Scottish provisions for vulnerable witnesses

Cooper and Grace discussed the special measures for vulnerable witnesses in England and Wales[1]. We hope to provide the context of these provisions in Scotland.

In Scottish legislation an individual may be deemed vulnerable when giving evidence if they are under 18 or have a mental disorder which may affect the quality of this evidence. Under the Victims and Witnesses (Scotland) Act 2014 'standard special measures' are given for vulnerable witnesses. In contrast to England and Wales, these measures also apply to those who are accused. The following measures are included in the Criminal Procedure (Scotland) Act 1995 (3) (Section 271H).

'Taking of evidence by a commissioner': an individual appointed by the courts takes the evidence.

'Use of a live television link': the witness gives evidence from somewhere outside the courtroom by means of a live television link, not necessarily within the court building.

'Use of a screen': the accused is physically concealed from the witness, although the court ensures that the accused can watch and hear the witness giving evidence.

'Use of a supporter': supporters can be selected by witnesses or on their behalf. Their role is to support witnesses while the witnesses give evidence. If they also have to give evidence, they must do so before acting as supporters.

'Giving evidence in chief in the form of a prior statement': a statement by the witness is lodged in evidence without the witness having to speak in court.

If it is felt that these measures are necessary, a Vulnerable Witness Application must be lodged by those who are citing the witness. This application includes which measures are being requested and the views of the witness, including any carer if possible. The court has the final decision on which measures are most appropriate.

In contrast to England and Wales legislation, the Vulnerable Witnesses (Scotland) Act 2004 put an end to the competence test for witnesses. Competency is set out in England and Wales legislation under the Youth Justice and Criminal Evidence Act 1999. The advantage of removing this test is that it allows the judge or jury to determine the witness's reliability, rather than a test which did not necessarily ensure the truthfulness of their evidence. This ensures that vulnerable people have the opportunity to be heard.

It is important that practitioners working with vulnerable witnesses who may be appearing in the Scottish courts are aware of these procedures, as their input could drastically change a witness's experience of the court. Psychiatrists are in a position to advise on optimum conditions to aid a patient's mental state, and in so doing not only ensure a fair legal process, but also a legal process that is as stress-free as possible.

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1 Cooper P, Grace J. Vulnerable patients going to court: a psychiatrist's guide to special measures. *BJPsych Bull* 2016; **40**: 220–2.

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Voting and mentally disordered offenders: a Scottish (and post-Brexit) supplementary

Rees and Reed advocate expanding the electoral franchise to convicted mentally disordered offenders,[1] referring to a judgment of the European Court of Human Rights. The current prime minister has spoken in favour of withdrawing from the jurisdiction of the Court[2] – a possibility in the era of Brexit – so their suggestion is unlikely to come to pass. However, they also provide a helpful summary of which mentally disordered offenders have the right to vote. We would like to reply with a summary of the situation in Scotland, which was notably omitted from their editorial.

The Representation of the People Act 1983 was amended in 2000 and has specific provisions for Scotland. Patients detained on civil provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 are eligible to vote by virtue of the amended 1983 Act, as are those subject to guardianship orders under the Adults with Incapacity (Scotland) Act 2000. Remand prisoners and civil prisoners are also eligible to vote.

Those at the pre-trial stage in Scotland may be detained in hospital on Assessment Orders or Treatment Orders. As untried persons, they can vote. By virtue of Section 3A(3) of the amended 1983 Act, those subject to one of the various psychiatric disposals are ineligible to vote. These are a Compulsion Order, which authorises hospital treatment, or a Hospital Direction, which authorises hospital treatment and return to prison when well enough, or a Compulsion Order and Restriction Order, which involves special restrictions. Those found unfit for trial and subject to a temporary Compulsion Order cannot vote, and neither can those admitted from prison on a Transfer for Treatment Direction.

That is all similar to England. However, in Scotland, patients can be subject to a unique form of community-based criminal detention without a precise English analogue. This is a Compulsion Order without a provision under Section 57A(2)(8)(a) to authorise detention in hospital. Such patients are ineligible to vote by a strict reading of the amended 1983 Act, which was probably not written with such a scenario in mind. Conditionally discharged restricted patients, living in the community, are also ineligible.

Even if the current position in Scotland is clear, the future is less clear. The Scotland Act 2016 has expanded the legislative remit of the Scottish Parliament with respect to electoral law, and the voting age for local and Holyrood elections has been lowered to 16, giving different franchises for elections to Holyrood and to Westminster.

So Holyrood could now legislate to expand the franchise for Scottish elections. However, there may be little appetite for Rees and Reed's recommendations, since the Scottish Parliament did not allow prisoners to vote in the 2014 independence referendum – a decision upheld in the Court of Session and the Supreme Court of the United Kingdom.[3]

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1 Rees G, Reed J. Patients or prisoners? Time to reconsider the voting rights of mentally disordered offenders. *BJPsych Bull* 2016; **40**: 169–72.

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2 Asthana A, Mason R. UK must leave European convention on human rights, says Theresa May. *The Guardian*, 2016; 25 April (https://www.theguardian.com/politics/2016/apr/25/uk-must-leave-european-convention-on-human-rights-theresa-may-eu-referendum).

