be systemic remedies available. These should require the State to address these problems within a reasonable timeframe.

Sentencing

3. Supervision and treatment order: removal

A supervision and treatment order can only be imposed after a partial acquittal (i.e. a finding that a person is unfit to stand trial or not guilty by reason of mental disorder). This order cannot be made if it would be appropriate to impose a compulsion order. As such, this is clearly to be seen as a lesser intervention than a compulsion order. The orders are very rarely used.

We are interested in any views you have on the current need for this type of order. (We consider whether it may have a renewed purpose as a result of our proposals in Section 4.4. below).

4. Criteria for forensic orders – overarching drive towards standardisation

The criteria for diverting an individual who has offended into the mental health system are largely the same as those for a civil mental health order. In terms of the effects of the orders, these are also largely the same. But differences do remain. It is not necessary to establish that the person has a significant impairment of decision-making ability (SIDMA) for a forensic order. And recorded matters are not available for patients subject to compulsion orders. (There are also significant differences for restricted patients, which we discuss later).

We do not want to create or perpetuate differences between these regimes, except where those differences can be justified. The Millan Committee originally proposed having the same criteria. We need to review the degree to which we can achieve greater standardisation between the regimes. We need to ensure that any differences are justified in terms of current human rights law with a view to removing or minimising them.

There are questions as to how well criteria are being applied in practice. We have also heard concerns that those who have offended may not always be being appropriately diagnosed and diverted. Courts and prosecutors may not have sufficient information available to them. Defence lawyers may not have sufficient awareness, of or exposure, to such cases to become familiar with these. The accused may be unwilling to disclose aspects of their mental health. Delayed, partial

or staged disclosure of such information can be an impact of trauma the individual has experienced. We do not have any specific proposals but are interested to hear if you think there are any legal changes that are needed to help address this.

4.1. Criterion: mental disorder

We are considering the continued use of 'mental disorder' within our mental health and capacity laws overall. There is an argument that any order that can result in a deprivation of liberty has to rely on a diagnostic element, to comply with Article 5(1)(e) of the ECHR. The converse is also true. If a person is going to be detained, they should be detained in an appropriate establishment. This means if a person is going to be detained in a psychiatric hospital, they should have a mental disorder.

At the moment the mental disorder diagnostic criterion is fairly significant in a criminal justice context as there is no SIDMA test.

Our wider proposals may create a tension if applied in this area due to the historical requirement for 'mental disorder' to justify interference in rights. We explore some possible tensions below and seek your views.

4.2. Criterion: SIDMA (or ADM)

A current difference between civil and forensic orders is the absence of a Significantly Impaired Decision-Making Ability (SIDMA) test. The Millan Committee felt that the criteria for compulsion should be the same for these two sets of orders. However, the Scottish Government did not extend the SIDMA test to forensic patients in the final legislation. UNCRPD has since increased our focus on a person's autonomy and the need not to discriminate. This means we need to consider if there remains a justification for this difference.

The SIDMA test is currently used to justify intervention in the absence of the person's ability to consent. This test has been subject to some criticism and views were sought in our earlier consultation on whether it should remain or not. We have proposed a new test of Autonomous Decision Making (ADM), which could replace SIDMA as a justification for non-consensual treatment for mental disorder. More detail on these proposals is in Chapter 6 of our earlier consultation paper.

The continuing absence of any test of impairment of decision-making ability from the forensic criteria is likely to be problematic. Especially because a compulsion order can last significantly longer than any conventional criminal disposal.

However, we need to consider the consequences of extending SIDMA or an ADM test to forensic patients. A key concern is that this could mean that a person who is acutely unwell but is able to make treatment decisions might not be able to access the mental health system, and would be placed or remain in prison instead. (This is why SIDMA is not part of the test at the moment).

