SCOTTISH EXECUTIVE

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2 July 2004

Dear Consultee

MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003
DRAFT CODE OF PRACTICE: VOLUME 3

Please find enclosed a copy of Volume 3 of the draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act"). We are inviting written responses to this draft Code of Practice by **3 September 2004**.

Contents of this consultation document

The Act substantially reforms the law relating to people with mental disorder who enter the criminal justice system. The changes brought about by the Act, as informed by the Millan Committee, give the court new provisions to use when dealing with a person with mental disorder.

Currently, the Criminal Procedure (Scotland) Act 1995, ("the 1995 Act"), sets out the range of disposals and their related court procedures, and the Mental Health (Scotland) Act 1984, ("the 1984 Act"), sets out the consequences of being made subject to these disposals. The 1984 Act will be repealed by the new Act, but this division will be retained. Part 8 of the Act inserts new mental health orders into the 1995 Act and Parts 9 to 13 set out the consequences of these orders, and the procedures for their variation, renewal and revocation.

Procedures for the disposal of cases of persons with mental disorder who are involved in criminal proceedings are set out in Part VI and sections 200 and 230 of the 1995 Act. Provisions in the Act have replaced or made amendments to some of these procedures.

Part 1 of this volume addresses the procedures relating to mentally disordered offenders under the 1995 Act as amended by Part 8 of the 2003 Act.

Part 2 of this volume addresses the consequences of the new mental health disposals inserted into the 1995 Act by the Act, and the procedures for their renewal, variation and revocation under Part 9 to 13.

Accessing this consultation document

If you wish to access this consultation online, go to the following website: http://www.scotland.gov.uk/view/views.asp. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is.

If you have any queries or would like additional copies of this document, please contact Pamela Beer on 0131 244 3758.

Responding to this consultation document

We are inviting written responses to any aspect of this draft Code of Practice by **3 September 2004.** We regret that we have not been able to provide a longer consultation period. We wish to have the Code published in the autumn so that it can be used for training and distribution of information purposes in good time for the Act coming into effect in April 2005. Please accept our apologies for any difficulties that this may present in responding to this consultation.

Please send your response to mentalhealthlaw@scotland.gsi.gov.uk or to the postal address at the head of this letter. When you are submitting your response, please make sure to include the respondee information form to be found in annex 1 to this letter.

We would be grateful if you could clearly indicate in your response which questions or parts of the consultation paper you are responding to as this will aid our analysis of the responses received.

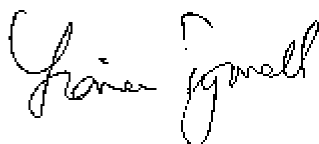
In addition to seeking written responses to this draft Code of Practice, we plan to organise some events which will both raise awareness of the publication of this draft Code of Practice and seek the views of interested parties on its contents. Further details about these events will be available shortly.

Access to consultation responses

We will make all responses available to the public in the Scottish Executive Library unless confidentiality is requested. All responses not marked confidential will be checked for any potentially defamatory material before being logged in the library or placed on the website. We draw your attention to the material in annex 2 of this letter which sets out information on the consultation process used by the Scottish Executive.

Finally, thank you in advance for your responses to this consultation document.

Yours sincerely



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ANNEX 1: RESPONDEE INFORMATION FORM

Please complete the details below and attach it with your response. This will help ensure we handle your response appropriately:

Name:

Postal Address:

Consultation title: Volume 1 of the draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003

1. Are you responding as: (please tick one box)

(a) an individual ☐ (go to 2a/b)
(b) on behalf of a group or organisation ☐ (go to 2c)

2a. INDIVIDUALS:
Do you agree to your response being made available to the public (in Scottish Executive library and/or on Scottish Executive website)?

Yes (go to 2b below) ☐
No, not at all ☐

2b. Where *confidentiality is not requested*, we will make your response available to the public on the following basis (please tick one of the following boxes):

Yes, make my response, name and address all available ☐
Yes, make my response available, but not my name or address ☐
Yes, make my response and name available, but not my address ☐

2c ON BEHALF OF GROUPS OR ORGANISATIONS:

Your name and address as respondees will be made available to the public (in the Scottish Executive library and/or on Scottish Executive website). Are you content for your response to be made available also?

Yes ☐
No ☐

SHARING RESPONSES/FUTURE ENGAGEMENT

3. We will share your response internally with other Scottish Executive policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Executive to contact you again in the future in relation to this consultation response?

Yes ☐
No ☐

ANNEX 2: THE SCOTTISH EXECUTIVE CONSULTATION PROCESS

Consultation is an essential and important aspect of Scottish Executive working methods. Given the wide-ranging areas of work of the Scottish Executive, there are many varied types of consultation. However, in general Scottish Executive consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body. Consultation exercises may involve seeking views in a number of different ways, such as public meetings, focus groups or questionnaire exercises.

Typically, Scottish Executive consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the area of consultation, and they are also placed on the Scottish Executive web site (http://www.scotland.gov.uk) enabling a wider audience to access the paper and submit their responses. Copies of all the responses received to consultation exercises (except those where the individual or organisation requested confidentiality) are placed in the Scottish Executive library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4552).

The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

If you have any comment about how this consultation exercise has been conducted, please send them to the Mental Health Division Branch 3 at the address at the head of this letter.

MENTAL HEALTH (CARE AND TREATMENT) SCOTLAND ACT 2003

DRAFT CODE OF PRACTICE

VOLUME 3

Introduction to Volume 3

Coverage of this volume

1. Volume 3 of the draft Code of Practice for the Mental Health Care and Treatment (Scotland) Act 2003 covers a range of issues relating to mentally disordered offenders.

2. Procedures for the disposal of cases of persons with mental disorder who are involved in criminal proceedings are set out in Part VI and sections 200 and 230 of the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act“). Provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003, (“the Act“) have replaced or made amendments to some of these procedures.

3. The 1995 Act set out a wide range of disposals at various stages of the criminal justice process. The changes brought about by the Act, as informed by the Millan Committee, built on rather than made any fundamental changes to the system.

4. Previously, the 1995 Act set out the range of disposals and their related court procedures, whilst the Mental Health (Scotland) Act 1984, (“the 1984 Act“), set out the consequences of being made subject to these disposals. The 1984 Act will be repealed by the new legislation, but this division will be retained. Part 8 of the Act inserts new mental health disposals into the 1995 Act and Parts 9 to 13 of the Act set out the consequences of these disposals and the procedures for the variation, renewal and revocation of the disposals.

5. Part 1 of this volume addresses the procedures relating to mentally disordered offenders under the 1995 Act as amended by Part 8 of the Act.

6. Part 2 of this volume addresses the consequences of the new mental health disposals inserted into the 1995 Act by the Act, and the procedures for the renewal and revocation of the disposals.

Structure of this volume

Part 1

7. Following a brief overview of the procedures for mentally disordered offenders under the 1995 Act as amended by the Act, Part 1 consists of six chapters. The first chapter provides a general overview of the changes made to the 1995 Act by the Act. Chapters 2 to 5 cover the different stages of the criminal justice process: pre-conviction, insanity, post-conviction and pre-disposal, and final disposal. Chapter 6 covers over-arching issues relevant to many of the new mental health disposals. Unless detailed otherwise, all section numbers in Part 1 refer to the 1995 Act.

8. Each chapter begins with an overview of that stage of the criminal justice process and how the presence of mental disorder may be addressed at that time. Following this each chapter is separated into sections related to the various orders available. For each order there is an introductory section with background, the purpose of the order and an overview of the legislation. This is followed by detailed material relating to each order.

Part 2

9. Part 2 covers a range of issues relating to the effect of the mental health orders that may be imposed by a court in terms of the Act when it makes a final disposal in the case of a mentally disordered offender. It therefore provides Code of Practice material on Parts 9, 10, 11, 12 and 13 of the Act.

10. Part 2 consists of eleven chapters. Chapters 1 and 2 cover the effect of the compulsion order under Part 9 of the Act. This is an order which authorises compulsory treatment of a mentally disordered offender for a period of at least 6 months at a time. This chapter describes the review and renewal procedures for a compulsion order (CO). These procedures are very similar to those for a compulsory treatment order (CTO) under Part 7 of the Act, an order made in relation to patients detained under civil proceedings. Rather than duplicating the information contained in Volume 1, Chapters 5 and 6 of the Code of Practice for the Act which describes these procedures for a CTO, this chapter simply points out where the two procedures are different.

11. Chapter 3 examines the processes to be followed when carrying out a review of a compulsion order when combined with a restriction order (CORO) as set down in Part 10 of the Act. Chapter 4 outlines the procedures surrounding the conditional discharge and absolute discharge of a patient subject to a CORO.

12. Chapter 5 sets out the formal procedures involved in the making of a transfer for treatment direction under section 136 of the Act. This direction allows for the transfer of a sentenced prisoner from prison to hospital for care and treatment for mental disorder under the Act.

13. Chapter 6 covers the effect of the hospital direction and the transfer for treatment direction in operation as set down in Part 11 of the Act. Chapter 7 describes the processes associated with their review and revocation. Chapter 8 describes the different scenarios which may arise at the expiry of the patient's sentence in relation to his/her detention under the Act

14. Chapter 9 describes the procedures associated with "suspension of detention" procedures as set down in Part 13 of the Act in relation to patients who are subject to a treatment order, an interim compulsion order, a CORO, a hospital direction and a transfer for treatment direction.

15. Chapter 10 details the processes associated with the transfer to another hospital of a patient who is subject to a CORO, a hospital direction and a transfer for treatment direction as set down in Part 12 of the Act.