3 Moohan and another *v* Lord Advocate [2014] UKSC 67 (https://www.supremecourt.uk/decided-cases/docs/UKSC_2014_0183_Judgment.pdf).

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Liaison psychiatry: a brief history

Aitken *et al* suggest that it was the bringing together of the alienists (asylum doctors) and academics that 'enabled' liaison psychiatry to be recognised as a subspecialty by the newly founded Royal College of Psychiatrists.[1] However, I would argue that change in the practice of psychiatry prior to that date was much more determined by the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*[2] that led to the 1957 Mental Health Act. Foremost among its recommendations were:

(1) to place mental illness and mental deficiency on the same footing as other illnesses or disabilities
(2) to abolish special designation of psychiatric hospitals
(3) to expand community services.

Subsequently, W. S. Maclay gave an academic address to the 1st Canadian Mental Hospitals Institute entitled *Experiments in Mental Hospital Organisation*, in which he outlined the likely future progression of these recommendations based on developments in the Manchester region. As early as 1948 the medical administrative staff of the Manchester Regional Hospital Board had begun to address how best to serve the care of psychiatric patients. It was agreed that psychiatric care should be as far as possible analogous to that of all healthcare – community facilities together with primary medical services, and secondary medical provision within local general hospitals. Psychiatric units of 100 to 200 beds were developed within district general hospitals (DGHs) and a consultant psychiatrist and support staff appointed to each unit from 1954.

Initially, there was little or no support from the large hospitals or academic psychiatric departments of the region. However, the regional clinical research committee requested a review of such units in 1960. This was carried out by Dr Stanley Smith, the superintendent of a large mental hospital. It is worth quoting the final paragraph of his 'Review of Psychiatric Units Associated with General Hospitals in the Area of the Manchester Regional Hospital Board':

> 'In my view they (these units) may well be the most significant social development in British psychiatry today'.

The existing DGHs of the Manchester region were based on the needs of individual communities ('ecologies'). They were built physically and conceptually from the provision made available by central and regional health services, local government and the community and charitable resources of each area. 'Liaison' was implicit to successful provision of overarching healthcare in such facilities.

Services continued to evolve in the DGH psychiatric unit in which I had my longest experience – and which served 200 000 people. These included in-patient beds for people with acute illness, those with chronic illness and elderly patients. A number of beds on the general wards were assigned to psychiatry; they were used for investigation of mental illness and for drug withdrawal. Additionally, beds were held on medical wards for the direct admission of patients who had attempted suicide by drug overdose – these were seen by consultant psychiatrists and social workers before discharge. The average duration of stay of all in-patients was 3 to 4 weeks throughout those 30 years.

Progress in modes of psychiatric treatment was readily acknowledged by the hospital management. The advent of behaviour therapy led to the establishment of a clinical psychology department in 1966 – probably the first of its kind in a DGH. Psychiatric social workers were attached to each consultant team. The laboratory biochemical facilities were extended to allow monitoring of drug therapy and substance misuse.

Before the formal role of community psychiatric nurse was established, nurses from the hospital used to visit patients in their homes if this was felt appropriate. Readily available links to psychiatric assessment were made with the police, the large local Salvation Army hostel and local organisations that dealt with homelessness. A drug team was jointly established with the local authority. An industrial unit served those with work maladjustment. An Alcoholics Anonymous group held its meeting within the hospital. There was a well-recognised postgraduate teaching centre within the DGH which organised regular seminars that included psychiatric topics.

Consultant numbers grew from one to four, enabling a duty consultant to cover intra-hospital consultations and out-of-hours emergency calls from whatever source, in addition to requests from primary care and community organisations. All waiting list referrals were seen within 4 weeks. All the intervention categories that Aitken *et al* describe were part and parcel of the service.

Guthrie *et al* commented that one of the most difficult aspects of any provision is that of measuring outcomes.[3] The DGH model aimed to give 'comprehensive' healthcare to a district, defined as the smallest population for which such healthcare could be satisfactorily planned, organised and provided. This required the greatest possible co-ordination between health services and the local authority, particularly social services. The majority of districts were expected to serve a population of less than 250 000.

Owing to the closed population and ready liaison with groups and individuals, outcomes could easily be measured. Follow-up clinics, re-referrals and community responses, together with statutory and non-statutory data collection, ensured awareness of changing needs. The importance of early clinical intervention and continuity of care became apparent and data were used to sustain appropriate staffing, bed numbers and budgeting in the DGH.

Lastly, it is my personal view that the Mental Health Act 1983 and the establishment of mental health trusts have hugely emphasised the dichotomy between mental and physical healthcare. I believe that liaison – intimate communication – with both the individual and his or her 'ecosystem' is necessary to all good quality care and cannot be prescribed. It is not particular to psychiatric practice; it is the hallmark of good doctoring in all specialties.

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1 Aitken P, Lloyd G, Mayou R, Bass C, Sharpe M. A history of liaison psychiatry in the UK. *BJPsych Bull* 2016; **40**: 199–203.

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