There are a number of options consider:

- We could keep things are they are. This would mean that the criteria for a compulsion order do not make any reference to decision-making ability.
- We could make the provisions for a compulsion order the same as for a compulsory treatment order, but allow transfers for treatment or hospital directions to take place without a requirement of impaired decision making.
- We could consider the changes made in Northern Ireland. Their Mental Capacity Act contains powers for involuntary admissions of forensic patients to hospital. However, treatment decisions need to be based on capacity to consent.
- We could provide that prisoners could be treated as voluntary in-patients if this was appropriate to meet their needs.

We favour the second approach. If compulsion orders only last as long as the equivalent civil order can be justified, it reduces the risk that a person with a mental disorder may be disadvantaged by being transferred out of the prison system into the mental health system.

We are interested to hear whether you think SIDMA (or a similar requirement like ADM) should to be added to the criteria for forensic orders. What consequences might there be to this? And also, should it be extended generally or just to a limited set of orders or circumstances?

4.3. Criterion: harm to self

While working towards greater standardisation between civil and forensic criteria, there is one area where we are seeking people's views on introducing a difference. This concerns the criterion around risk. Part of the test for forensic orders is that, without medical treatment, there is a risk to the health, safety or welfare of the individual who has offended, or to the safety of any other person. The means that an order can be made on the basis of the assessed risk to the person who has offended, even if they pose no risk to others. We do not want to prevent a patient receiving the appropriate medical care. But equally the imposition of an order from a criminal court, when the patient is not a risk to others, may not be appropriate. The criminal law does not typically act to prevent an individual from harming themselves.

We are interested in your thoughts on removing this element of the test for compulsion orders. What difficulties may arise? (We are not considering this for transfer for treatment or hospital directions. This is because we think these can more legitimately can relate to danger to self).

4.4. Criterion: severity

We think that the criteria for forensic orders should require that the offence is one punishable by imprisonment. Currently, a compulsion order can only be made in relation to a conviction for an offence punishable by imprisonment. Given the common law basis of much of Scots law – where any offence can result in imprisonment - this does not amount to much of a restriction. Moreover, these only restrict the post-conviction disposals, other disposals are not so limited.

If a forensic order can deprive the individual who has offended of their liberty then we think that it should only be imposed in relation to a criminal act that would be punishable by imprisonment. This already applies to people who are convicted, but not people who are found unfit to plead or acquitted by reason of mental disorder. Under section 57 of the Criminal Procedure (Scotland) Act 1995, these people can be given an order depriving them of their liberty even if they could not be imprisoned if convicted for the offence. We do not see how this distinction can be justified. We

think the same requirement should apply in these circumstances and are interested to hear what you think.

If this change were to be made, this could be a justification for retaining supervision and treatment orders as an alternative.

5. Criteria for restriction orders

We propose that restriction orders be retained. We are not proposing any change of substance of the test for these either. But we welcome your views on this.

The wording of the criteria for these orders dates from the Mental Health (Scotland) Act 1960 and so could benefit from being expressed in more modern terms. Also, the requirement to consider the risk, as a result of a person's mental disorder, of them committing offences 'if set at large' is not sufficiently clear. Is the test if the individual who has offended is in the community with no supervision or supports. Or is the test if the individual who has offended is in the community with a compulsion order in place given the court is necessarily imposing a compulsion order on the individual who has offended when applying the test?

There is no comparable civil order to a compulsion order and restriction order (CORO). Despite some differences, the nearest comparator appears to be a prisoner subject to an Order for Lifelong Restriction (OLR). Among the differences is the element of a punishment part in an OLR which must be served before the person can be considered for release. We want to hear more however about the differences in the tests and procedures for imposing an OLR and a CORO. Those for the OLR are more highly regulated. Given the serious consequences of both disposals, we think a greater degree of regulation may be appropriate for restriction orders.

We are considering whether to limit the power to impose a restriction order to the High Court.

Ongoing management of people under forensic orders

6. Standardisation of effect

In the same way we are looking towards standardisation of entry criteria in the civil and forensic regimes, we want to look to standardise the effect of civil and forensic orders. We are looking to minimise differences that do exist and avoid creating unnecessary differences in the proposals we are making elsewhere.