16. Finally, chapter 11 provides a glossary of commonly used terms throughout this volume.

Note on abbreviations

17. Although the use of abbreviations has been avoided wherever possible, the following are used commonly throughout this volume:

AMP: approved medical practitioner
CO: compulsion order
CORO: compulsion order and a restriction order
CTO: compulsory treatment order
EDL: earliest date of liberation
EOF: examination of facts
HD: hospital direction
LPT: Life Prisoner Tribunal
MHO: mental health officer
MWC: Mental Welfare Commission
PCS: police casualty surgeon
PF: procurator fiscal
PQD: parole qualifying date
RMO: responsible medical officer
SCR: social circumstances report
SER: social enquiry report
STO: supervision and treatment order
Tribunal: The Mental Health Tribunal for Scotland
TTD: transfer for treatment direction

18. The following pieces of legislation are also on occasion referred to in an abbreviated form:

“the 1984 Act”: Mental Health (Scotland) Act 1984
“the 1993 Act”: Prisoners and Criminal Proceedings (Scotland) Act 1993
“the 1995 Act”: Criminal Procedure (Scotland) Act 1995
“**the 2000 Act”:** Adults with Incapacity (Scotland) Act 2000
“the 2003 Act”, “the Act”, or **“this Act**”: Mental Health (Care and Treatment) (Scotland) Act 2003

PART 1

PART VI OF THE CRIMINAL PROCEDURE (SCOTLAND) ACT 1995

AS AMENDED BY

THE MENTAL HEALTH (CARE AND TREATMENT)(SCOTLAND) ACT 2003

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CHAPTER 1: OVERVIEW

Introduction

This chapter begins by setting down the requirement to apply the principles in Part 1 of the 2003 Act to persons with mental disorder who are involved in criminal justice proceedings.

The chapter then provides a brief overview of the changes made to the 1995 Act by the 2003 Act.

Finally the chapter describes the different stages of the criminal justice process in relation to summary and solemn procedure.

All section numbers in this chapter refer to the 1995 Act unless stated otherwise.

PRINCIPLES OF THE ACT

Taking account of the principles

1. The changes in the legislation aim to provide more flexible procedures for the assessment and treatment of persons pre-trial and pre-sentence; to make the status of persons detained in hospital pre-trial and pre-sentence similar to that of persons detained under civil proceedings; to allow compulsion in the community as well as in hospital as a disposal in line with the compulsory treatment order in civil cases; and to allow for a thorough assessment of mental disorder, needs and risk in cases where serious offences have been committed.

2. Although persons subject to these procedures have been charged with, or convicted of offences, the principles as detailed in Part 1 of the 2003 Act and which apply to patients subject to civil proceedings, should also be applied when medical practitioners and mental health officers are making recommendations for orders.

3. Where serious offences have been committed or a person is considered to pose a significant risk to others, public protection will of course be a major concern. However, even in such cases, the principles, as detailed in Part 1 of the 2003 Act, should not be overridden by public protection concerns. For example in a case where a serious offence has been committed and the offender appears to pose a high risk of further offending, a mental health disposal should not be recommended unless there would be some prospect of benefit to him/her and reduction in risk as a consequence of treatment.

OVERVIEW

4. The diagrams on pages 15 and 16 show an overview of procedures for mentally disordered offenders as set out under the 1995 Act as amended by the 2003 Act.

Pre-trial

5. Previously at the pre-trial stage, a person could be remanded to hospital for assessment under section 52 of the 1995 Act or transferred from prison to hospital under section 70 of the 1984 Act. Following the amendments made to the 1995 Act by the 2003 Act the court can impose an assessment order (sections 52B to J) or a treatment order (sections 52K to S) whether the person is appearing in court as part of the criminal justice process or at a hearing specifically requested by the prosecutor or the Scottish Ministers (for persons already remanded in custody). The assessment order may be followed by a treatment order, or a treatment order may be imposed without an initial assessment order having been made. An assessment order can only last up to 28 days (extendable by a further 7 days), whereas a treatment order may last for the whole pre-trial period (section 52R).

Insanity

6. A person may be found insane in bar of trial (sometimes referred to as unfit to plead) before or during a trial (section 54). A temporary compulsion order may then be imposed until there is an examination of facts (section 55) to determine whether he/she committed the offence(s) libelled. If this is not established to the usual criminal standard of proof, beyond reasonable doubt, the person is acquitted. In an examination of facts the court will also consider, on a balance of probabilities whether there are any grounds for acquittal. Where a person is found to have committed the offence(s) but on a balance of probabilities it appears to the court that the accused was insane at the time, the accused will be acquitted on that ground.

7. At trial a person may also be acquitted on the grounds of insanity at the time of the offence. The legal criteria for insanity in bar of trial and acquittal on the grounds of insanity are not statutory, and are set out in common law.

8. The disposals available in cases where a person is found insane in bar of trial and the examination of facts finds that he/she committed the offence, or where there is an acquittal on the grounds of insanity at the time of the offence are: a compulsion order (section 57(2)(a)), a compulsion order with a restriction order (section 57(2)(a)&(b)), an interim compulsion order (section 57(2)(bb)), a guardianship order (section 57(2)(c)), a supervision and treatment order (section 57(2)(d)) or no order (section 57(2)(e)).

Conviction

9. Most mentally disordered offenders are not found to be insane in bar of trial, or at the time of the offence. Where a mentally disordered offender is convicted at trial, a number of procedures are available to the court to allow for further assessment and for final mental health disposals to be made, as set out over page.

Acquittal

10. If a person is acquitted (other than on account of insanity) but recommendations had been made in the case for a mental health disposal, then the person may be kept in a place of safety (section 60C) to allow for further examination to determine if emergency detention (section 36 of the 2003 Act) or short-term detention (section 44 of the 2003 Act) should be applied.

Post-conviction / Pre-sentence assessment

11. Assessment orders (under section 52B to J) and treatment orders (under section 52K to S (see paragraph 5 above) are available pre-sentence, as well as pre-trial, to allow further assessment prior to the court making an ultimate disposal.

12. In cases where the offence is serious and/or the person may pose a significant risk such that consideration is being given to a compulsion order with a restriction order or a hospital direction, then an interim compulsion order (section 53) may be imposed (for an initial period of 12 weeks but is then capable of being extended up to a total period not exceeding 12 months) to allow for a period of detention in hospital for the purpose of assessing whether the patient meets the criteria set down in section 53(5). Medical treatment may be given in accordance with Part 16 of the 2003 Act.

13. In cases where mental disorder has not so far been raised, or sufficiently addressed, as an issue following conviction, a remand for inquiry into the mental condition of the person continues to be available after conviction under section 200. However given that assessment orders and treatment orders are available post conviction, it would be expected that section 200 would only be used to remand a person on bail for reports on an outpatient basis.

Sentencing

14. A compulsion order (section 57A) replaces the hospital order (previously section 58). Like the compulsory treatment order in civil cases, compulsion can be in hospital or in the community.

15. A restriction order (section 59) remains available, and may be imposed where a compulsion order authorising the detention of a person in hospital is made, in cases where it is necessary for the protection of the public from serious harm for the person to be subject to additional scrutiny and strict supervision as they progress through the mental health system.

16. A hospital direction (section 59A) allows for a prison sentence to be combined with initial detention in hospital. It may be imposed, like restriction orders, in serious cases where there is not a close relationship between the mental disorder and the offence or where treatment of the mental disorder may not address the risk of further offending.

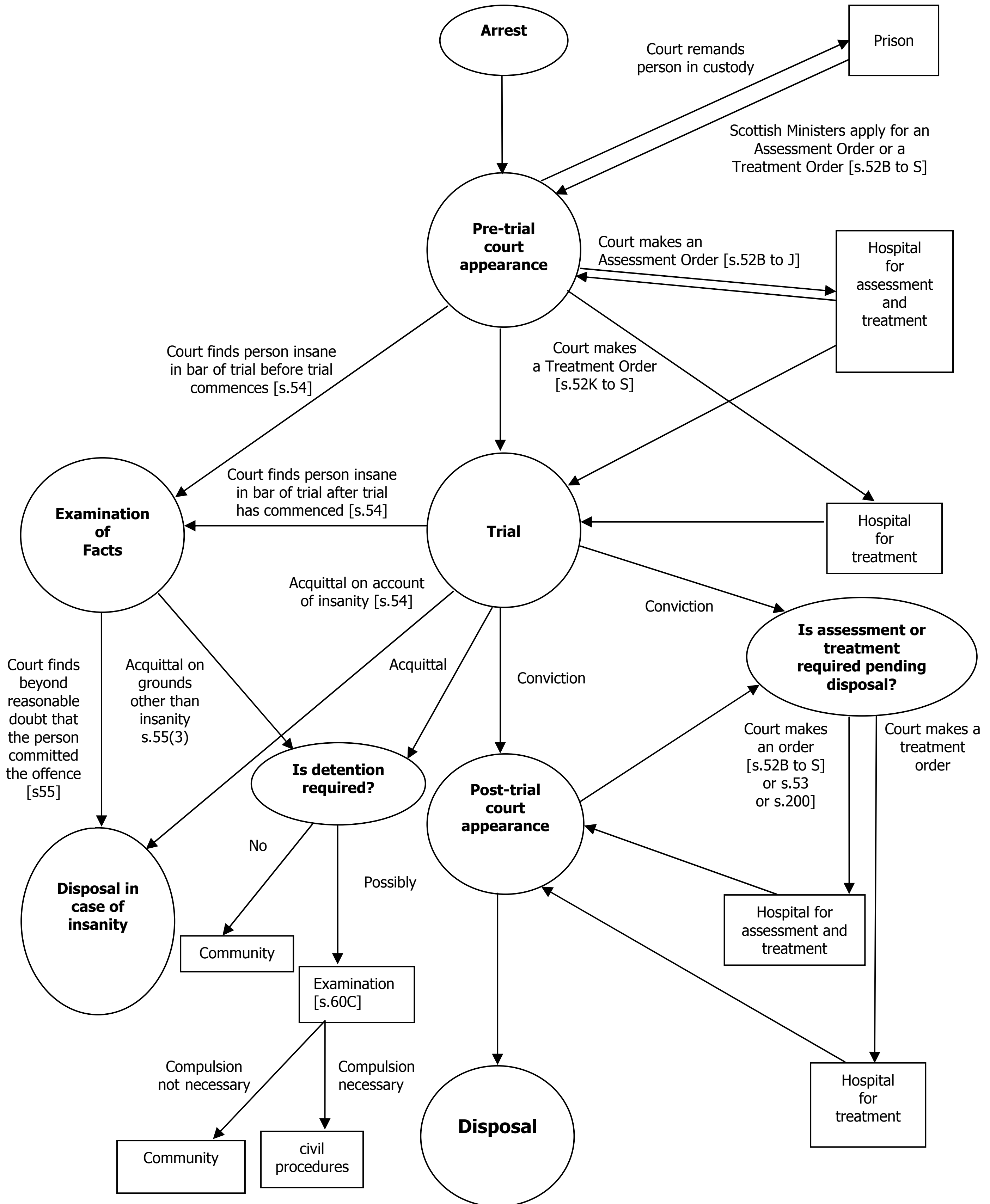
17. A guardianship order (section 58(1A)) may be imposed and confer powers set out in the Adults with Incapacity (Scotland) Act 2000, to appoint a welfare guardian.

18. Probation with a condition of treatment under section 230 remains available in cases where: a person's mental disorder is not such as to warrant a compulsion order or a

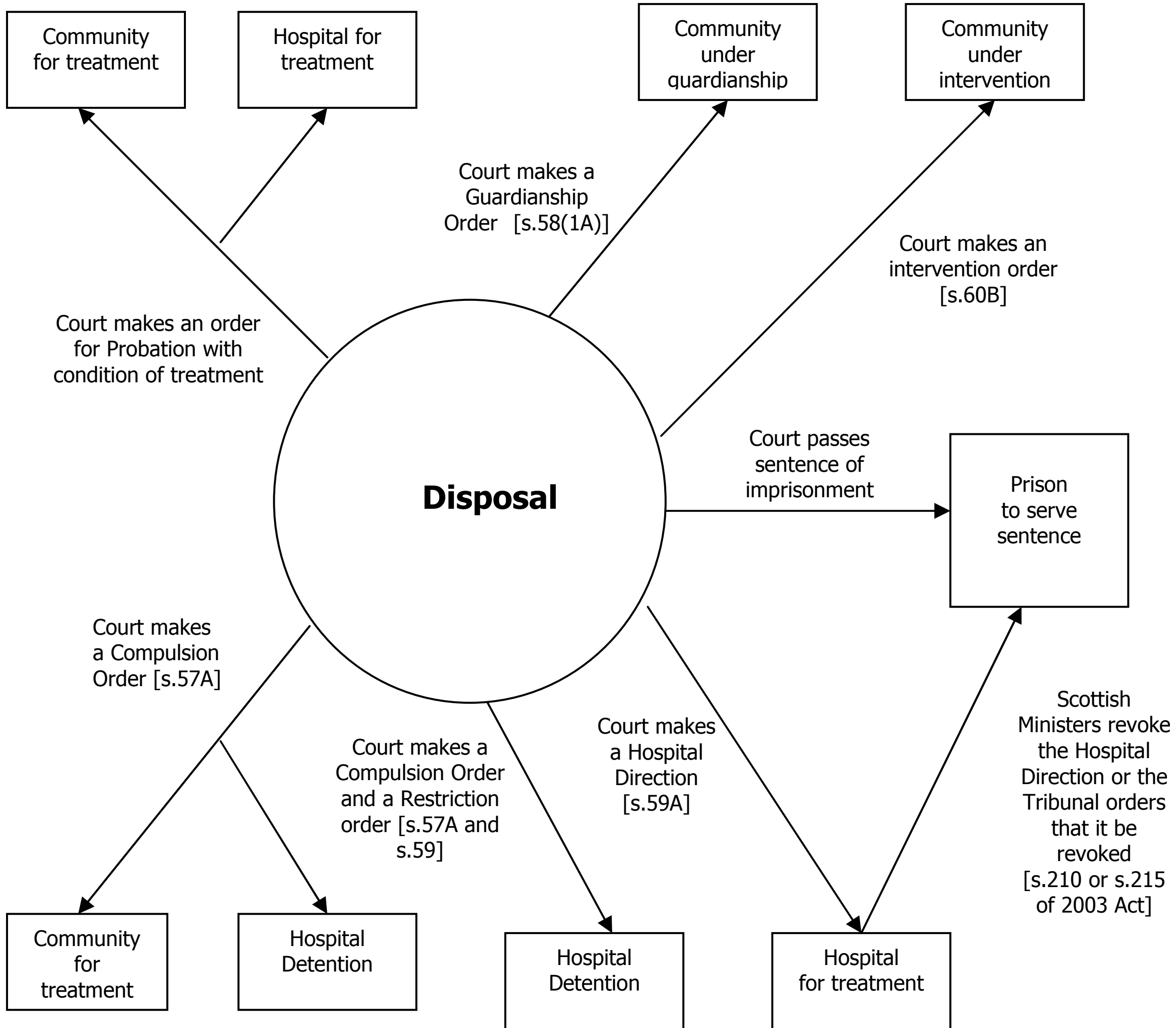
compulsory treatment order; the local authority supervising officer is willing to supervise the person; and the person is agreeable to submit to the conditions of the order.

19. If a person with a mental disorder receives a prison sentence, or if a person who receives a prison sentence develops a mental disorder, section 136 of the 2003 Act allows for the transfer of sentenced prisoners to hospital for treatment. Information about this procedure is included in Part 2 of this Code of Practice.

OVERVIEW OF COURT PROCEDURES WHEN A PERSON WITH MENTAL DISORDER IS INVOLVED IN CRIMINAL PROCEEDINGS



DISPOSAL AFTER CONVICTION



STAGES OF THE CRIMINAL JUSTICE PROCESS

Overview

20. The pre-conviction stage covers the period from a person's arrest until they are convicted (either following a guilty plea or trial), acquitted or proceedings are abandoned. The stages of the criminal justice process will depend on whether the offence is being dealt with under summary or solemn procedure and the prosecutor decides the forum in which the case should be prosecuted. (In some cases the procurator fiscal may not instruct a prosecution, but as an alternative, he/she may divert the case to a local Mental Health diversion scheme, if available.) The flowcharts on pages 19 and 20 set out the stages of the solemn and summary procedures. Not all cases will pass through all the stages.

Summary procedure

21. Summary procedure applies in the sheriff and district courts in which less serious offences are prosecuted. The procurator fiscal arranges for service of a complaint setting out the relevant charge(s) on the accused person. At the first calling of the case, the person may appear from police custody, or following release on a police undertaking, or may simply be cited (by postal or personal citation) to appear.

22. At the first calling of the case the person may enter a plea of guilty or not guilty. If he/she pleads not guilty dates are fixed for intermediate and trial diets. The court will require to consider the status of the accused person pending trial. The court may simply ordain him/her to appear at future diets or alternatively remand him/her on bail or in custody. Where the he/she is remanded in custody the trial must commence within 40 days from the date of the first calling.

23. At the intermediate diet the prosecution and the defence are required to advise the court of their state of preparation and the case will then proceed on the trial date. In some circumstances it may be necessary to adjourn the trial at this stage, and fix new intermediate and trial dates.

24. At any stage in the proceedings the accused person may choose to change a plea of not guilty to one of guilty. However where the case proceeds to trial, at the conclusion of evidence the judge (the sheriff in the sheriff court, or a lay justice or stipendiary magistrate in the district court) is required to reach a verdict of guilty, not guilty or not proven. Whether following a plea of guilty or a conviction after trial, the court may immediately proceed to sentence the person or alternatively adjourn the case for pre-sentence reports.

Solemn procedure

25. Solemn procedure applies in the prosecution of more serious cases. The accused person will first appear in the sheriff court and at this stage the procurator fiscal will arrange for service of a petition containing the charge(s) against him/her. At the first calling of the case the accused person may make a declaration (which may include admitting to or denying the charge) but may not enter a plea. In some cases the procurator fiscal may decide to question him/her before the sheriff. This is known as a judicial examination and must be restricted to clarifying any statement made by the person and to establishing whether a

special defence is likely to be advanced at trial. The procurator fiscal will usually ask for the person to be committed for further examination. The court will then remand him/her either in custody or on bail.

26. Where the accused person is remanded in custody, he/she must appear again in the sheriff court within eight days. At this stage the procurator fiscal will ask for him/her to be fully committed for trial and the court will again either remand him/her in custody or on bail. Where the accused is remanded in custody the trial must commence within 110 days from the date of full committal.

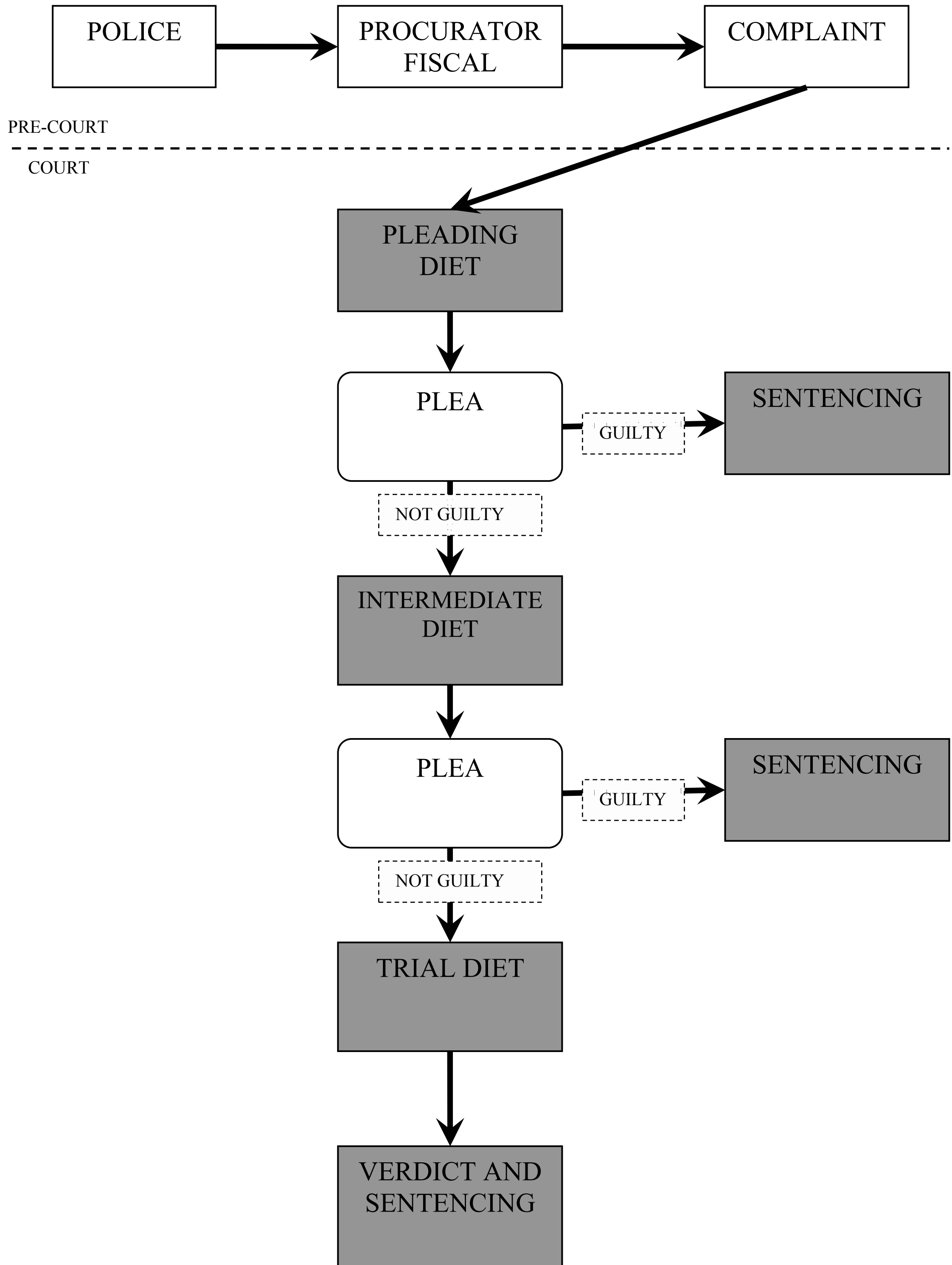
27. Prior to the trial, the procurator fiscal further investigates the case, which may involve interviewing witnesses, and assesses the available evidence and whether it is appropriate to proceed with a prosecution. These findings and recommendations are considered by Crown Counsel who decide whether to take proceedings or not.