One justification for continued differences is that forensic patients have committed a criminal act. This can range from the most serious to very minor offences. However, the risks posed by, and the clinical needs of, clinical and civil patients may be the same. It can often be a matter of chance whether a patient comes in to hospital subject to a compulsory treatment order or a compulsion order.

We need to consider whether the consequences of a mental health disposal can be out of proportion to the offence. We have heard that some offenders believe that highlighting a mental disorder may result in a loss of their liberty for a substantial time. The Barron Review heard from people progressing through inpatient forensic settings who felt that if they remained in the criminal justice system they would have been handed a determinate sentence, served it and been released. This idea that someone who has offended can end up being detained for longer in the forensic mental health system than if they had they been sent to prison is concerning from a UNCRPD compliance perspective.

We recognise the potential in the current system for disproportionality between offence and consequences. We see this particularly at the less serious end of the spectrum. Mental health disposals are largely risk based so if a patient continues to pose a risk, they continue to be detained. This is the way mental health law operates in Scotland at the moment. In the criminal justice system that sort of indeterminate risk-based detention is reserved for the most serious or dangerous offending (i.e. life sentence and Order of Lifelong Restriction prisoners). Of course, the converse can also be true. Someone on a compulsion order may have committed a very serious act and regain their liberty in fairly short order if the risk that they pose is deemed low enough.

Our concerns around disproportionality centre on the possibility of lengthy and indefinite detention under a compulsion order (with or without restrictions), regardless of the severity of the index offence.

One possibility would be to time limit compulsion orders (as is the case for hospital directions) – so that, after a certain amount of time, the patient converts to civil detention or freedom. With restriction orders, there could be time related options for the additional restrictions. These could be applied in relation to the severity of the offence in the same way that is applied for criminal sentences. This could still allow for the equivalent of an indeterminate order where justified, as well as orders that stipulate a set time, or extended time. 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. So we want to hear your views on the need and implications of reintroducing this now.

Finally, there is a need for greater systematic data collection to proactively identify the way in which the forensic system may be disproportionately impacting those within it. This is both in terms of comparisons with individuals who have offended in the prison system, but also when comparing different groups within the forensic system, e.g. people with learning disabilities.

7. "Serious Harm" Test

Section 193(2) of the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the 'serious harm' test. In short, the effect of this provision the prevention of substantive consideration of the case of a patient who has a mental disorder if "as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment". If the "serious harm" test met in this context is then the Mental Health Tribunal for Scotland has to make no order.

This test was introduced by emergency legislation in 1999. It was a legislative fix intended only to apply to a very limited number of untreatable highly dangerous patients. It continues to be applied in a number of cases and in more expansive ways than intended. This is despite the court setting out guidance for its use in B v. Scottish Ministers, 2010 SC 472. The Millan Committee recommended it should not

be included in the current legislation. It said that, if it had to be retained as a transitional measure for a small group of high risk patients, it should be drawn in precise terms to ensure that it did not extend beyond this group. The Scottish Parliament, however, decided to retain the test.

In Rooman v Belgium (2019), the European Court of Human Rights strongly suggested that treatability should be a requirement for detention in terms of Article 5(1)(e). As such, we are concerned that the arguments accepted in the Reid case (Reid v UK 2003 ECHR 94) for retaining this provision would not be accepted today. Our system is currently set up on the basis that patients are treatable. Our hospitals are founded on making patients better, not merely keeping them somewhere. The availability of hospital directions should mean that people who present a danger even after recovery from any treatable mental disorder can be given a criminal justice disposal but still receive appropriate mental health care.

We also recognise fears that the abolition of the test may result in the release of seriously dangerous patients into the community.

We believe that the test is being applied beyond its intended application, and should be done away with, or significantly restricted. Various approaches have been suggested, including:

- Straightforward abolition
- Abolition for any patients sentenced after the change in the law
- Restricting the test to patients at the State Hospital
- Allowing for a case to be referred back to a court for resentencing if it becomes clear that a compulsion order is not appropriate if, for example, it is established that there is no treatable mental disorder.

We are interested in your views on these, or other alternatives.

8. Restricted Patients

A key way that forensic orders differ from civil orders is the role that Scottish Ministers have in the ongoing management of restricted patients. The Millan Committee originally recommended ending this Ministerial role.

The current Mental Health (Care and Treatment) (Scotland) Act did reduce the role of Scottish Ministers to some extent. The responsibility for discharge decisions was given to the Mental Health Tribunal. However, Scottish Ministers retain significant roles in respect of restricted patients. They are responsible for approving suspensions of detention and transfers. They have the power to recall and vary the conditions under which someone has been conditionally discharged. Scottish Ministers also have a duty to refer people's cases to the Tribunal if they are satisfied that the detention criteria no longer apply or the order needs to be varied.

We are considering whether a human rights based approach supports Ministers taking decisions in relation to individual offenders other than in cases of recall and conditional discharge. We have received no evidence that Ministers do anything other than take their responsibilities seriously and discharge them with integrity. However, there always remains the risk that their decision making will be influenced by political considerations or public pressure in a way an independent or judicial body would not.

We welcome your views on whether the Mental Health Tribunal should have a role in the recall of conditionally discharged restricted patients, and how such a role would work alongside the role of Scottish Ministers. In Section 8.1 below we also ask for views on our proposal that the Mental Health Tribunal should be given the power to vary conditions of conditional discharge.

We would like to hear what you think about keeping or further reducing the current role of Scottish Ministers in the ongoing management of people's progression through the forensic system. This includes suggestions for which bodies should more appropriately take any of these roles on.

8.1. Conditional discharge: power to vary

In 2009, the court considered decisions the Mental Health Tribunal had made in the cases of NG & PF (2009 SC 510). The court concluded that the Mental Health Tribunal does not have the power to vary the conditions they have conditionally discharged a restricted patient on. It ruled that if a patient has been conditionally discharged, any variation to their conditions can only be done by Scottish Ministers

(under section 200). People can appeal to the Mental Health Tribunal about any such change.

We think that the Mental Health Tribunal should have the power to vary the conditions in respect of which a patient has been conditionally discharged. It seems to us to be appropriate that a judicial body has that power. We welcome people's views on this. We are interested to hear your views on whether this power should sit alongside the existing power of Scottish Ministers or whether all decisions on variations should go through the Mental Health Tribunal.

8.2. Conditional discharge: deprivation of liberty

In 2008, the Supreme Court considered the case of the Secretary of State v MM (2018 UKSC 60). It decided that a patient could not be conditionally discharged when the conditions of discharge amounted to a deprivation of liberty. There is an argument that this case ought not to be followed in Scotland as it relies partly on the specific statutory scheme of the (English) 1983 Act. However, there remain unanswered concerns that, if tested in court, the Mental Health Tribunal in Scotland may also not be able to discharge a patient into conditions that amount to a deprivation of liberty. It is not helpful to have doubt or confusion about the position.

We think that there are circumstances where being able to do this may be appropriate and ECHR compliant, if legislated for (e.g. to allow discharge to an intensive community care placement from hospital). We think the Mental Health Tribunal should have the power to conditionally discharge a patient into conditions that amount to a deprivation of liberty if it considers that appropriate and a number of conditions are met. Critically, the Mental Health Tribunal must be aware and make explicit that they are discharging the person into a legislative scheme which meets the requirements for lawful deprivation of liberty. There must also be regular reviews with the Mental Health Tribunal given sufficient powers to alter the conditions.

9. Cross-border transfers

We know that the differences in current legislation across UK jurisdictions already makes cross border transfers between forensic systems difficult. We acknowledge that any increased divergence between legislative frameworks, which our own

proposals may result in, has the potential to further exacerbate this. We would like to know if this would result in any practical problems. We are not suggesting we pull back from necessary change to avoid additional difficulty in this area but it is worth keeping it in mind in the changes we propose. Cross-border dialogue is important and must continue.