28. When solemn proceedings are taken in the sheriff or High Court, an indictment is served on the accused person, which is the document containing details of the charge(s) and is presented in the name of the Lord Advocate.

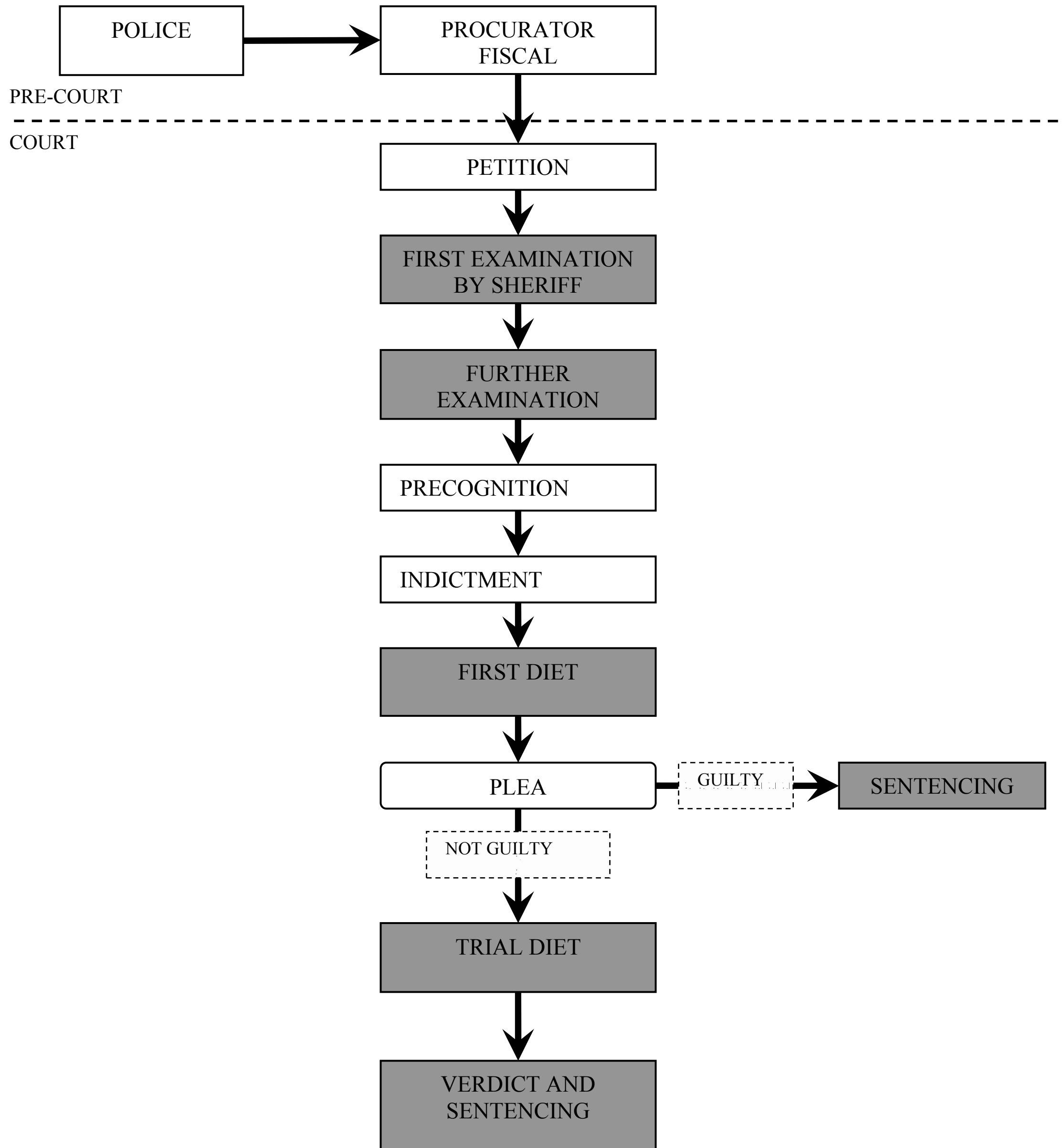
29. In some cases there may be a preliminary diet where the accused person wishes to raise a legal challenge to the proceedings. This also provides the court an opportunity to assess the state of preparation of the prosecution and defence for the trial. In solemn proceedings in the sheriff court, this diet is called a first diet and is mandatory.

30. The accused person can intimate by letter his intention to plead guilty at an early stage and he can tender his/her plea of guilty at an accelerated diet, making the trial unnecessary. Where the case proceeds to trial, at the conclusion of the evidence, the jury are required to reach a verdict of not guilty, guilty or not proven. Subsequent to a plea of guilty or a conviction, as in summary proceedings, the court may immediately proceed to sentence the person, or alternatively adjourn the case for pre-sentence reports.

SUMMARY PROCEDURE



SOLEMN PROCEDURE



CHAPTER 2: PRE-CONVICTION

Introduction

The pre-conviction stage covers the period from a person's arrest until he/she is convicted (either following a guilty plea or trial), acquitted or proceedings are abandoned.

This chapter begins by setting out best practice points for the initial assessment of a person while in custody. It goes on to describe the procedures surrounding the imposition of an assessment order and a treatment order by the court under section 52D and 52M respectively. The chapter then describes the procedures for the review, variation and revocation of these orders.

ASSESSMENT OF A PERSON IN CUSTODY

Factors that may alert criminal justice personnel to the presence of mental disorder

1. The police, prosecutor, court (including the court social work services) or the person's solicitor may be alerted to the potential presence of mental disorder by:

- knowing there is a history of previous psychiatric treatment
- the nature of the alleged index offence
- the behaviour of the person in custody or in court
- concerns expressed by others (e.g. relatives, a mental health officer, a social worker etc) about a person's recent mental state

In such circumstances the police, prosecutor or court will usually request that a mental health assessment is undertaken.

Assessment of an accused in police custody

2. A psychiatric assessment may be performed while a person is in police custody having been detained or arrested. (Procedures are available allowing the police to detain a person who appears to be mentally disordered in a place of safety to enable a medical examination to be carried out, and arrangements made for the person to receive care and treatment (sections 297 and 298 of the 2003 Act). These are described in Volume 1, Chapter 9 of the Code of Practice to the 2003 Act and are not covered here. These paragraphs concern persons who have been taken into police custody.)

3. Although the person is not yet within the court's remit, findings at this stage may have an impact on the subsequent court process, and in some circumstances a medical practitioner who examines a person in police custody may make recommendations relevant to the person's first court appearance.

4. The initial assessment will usually be undertaken by the Police Casualty Surgeon, (PCS). In some areas the PCS may be able to request an urgent assessment by a psychiatrist

at the police station where he/she considers it necessary and this may be done without reference to the Procurator Fiscal (PF). The PCS may also be able to seek an assessment by a mental health officer (MHO).

5. A psychiatric assessment may be undertaken at a hospital or clinic, which the police would need to convey the person to. In some circumstances an urgent psychiatric assessment may not be available or appropriate, and the PCS may proceed him/herself, sometimes with advice from a psychiatrist and an MHO. The conclusions of the assessment should be communicated to the police who would include this in their report to the PF if one is submitted. A report may also be produced which may be submitted to the PF for the person's first court appearance.

6. At this stage there may be limited information available. The person may be unable to give a detailed or coherent account due to his/her mental state and/or intoxication, there may be difficulty accessing background information from previous records or from someone who knows the person well and there may be limited information available about the alleged offence. The MHO may be able to provide useful information about the person. Every effort should be made to also take account of the relevant sources that may be accessible such as a relative or significant other.

7. The main issues that would be expected to be addressed under these circumstances are:

- does the person <u>appear</u> to be suffering from mental disorder?
- does he/she currently pose a risk to themselves or other people?
- does he/she require assessment or treatment in hospital?
- if so, how urgently is this required?
- whether the person is fit to be interviewed and whether he/she requires an appropriate adult?
- is the person fit to plead were he/she to appear in court?
- may the person require community care mental health services?

8. The following options are available depending on the mental condition of the person, the urgency of their need for psychiatric treatment, their willingness to accept treatment, the nature of the alleged offence and the risk they pose:

- *informal* admission or contact with psychiatric services (including community care mental health services)

- non-urgent application for a civil *compulsory treatment order* (section 63 of the 2003 Act)

- immediate application of *emergency civil detention* (section 36 of the 2003 Act) or *short-term civil detention* (section 44 of the 2003 Act)

- recommendation for an *assessment order* (section 52D) or a *treatment order* (section 52M) when the person appears in court on the next working day. This would be the most appropriate option where the alleged offence is serious and/or the person appears to pose a significant risk to others. If despite this the person requires immediate

admission to hospital, then he/she may be detained under civil detention procedures and a report recommending an assessment or treatment order should also be prepared.

- make *no recommendation* at present, but suggest that a non-urgent psychiatric assessment is sought while the person is on remand (either in custody or on bail).

9. If the person is immediately diverted to psychiatric services, either informally or under civil procedures, the police may still submit a report to the PF.

Appropriate Adults

10. It would be expected that the police would always have an appropriate adult present when they interview a mentally disordered person. The role of the appropriate adult is to facilitate communication between the police and the mentally disordered person and to provide support for the person.

11. The responsibility for the decision to request the presence of an appropriate adult belongs to the police. A medical assessment is not required before the police decide whether an appropriate adult is requested, however if following an assessment a medical practitioner decides that a mentally disordered person is fit to be interviewed then the police should be advised to contact an appropriate adult. In some areas this may be done via the emergency social work service.

Assessment at the first court appearance

12. A psychiatric assessment addressing issues relevant to a person's first court appearance may have been conducted whilst the person was in police custody. Similarly an assessment by an MHO may also have been carried out. In some cases even though assessments were done in police custody further assessments may be required on the day of the first court appearance, particularly if perhaps due to intoxication or lack of background information, the best way to proceed was unclear. However it is possible that a mentally disordered person may not have been assessed whilst in police custody.

13. Some areas have court liaison schemes, which are able to provide urgent psychiatric and MHO assessments for the courts. In other areas psychiatrists and MHOs may be available to perform these assessments, even though there is no formal scheme operating. In many areas there is no urgent psychiatric assessment available at the court itself. In these circumstances if there appears to be a clinical emergency, the person would need to be referred for an urgent assessment in the same way as such an assessment would be requested from a general practitioner.

14. The police may instruct an assessment on the day of the person's first court appearance and they may do so without any reference to the PF. This notwithstanding, the police would always be expected to provide full information to alert the PF to such issues and allow consideration by the PF as to whether such an assessment is necessary.

15. At this stage, as with assessments in police custody, there is usually limited information available. The main issues that would be expected to be addressed under these circumstances are similar to those set out above for people in police custody:

- does the person appear to be suffering from mental disorder?
- does he/she currently pose a risk to themselves or other people?
- does he/she require assessment or treatment in hospital?
- if so, how urgently is this required?
- is the person fit to plead? (this may not be able to be determined at this stage)
- may the person require community care mental health services?

16. The options available are identical to those set out in paragraph 8 for persons in police custody. However in these circumstances it would be expected that informal diversion or civil procedures would only be applied if criminal proceedings are abandoned, generally where the offence is considered to be minor.

17. If at this early stage it appears that the person is *insane in bar of trial* then this should be reported to the court. The person will not be found insane in bar of trial at their first court appearance; this finding has to be determined by the court on the basis of evidence from two medical practitioners.

18. If there is doubt about a person's fitness to plead or he/she appears to be insane in bar of trial, he/she will usually be in need of urgent psychiatric assessment and/or treatment in hospital. The options available in such a case are as outlined in paragraph 8.

19. In many cases where a person appears to be insane in bar of trial, the offence will be minor and proceedings will be abandoned, with arrangements being made for diversion either informally or under civil proceedings. Where there is doubt about the seriousness of the alleged offence then it would usually be appropriate to use provisions under the 1995 Act rather than abandoning criminal proceedings.

Assessment subsequent to the first court appearance

20. At the first court appearance an accused person may be remanded in custody or on bail, or may be admitted to hospital on an assessment order (section 52B to J) or a treatment order (section 52K to S).

21. Under summary procedure the person may plead guilty at a first court appearance and therefore is no longer at the pre-trial stage but rather post conviction. A plea cannot be entered at the petition stage in solemn cases.

22. Following the first court appearance psychiatric and MHO assessments may be undertaken of a person who is on bail, in custody, or detained in hospital on an assessment order or a treatment order. Unlike the urgent assessments in police custody or for the first court appearance, at this stage there will usually be time and resources available to gather detailed background information, to interview the person at length, to consider the details of the alleged offence and to refer and consult thoroughly with the MHO service.

23. This psychiatric assessment would be expected to address:

- whether the person appears to be suffering from mental disorder
- whether an assessment or treatment order is indicated
- whether the person is insane in bar of trial
- the risk the person poses to themselves or others
- whether the person's mental condition may have a bearing on his/her responsibility for the alleged offence
- whether, if the person were convicted, a mental health disposal would be indicated

24. In most cases where the person appears to be mentally disordered the most appropriate initial recommendation would be expected to be an assessment order or a treatment order. In some cases where the presence of mental disorder is clear and the offence is relatively minor (not solemn cases) it may be appropriate to recommend a final disposal at this stage, to be applied if the person is convicted. It would not be expected that final mental health disposals would be recommended in a pre-trial report in serious cases. In all such cases the recommendation should be for an assessment order or a treatment order (either pre- or post-conviction) or an interim compulsion order (post-conviction).

25. If the person appears to be insane in bar of trial and/or to have been insane at the time of the offence, it would be expected that in most cases an assessment order or a treatment order would be recommended pre-trial.

Mental disorder detected during a remand in custody

26. Most prisons and young offenders' institutions have visiting psychiatrists (who are usually forensic psychiatrists) and mental health multi-disciplinary teams with access to MHO services. If there are concerns that a person on remand is mentally disordered he/she is usually referred by prison staff, or refer themselves, to the prison medical officer (usually a general practitioner) or to the mental health team. If it then appears that a mental health assessment is necessary the person may be referred to a visiting psychiatrist and an MHO. If the outcome of the assessment is that the person requires to be transferred to hospital for assessment or treatment, an application should be made via the Scottish Ministers for an assessment order or a treatment order (in terms of sections 52C and 52L respectively).

BEST PRACTICE POINTS

Examinations in police custody

27. When examining a person who has been detained or arrested by the police, the medical practitioner should consider issues which may be relevant to the person's first appearance in court, such as fitness to plead and whether an assessment order should be made.

28. If these issues are unclear at this stage, then a further psychiatric assessment should be recommended, either that day or the next (if there are urgent clinical issues) or whilst the person is on remand (on bail or in custody).

29. The medical practitioner should seek the opinion of an MHO to assist in the assessment and decision making process.

30. Where possible, consideration should be given to the person's possible need for psychiatric or community care mental health services on a voluntary basis. Such information may have relevance for the procurator fiscal in any consideration of diversion.

31. There should be a clear procedure to enable the police to arrange for the assessment of a person in their custody who appears to be mentally disordered. In each area this procedure should be known to the police, the prosecutor, the courts, social work and mental health services.

32. If a person is in police custody charged with a serious offence or the person appears to pose a significant risk to others, the most appropriate step would be to recommend an assessment order or a treatment order at his/her first court appearance. If emergency admission prior to the first appearance is necessary then emergency or short-term detention under sections 36 and 44 of the 2003 Act should be applied for, the police should report the case to the procurator fiscal and a report recommending an assessment order should be submitted to the procurator fiscal for the first court appearance.

33. Medical practitioners should not recommend that a person is remanded in custody or imprisoned.

First court appearance

34. When assessing a person for his/her first court appearance a medical practitioner should, at a minimum, address whether the person is fit to plead, whether an assessment order should be made and whether the person should be admitted informally or under civil procedures if charges are dropped. An MHO opinion should also be sought. This has particular relevance in relation to the person's possible need for community care mental health services if there is a possibility of charges being dropped or if consideration is being given to civil procedures.

35. There should be a clear procedure to enable the prosecutor or the court to obtain a psychiatric assessment and an MHO assessment if an accused appears to be mentally

disordered at or before their first court appearance. In each area this procedure should be known to the police, the prosecutor, the courts, social work and mental health services.

36. Every mental health service should be able to provide an emergency assessment, as it would for a person referred by a general practitioner, if an accused appears to require one on clinical grounds.

37. A recommendation for an assessment order or a treatment order should only be made after the medical practitioner has discussed the case with a consultant from the unit where the person would be admitted and only after this consultant has agreed to admit the patient. The medical practitioner should also seek the opinion of an MHO in an advisory capacity to inform any knowledge of background and possible alternatives, and to assist in the assessment and decision making process.

38. If an assessment order or a treatment order is made then the person should be admitted to a unit of appropriate security considering the risk they pose to themselves and/or others. A person should not be admitted to a secure ward or unit, solely on the grounds of having been detained under sections 52B – J or 52K - S.

39. Medical practitioners should not recommend that a person be remanded in custody.

Subsequent court appearances

40. When assessing a person for a subsequent court appearance a medical practitioner should consider whether the person is sane and fit to plead, issues related to his/her responsibility for the alleged offence, whether a mental health disposal should be made pre-sentence, and whether a mental health disposal should be made if the person is convicted or found to be insane in bar of trial and /or to have been insane at the time of the offence.

41. If the person has previously been made subject to one of the orders described in section 232 of the 2003 Act as a 'relevant event', an MHO will have been designated as having responsibility for the person's case. The medical practitioner should contact this MHO to assist in the assessment and decision making process. The MHO will also have produced a Social Circumstances Report, (SCR), following the making of the previous order which should be used as a source of information.

42. In most cases where admission to hospital is indicated the initial recommendation should be for an assessment order or a treatment order.

43. In serious cases, or where the person might pose a significant risk to others, if a recommendation is made as to disposal following conviction or a finding of insanity, this recommendation should be for an assessment order, a treatment order or an interim compulsion order.

44. A recommendation for a mental health order should only be made after the medical practitioner has discussed the case with a consultant from the unit where the person would be admitted and only after this consultant has agreed to admit the patient.

45. If a mental health order is made then the person should be admitted to a unit of appropriate security considering the risk they pose to themselves and/or others. A person should not be admitted to a secure ward or unit, solely on the grounds that he/she is detained under provisions set out in the 1995 Act.

46. There should be a clear procedure to enable the prosecutor or court to request a psychiatric assessment and an MHO assessment of a person remanded on bail, in custody or in hospital. In each area this procedure should be known to the prosecutor, the courts, social work services and mental health services. If the person is already in hospital it would be the patient's responsible medical officer, (RMO), who would be instructed to prepare a report.