10. Duty on Scottish Ministers

We know that there are people who find themselves "stuck between two stools". These are people who are not seen as suitable for prison by the prison authorities and not seen as suitable for hospital by the hospital authorities. Scottish Ministers would be responsible for prisoners both in prison and if transferred. We are considering a duty on the Scottish Ministers to ensure that people are accommodated in a place which is safe and appropriate for their needs. We are interested to hear what you think about this. This may require more flexibility in the test for transfer for treatment directions in section 136 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Mental Health Tribunal for Scotland powers

We have considered extended powers and roles for the Mental Health Tribunal in relation to restricted patients earlier. Here, we set out some further proposals for changes to the powers of the Mental Health Tribunal.

11. Recorded matters

Recorded matters are one of the two main differences between a compulsion order and a compulsory treatment order. (The other is the absence of a SIDMA test for a compulsion order). We proposed strengthening the Mental Health Tribunal's power to grant 'recorded matters' in our earlier consultation document. (See Chapter 8 of that document for more details). In summary, the proposals we made would allow the Mental Health Tribunal to require relevant bodies to provide such care and support as is required to avoid the need for an individual's compulsion, or ensure that any necessary compulsion respects the human rights of the patient.

We feel that recorded matters in this strengthened form should also be allowed for forensic orders. We welcome your views on this.

12. Appeals against conditions of excessive security

The Barron Review recommended that the right to make an application to the Mental Health Tribunal against conditions of excessive security should be extended to people in low secure units. The Scottish Government has committed to giving this 'thorough consideration'. It also however wishes to take account of any recommendations made by our Review. We said in Chapter 8 of our earlier consultation document that we agreed these appeal provisions need to cover people in low secure settings. In addition, proposed that all patients subject to compulsion should have the right to appeal against being subjected to unjustified restrictions.

We also propose that such appeals should extend beyond the right to move to a less restrictive care or treatment setting. We propose that people should also have the right to challenge the level of restrictions in place within an appropriate setting.

We intend these proposals to cover people under either forensic or civil orders, and welcome any views you have on this.

In 2015, amendments were made to excessive security appeal provisions. These included introducing the need for any appeal to be supported by a medical report by an approved medical practitioner. This was proposed by the Scottish Government to ensure that the appeals could operate effectively. We are questioning whether an individual's right to make an application against excessive security appeals should continue to be linked to a medical professional's opinion in this way.

We would like to hear what you think about removing the limitation to these appeals. This includes any unintended consequences we would need to address.

Voting rights

Advocacy groups who responded to the Barron Review called for an end to the lack of voting rights for people in the forensic mental health system. We welcome any views you have on this.

Summary of questions

We welcome any comments, thoughts or suggestions you have about our forensic proposals. We did also ask some specific questions. These were:

1. Do you agree that we should introduce intermediaries to support people who need them in criminal proceedings? (Section 1)
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)
3. What are your views about whether supervision and treatment orders continue to be needed or not? (Section 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)
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)
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)
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)
8. Do you think forensic orders should only be allowed if the offence is punishable by imprisonment? (Section 4.4)
9. Do you have any suggestions for updating the criteria for imposing a restriction order? (Section 5)
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)
11. What do you think about our proposals for time limiting compulsion orders, with or without restriction orders? (Section 6)

12. What do you think about our suggestions to either remove or significantlyrestrict the ‘serious harm’ test introduced in 1999? (Section 7)

13. Do you think the current roles that Scottish Ministers have in the managementof restricted patients should be reduced, and to what extent? (Section 8)

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 powerto discharge to conditions that amount to deprivation of liberty)? (Sections 8, 8.1 and 8.2).

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

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

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

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

19. What do you think about removing the need for excessive security appeals tobe supported by a medical report by an approved medical practitioner? (Section 12)

20. What do you think about giving voting rights to people in the forensic mentalhealth system? (Section 13)

21. Do you have additional proposals for change?