47. If a medical practitioner wishes to recommend an order requiring two medical recommendations, then he/she may find an appropriate medical practitioner, and inform the prosecutor or court that a second assessment is required and that they have identified someone who may provide this. Where practicable the second opinion should be as independent as possible, e.g. from a medical practitioner working in a different unit. The prosecutor or court would then, if appropriate, instruct this second medical practitioner to examine the person.

48. Where possible a mental health disposal at this stage should have one recommendation by a medical practitioner from the unit where it is proposed that the person should be admitted. This is a statutory requirement in terms of section 61(1A) for certain orders (see chapter 6 of this part of the Code of Practice).

49. Medical practitioners should not recommend that a person is remanded in custody or imprisoned.

PRE-TRIAL COURT PROCEDURES

Duty of the prosecutor to bring before the court any available evidence on the mental condition of the accused (section 52)

50. When a person has been arrested and charged with an offence, and it appears to the police that he/she may be suffering from a mental disorder, the police would be expected to seek mental health assessments by a medical practitioner and an MHO. Where the outcome of the assessment is that the person appears to be suffering from a mental disorder, the medical practitioner will so advise the court before which the person first appears.

51. The prosecutor has a statutory duty, where it appears to him/her that a person may be suffering from mental disorder, to bring before the court such evidence as may be available of the mental condition of the person. However, it may be the case that the person's apparent mental disorder is not detected until later and perhaps not until he/she actually appears in court. It is open to anyone with an interest in the case, i.e. police, defence agent, prosecutor, judge or sheriff, doctor, MHO, court social worker, named person etc to raise the possibility of mental disorder with the court.

Remit of certain mentally disordered persons from district court to sheriff court (section 52A)

52. A person charged in a district court with an offence punishable by imprisonment, who appears to have a mental disorder, must be remitted to the sheriff court. he sheriff court can then deal with the case in the same manner as if the charge had originally been raised in that court. This would include, but is not restricted to, the granting of a mental health disposal.

ASSESSMENT ORDERS AND TREATMENT ORDERS

Background

53. Previously at the pre-trial stage, section 52 of the 1995 Act allowed a court to remand a person to hospital instead of in custody, where it appeared that the person was suffering from a mental disorder. This did not allow for the person to receive medical treatment under the 1984 Act. If the person had been remanded in custody, section 70 of the 1984 Act allowed for the person to be transferred to hospital for treatment if he/she fulfilled the same criteria for detention as applied to civil cases, but it did not allow for the person to be transferred for assessment.

54. The Millan Committee recommended that assessment or treatment in hospital should be available pre-trial whether the person is appearing in court or has been remanded in custody and that the position of patients detained in hospital pre-trial should be similar to those detained under civil legislation.

55. The 2003 Act inserts sections 52B to U into the 1995 Act which makes provision for two new orders to be used by the courts prior to trial where it appears that the person charged has a mental disorder. These are an "assessment order" and a "treatment order" which together replace the powers of the court under section 52 of the 1995 Act and section 70 of the 1984 Act; they can be used after conviction and before sentencing to assist the court in making the appropriate final disposal.

Purpose

56. The key purpose of an *Assessment Order* is to allow the appropriate examination and assessment by an approved medical practitioner (AMP), of a person who is either awaiting trial or sentence. It authorises the removal to, and detention in, a specified hospital for up to 28 days and also the giving of medical treatment in certain circumstances. There is no right of appeal against this order.

57. Within 28 days the person's RMO (appointed by the mangers of the hospital – see Chapter 6 of this part of the Code of Practice) has a duty in terms of section 52G to report back to the court on his/her mental condition, including a view as to whether he/she meets the conditions specified in section 52D(7) (which are the same conditions as for a treatment order), so that the court can decide how to proceed. The designated MHO would be expected to contribute to this assessment.

58. The *Treatment Order* is for use in respect of a person with a mental disorder who is awaiting trial or sentence. It authorises his/her removal to, and detention in, a specified hospital and the giving of compulsory treatment in certain circumstances. Section 52R(2) and (3) sets out the circumstances in which the order ceases to have effect. There is no right of appeal against this order.

59. Within 21 days of the imposition of either an assessment order or a treatment order, the patient's MHO, (designated by the local authority in accordance with section 229 of the 2003 Act – see chapter 6 of this part of the Code of Practice), is required to provide the RMO

with a SCR unless he/she considers that to do so would serve little or no practical purpose (section 321). The purpose of this report is to contribute to the mental health assessment of the person and consideration of further recommendations in the case.

Overview

60. The assessment order and the treatment order provide flexible procedures at the pre-trial and post-conviction stage to allow a person to be admitted to hospital for assessment or treatment, and to inform the court in the consideration of an appropriate disposal.

61. Either may be applied for by the prosecutor, by the Scottish Ministers (where the person is in custody) or by the court on its own motion. Application by the Scottish Ministers is appropriate in cases where the person has been remanded in custody and waiting for the next court appearance would lead to an unreasonable delay or would not allow for an adequate assessment pre-trial or pre-sentence.

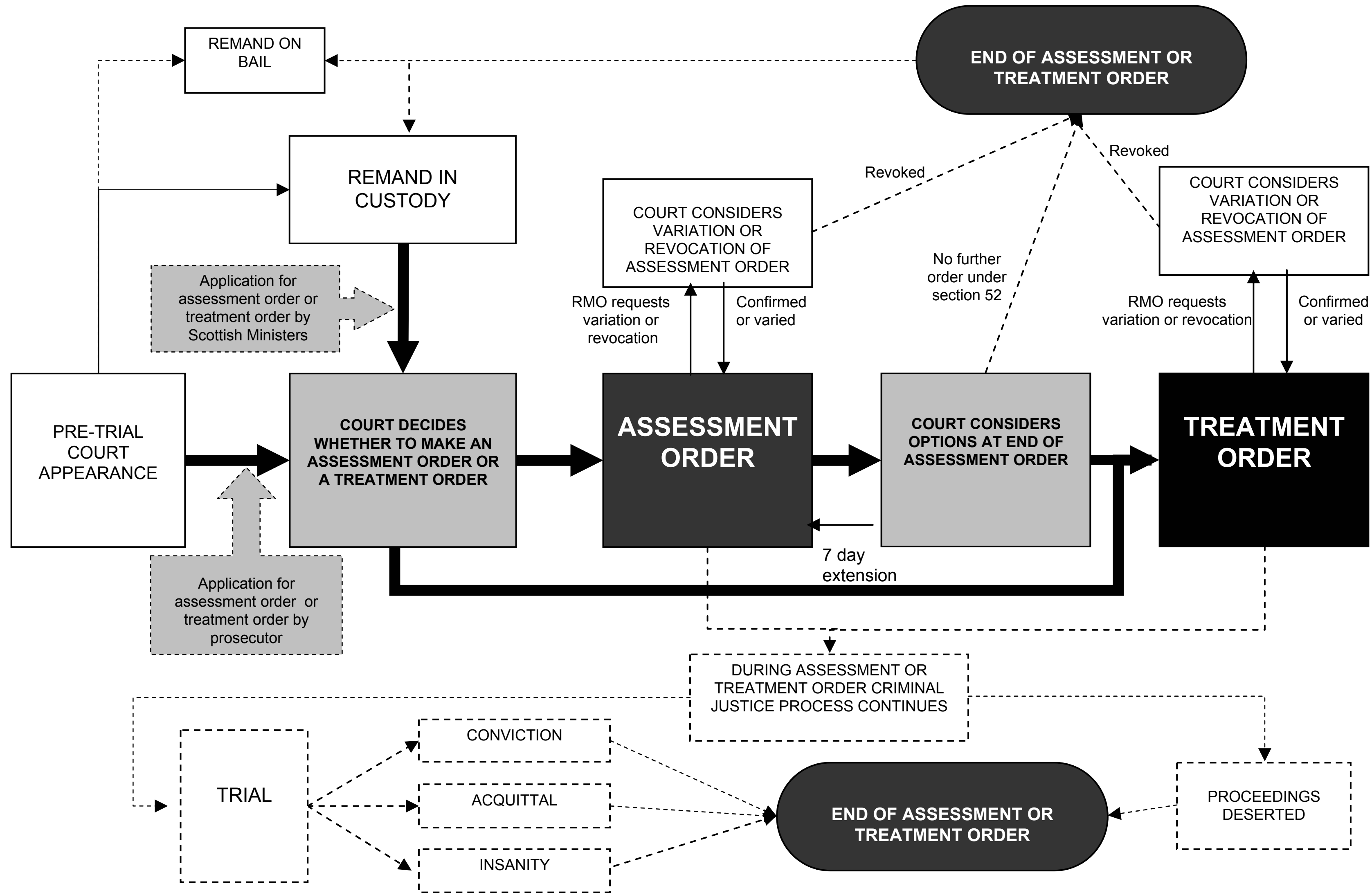
62. A person may be detained in hospital under either an assessment order or a treatment order but in most cases an assessment order would be expected to be used initially as it requires only one medical recommendation and the test is that the person only has to appear to be suffering from a mental disorder.

63. However in some cases where a person is clearly mentally disordered and requires treatment in hospital, and where two recommendations are available, a treatment order may be applied for directly. Where an MHO has been designated for the patient the RMO would be expected to consult him/her and to have regard to any SCR prepared before making an application for a treatment order.

64. An assessment order may only last 28 days (extendable by 7 days under certain circumstances in terms of section 52G(4)) whereas a treatment order may last for the whole of the pre-trial or pre-sentence stage. Although a person is on a treatment order, ongoing assessment will inform the most appropriate course of action at the next court appearance.

65. A flowchart setting out the court procedures relating to assessment orders and treatment orders is on page 32.

PRE-CONVICTION ASSESSMENT AND TREATMENT ORDERS



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ASSESSMENT ORDERS

General - Sections 52B to J:

Procedure prior to the making of an assessment order

66. Prior to conviction or a plea of guilty, the prosecutor (section 52B), or if the person is in custody awaiting trial or sentence, the Scottish Ministers (section 52C) may apply to the court for an assessment order to be made. The court may also make an assessment order on its own initiative (section 52E).

Application by prosecutor for assessment order (section 52B)

67. The prosecutor will apply for an assessment order having been alerted that a person may be suffering from mental disorder perhaps by the police or a medical practitioner who has previously examined the person, or because of the person's behaviour in court. A report may already be available to the prosecutor recommending an assessment order as set out in section 52D(2)(a). If not, the prosecutor would instruct that a medical practitioner should assess the person.

Making of assessment order by court on its own initiative (section 52E)

68. The court may have evidence available from a medical practitioner recommending an assessment order (as set out in section 52D) and may make an assessment order, or may suspect that a person appearing before the court suffers from mental disorder without having the necessary evidence available. In the latter circumstances the court would instruct a medical practitioner to assess the person.

Application by Scottish Ministers where person has been remanded in custody (section 52C)

69. If a medical practitioner examines a person remanded in custody and is of the opinion that the person should be transferred to hospital for assessment, then that medical practitioner should prepare a report recommending an assessment order (as set out in section 52D(2)(a)). This report should be sent to the prison governor or his representative. The prison governor or his representative should then notify the Scottish Ministers who may apply to the court for an assessment order using the supporting recommendation from the medical practitioner.

Making an assessment order (section 52D)

70. The criteria for making an assessment order are set out under section 52D(1) to (5). When a medical practitioner is assessing a person with a view to recommending an assessment order specific consideration should be given to the following matters:

(a) does it appear that the person is suffering from mental disorder? The category of mental disorder need not be specified.

(b) is it likely that detention in hospital is necessary to assess whether the conditions set out in section 52D(7) (which are the same as the conditions for a treatment order) are met? Those conditions are that:-

- the person in respect of whom the application is made has a mental disorder
- medical treatment would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder
- if the person were not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the person, or to the safety of others

(c) is it likely that there would be a significant risk to the person's health, safety or welfare or to the safety of any other person if the assessment order were not made?

71. It should be noted that for the above three issues: the medical practitioner need only be satisfied that *there are reasonable grounds for believing* that they are the case.

(a) is a suitable hospital placement available which will be able to admit the person within 7 days of the order being made? The medical practitioner should make arrangements with a specific hospital unit taking into consideration the nature of the person's mental condition and the risk they may pose.

(b) is there a reasonable alternative to enable the assessment to be undertaken rather than by making an assessment order? The medical practitioner would be expected to seek the opinion of an MHO to inform the consideration of alternatives.

Medical evidence

72. Evidence is only required from one registered medical practitioner who does not have to be approved under section 22 of the 2003 Act. If the medical practitioner is satisfied as to the points set out at paragraphs 70 and 71 above regarding criteria, then an assessment order should be recommended. The medical practitioner will usually submit his/her opinion and recommendation in the form of a written report, but oral evidence alone may be given to the court.

Attendance at court

73. The person should usually attend the court hearing at which the court decides whether to make an assessment order. However, if a person's mental condition is such that it may be detrimental to his/her health to appear in court or may pose a significant risk to him/herself or others if appearing in court then the medical practitioner should inform the prosecutor or the court of this, giving reasons for this opinion. The court may then make an assessment order in the absence of the person (section 52D(8)). Under such circumstances

the person's legal representative must be present and have an opportunity to be heard. Further, the court must be satisfied that it is impracticable or inappropriate for the person in respect of whom the order is being made to be brought before it.

Notification by the court of the order being made

74. As soon as is practicable after an assessment order has been made, the court must in terms of section 52D(10) inform the following parties of the making of the order:

- the person subject to the order
- any solicitor acting for that person
- where the person has been charged with an offence and a relevant disposal as defined in section 52B(4) has not been made in respect of the offence, the prosecutor
- where immediately before the order was made the person was remanded in custody, the Scottish Ministers
- the Mental Welfare Commission

Duty of a local authority to appoint an MHO

75. A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is practicable after an assessment order has been made in accordance with section 229 of the 2003 Act. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless the MHO records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the MWC within 21 days of the order being made. (For further information on SCRs see section 231 of the 2003 Act, or chapter 11 of the Code of Practice : Volume 1)

76. It would be expected that the medical records office of the hospital to which the person is admitted would ensure that the local authority is notified and sent a copy of the order. The notification would be sent to the Chief Social Work Officer for the relevant local authority. Hospital managers would be required to ensure that this is done speedily and, if possible, within 2 working days. Best practice would suggest that the relevant local authority should designate an MHO responsible for the patient's case within 2 working days of receiving notification. It would be expected that procedures would be developed to ensure that there is no undue delay in this process.

EFFECT OF AN ASSESSMENT ORDER

Removal to place of safety pending admission to hospital

77. An assessment order may include such directions as the court thinks fit for the removal of the person subject to the order to, and the detention of the person in, a place of safety pending the person's admission to a specified hospital in terms of section 52D(9). This place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. The person should be conveyed by one of the persons listed in section 52D(6)(a) to the specified hospital from the place of safety as soon as practicably possible.

Measures which may be authorised under an assessment order

78. The measures that can be authorised by the assessment order in terms of section 52D(6) are:

- the removal of the person to the specified hospital within 7 days of the making of the order by a constable; a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the hospital managers of that hospital to remove persons to hospital for the purposes of that section; or another specified person;
- the detention of the person in the specified hospital for 28 days beginning with the day on which the order is made; and
- during that 28 day period, the giving to the person of medical treatment in accordance with Part 16 of the 2003 Act (see paragraph 80 below).

Giving medical treatment under Part 16 of the 2003 Act

79. An assessment order may be made on the basis of evidence from one registered medical practitioner in terms of section 52D(2)(a).

80. Before medical treatment under Part 16 of the 2003 Act may be given, certain requirements must be satisfied. These are set out in section 242(5). Where the patient is subject to an assessment order, an opinion must be sought from an AMP who is not the patient's RMO. If this AMP determines treatment to be in the person's best interests of the patient, and this determination is recorded in writing (section 242(5)(e) of the 2003 Act) then such treatment may be given. It would be expected that this AMP might be another doctor employed in the same hospital, but not working in team responsible for the person's care

VARIATION OR REVOCATION OF AN ASSESSMENT ORDER

Change of hospital prior to admission and within 7 days of order being made (Section 52F)

81. If within 7 days of the assessment order being made it is apparent that the hospital specified in the assessment order is unable to admit the person, or inappropriate, then the court or, if the person was remanded in custody, the Scottish Ministers, should be notified. This would usually be done by the medical practitioner who recommended the assessment order or the prospective RMO, but may be another medical practitioner or someone else (e.g. hospital manager) depending on the circumstances.

82. The court or the Scottish Ministers may then direct in terms of section 52F that the person be admitted to an alternative hospital specified in the direction. Examples of situations where this may arise are:

- a deterioration in the mental condition of the person such that the specified hospital would no longer be an appropriate placement
- a bed being unavailable in the specified hospital due to emergency circumstances

83. When such change of circumstance is intimated to the court or the Scottish Ministers, a medical practitioner should make a recommendation for an alternative hospital after making arrangements with this hospital for the person to be admitted there. The medical practitioner would usually be the one who had recommended the assessment order, or the doctor who would have been the RMO, or a doctor from the alternative hospital, but may be another AMP depending on the circumstances.

Variation or revocation of assessment order after admission to hospital

84. Under section 52G(9), at any point during the assessment order the RMO may submit a report to the court seeking to have the order varied or revoked. Circumstances in which such a report may be submitted include:

- the assessment reveals that the person does not suffer from mental disorder
- it is apparent that the risk the person poses is such that they require a higher or lower level of security than that provided at the hospital where the person is currently detained

85. It would be expected that where the RMO is thinking of making a recommendation for the variation or revocation of the order, he/she should consult with the designated MHO who may have obtained information that could have a bearing on the matter. In particular, a recommendation for the revocation of the order may have consequences for the need to provide community care services, criminal justice social work services, the provision of local authority services in general or there may be matters that have implications for community or public safety.

86. In his/her report to the court, the RMO should set out the grounds for requesting a variation or revocation of the assessment order, and specify any variation. If admission to a

different hospital is proposed, then arrangements should be made with that hospital for the person to be admitted there following the variation of the assessment order by the court. The court may in terms of section 52G(10) confirm, vary or revoke the assessment order.

What should happen during an assessment order?

87. An RMO and MHO should be allocated for the person under section 230 and section 229 of the 2003 Act respectively (see chapter 6). A multi-disciplinary assessment should be undertaken to address the issues set out in paragraph 89 under 'Review of an assessment order (section 52G)'.

88. The designated MHO will prepare a Social Circumstances Report in terms of section 231 of the 2003 Act (unless he/she considers that to do so would serve little or no purpose) and send a copy to the RMO and MWC. However, even where the MHO considers that a SCR would serve little or no purpose, the MHO will still require to comply with the duties in section 231(2)(b of the 2003 Act).

Suspension of detention

89. Suspension of detention was called "leave of absence" under the 1984 Act. Sections 221 to 223 of the 2003 Act set out the statutory procedures for the suspension of the measure in an assessment order specifying detention of the patient. For further information on these procedures refer to Chapter 6 of this part of the Code of Practice, paragraphs 33 to 39.

Review of an assessment order (section 52G)

90. Before the expiry of the assessment order (that is within 28 days) the RMO should submit a written report to the court in terms of section 52G(1) addressing:

- whether the conditions set out in section 52D(7) (which are the same criteria for a treatment order) are met
- any other matters that may have been specified by the court as requiring to be included in the report when it made the assessment order

  or
- whether a further 7 days is required to complete the assessment (section 52G(4))

91. In terms of section 52G, the RMO must produce a report for the court before the expiry of the assessment order to address whether a treatment order should be made and to address any other issues specified by the court (under section 52D(2)) as set out in paragraph 89 above. It would be expected that the RMO would consult with the designated MHO in the preparation of the report.

92. In most cases medical evidence will also be necessary to address issues relevant to the trial (if pre-trial) or disposal (if pre-sentence), which would be requested by the prosecutor or court. In some cases this may be requested as 'any other issues' to be considered in the report under section 52D(2). In other cases a separate report may be requested.

93. So in some cases the two areas (issues to be dealt with in report under section 52D(2) and issues relating to trial or disposal) may be dealt with together in one report. For example, given that in summary cases pre-trial, the trial should be commenced within 40 days after the bringing of the complaint, and an assessment order may last up to a period of 28 days, it makes sense in light of these timescales to combine the two.

94. This also applies where the assessment order is post-conviction as disposal will occur directly or soon after the end of the assessment order. Whereas in other cases the two issues may be dealt with in separate reports. For example, in solemn cases pre-trial, as the trial should be held within 110 days of the bringing of the complaint, it may not make sense to combine the two as the end of the assessment order may be almost 3 months before the trial.

95. In most cases the main consideration during the assessment order will be whether a treatment order should be made. However, the RMO should consider other mental health issues and disposals depending on the stage of the case through the criminal justice process.

96. Where the RMO is considering recommending a mental health disposal, he/she would be expected to consult with the designated MHO (in the case of a proposed compulsion order, hospital direction or guardianship), or the proposed supervising officer (in the case of a probation order with a requirement for treatment of mental condition), well in advance of making such a recommendation to ensure that the MHO, or proposed supervising officer supports the recommendation and that any necessary services will be made available by the local authority.

97. This is of particular relevance where the RMO is considering making a recommendation for a compulsion order (with or without a restriction order) because the court, upon receipt of the RMO's evidence, will request a report from the MHO under section 57C, the purpose of which is to assist the court in considering whether a compulsion order is an appropriate and feasible disposal.

98. Late or ineffective consultation between the RMO and MHO may result in undue delay in disposal, or contradictory recommendations being presented to the court. For information about the imposition of a compulsion order see chapter 5 of this part of the Code of Practice.

99. Other issues that may need to be considered in the report if the assessment order is at the pre-trial stage are:

- insanity in bar of trial (see chapter 3)
- insanity at the time of the offence (see chapter 3)
- diminished responsibility (where the charge is murder); (see chapter 3)
- the appropriate disposal if the person is found to have been insane at the time of the offence (see chapter 3)
- the appropriate disposal if the person is convicted (see chapters 4 and 5)

100. Other issues that may need to be considered in the report if the assessment order is at the post-conviction stage are:

- whether an interim compulsion order should be made (this should be made in almost all cases where a hospital direction or compulsion order with a restriction order is being considered (see chapter 4))

- whether a final mental health disposal should be made (see chapter 5):
  - compulsion order
  - compulsion order with a restriction order
  - hospital direction
  - guardianship or intervention order
  - probation order with a requirement for treatment

101. In terms of section 52G(2), copies of the report must be sent by the RMO to the patient, the patient's solicitor, the prosecutor (prior to conviction or a plea of guilty) and the Scottish Ministers. It would be expected that the RMO would also send a copy to the MHO.

102. On receiving the report the court may, in terms of section 52G(3):

- make a treatment order
- commit the person to prison or another institution to which the person might have been committed had the assessment order not been made or deal with the person in any other way it considers appropriate
- extend the assessment order for a period not exceeding 7 days on one occasion only.

Extension of an assessment order

103. In terms of section 52G(4), an assessment order may be extended for a period not exceeding 7 days. This would be expected to be recommended if it remains unclear whether the criteria for a treatment order are met and there is good reason to believe that such an extension will enable a clear recommendation, or if the necessary evidence for a treatment order is not available. An extension of this order should not be sought solely for administrative convenience. A seven days extension to an assessment will authorise the same measures as the initial assessment order.

End of assessment order

104. In terms of section 52H(2)(a) and (b), if the person is on an assessment order pre-trial, the order ends if:
- a treatment order is made
- he/she is liberated in due course of law
- summary proceedings are deserted *pro loco et tempore* or *simpliciter*
- solemn proceedings are deserted *simpliciter* (but not *pro loco et tempore*)
- he/she is acquitted
- he/she is convicted
- he/she is found insane in bar of trial (an assessment order is not available in cases of insanity, a temporary compulsion order in terms of section 54(1)(c) may be used.)

105. In terms of section 52H(2)(a) and (c) and (3), if the person is on an assessment order post-conviction but pre-sentence, the order ends if:

- a treatment order is made
- sentence is deferred
- a sentence is imposed
- one of the following mental health disposals is made:
    - interim compulsion order
    - compulsion order
    - guardianship
    - hospital direction
    - any disposal under section 57
    - probation order with a requirement of treatment (section 230)

TREATMENT ORDER

General: sections 52K – U

Procedure prior to the making of a treatment order

106. Prior to conviction or a plea of guilty, the prosecutor (section 52K), or if the person is in custody awaiting trial or sentence, the Scottish Ministers (section 52L) may apply to the court for a treatment order to be made. The court may also make a treatment order on its own initiative (section 52N).

Application by prosecutor for treatment order

107. The prosecutor will apply for a treatment order having been alerted that a person may be suffering from mental disorder perhaps by the police or a medical practitioner who has previously examined the person, or because of the person's behaviour in court. In such cases the necessary reports will be available to the prosecutor recommending a treatment order as set out in section 52M. If not the prosecutor will instruct that the required assessments are carried out by medical practitioners.

Making of treatment order by court on its own initiative

108. The court may have evidence available from medical practitioners recommending a treatment order (as set out in section 52M) and may make a treatment order, or may suspect that a person appearing before the court suffers from mental disorder without having the necessary evidence available. In the latter circumstances the court would instruct that the required assessments are carried out by medical practitioners.

Application by Scottish Ministers where person has been remanded in custody

109. If a medical practitioner examines a person remanded in custody and is of the opinion that the person should be transferred to hospital for treatment, then that medical practitioner should arrange for two reports recommending a treatment order (as set out in section 52M) to be prepared. One of the reports must be prepared by a medical practitioner employed in the hospital where it is proposed that the person should be admitted (section 61(1A). It would be expected that the process would usually be initiated by the medical practitioner visiting the prison who would arrange for the other assessment/recommendation. These reports should be sent to the prison governor or his representative. The prison governor or his representative should then notify the Scottish Ministers who may apply to the court for a treatment order using the supporting recommendations from the medical practitioners.

Making a treatment order

110. The criteria for making a treatment order are set out under section 52M(1) to (5). When a medical practitioner is assessing a person with a view to recommending a treatment order specific consideration should be given to the following matters:

(a) the conditions set out in section 52D(7):
- does the person have a mental disorder?
- would medical treatment be likely to alleviate any of the symptoms or effects of the disorder, or to prevent a worsening of the mental disorder?
- would there be a significant risk to the health, safety or welfare of the person, or to the safety of others, if this treatment were not provided?

(b) is a suitable hospital placement available which will be able to admit the person within 7 days of the order being made? One of the medical practitioners should make arrangements with a specific hospital unit taking into consideration the nature of the person's mental condition and the risk they may pose. Both medical practitioners should agree this and specify the hospital to which the person will be admitted. It is expected that one of the medical practitioners would also inform the designated MHO.

(c) is there a reasonable alternative to enable the giving of medical treatment to the person? It would be expected that an MHO opinion would be sought to inform the consideration of alternatives.

111. When the assessment is being carried out, it would be expected that the opinion of the designated MHO would be sought to inform the decision making process.

Medical evidence

112. The person must be assessed by two medical practitioners, one of whom must be an AMP. If the medical practitioners are satisfied as to the points detailed in paragraph 110 then a treatment order should be recommended. One of the recommendations must be made by a medical practitioner from the hospital where it is proposed the person be admitted (section 61(1A). The medical practitioners will usually submit their opinions and recommendations in the form of written reports, but oral evidence alone may be given.

Attendance at court

113. The person should usually attend the court hearing at which the court decides whether to make a treatment order. However, if a person's mental condition is such that it may be detrimental to his/her health to appear in court or may pose a significant risk to him/herself or others if appearing in court then the medical practitioner should inform the prosecutor or the court of this, giving reasons for this opinion. The court may then make a treatment order in the absence of the person (section 52M(7)).

114. Under such circumstances the person's legal representative must be present and have an opportunity to be heard. Further, the court must be satisfied that it is impracticable or inappropriate for the person in respect of whom the order is being made to be brought before it.

Notification by the court of the order being made

115. As soon as is practicable after a treatment order has been made, the court must in terms of section 52M(9) inform the following parties of the making of the order:

- the person subject to the order
- any solicitor acting for that person
- where the person has been charged with an offence and a relevant disposal as defined in section 52B(4) has not been made, the prosecutor
- where immediately before the order was made the person was remanded in custody, the Scottish Ministers
- the Mental Welfare Commission

Duty of a local authority to appoint an MHO

116. A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is practicable after a treatment order has been made in accordance with section 229 of the 2003 Act. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless the MHO records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the MWC within 21 days of the order being made. (For further information about SCRs please see section 231 of the 2003 Act or chapter 11 of the Code of Practice: Volume 1).

117. It would be expected that the medical records office of the hospital to which the person is admitted would ensure that the local authority is notified and sent a copy of the order. The notification would be sent to the Chief Social Work Officer for the relevant local authority. Hospital managers would be required to ensure that this is done speedily and, if possible, within 2 working days. Best practice would suggest that the relevant local authority should designate an MHO responsible for the patient's case within 2 working days of receiving notification. It would be expected that procedures whould be developed to ensure that there is no undue delay in this process.

EFFECT OF A TREATMENT ORDER

Removal to place of safety pending admission to hospital

118. A treatment order may include such directions as the court thinks fit for the removal of the person subject to the order to, and the detention of the person in, a place of safety pending admission to a specified hospital in terms of section 52M(8). This place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. The person should be conveyed by a person listed in section 52M(6) to the specified hospital from the place of safety as soon as practicably possible.

Measures which may be authorised under a treatment order

119. The measures that can be authorised by the treatment order in terms of section 52M(6) are:

- the removal of the person to the specified hospital within 7 days of the making of the order by a constable; a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the hospital managers of that hospital to remove persons to hospital for the purposes of that section; or another specified person
- the detention of the person in the specified hospital; and
- the giving to the person of medical treatment in accordance with Part 16 of the 2003 Act

VARIATION OR REVOCATION OF AN TREATMENT ORDER

Change of hospital prior to admission and within 7 days of order being made (section 52P)

120. If within 7 days of the treatment order being made it is apparent that the hospital specified in the treatment order is unable to admit the person or inappropriate, then the court or, if the person was remanded in custody, the Scottish Ministers, should be notified. This would usually be done by the medical practitioner who recommended the treatment order or the prospective RMO, but may be another medical practitioner or someone else (e.g. hospital manager) depending on the circumstances.

121. The court or the Scottish Ministers may then direct in terms of section 52P that the person be admitted to an alternative hospital. Examples of situations where this may arise are:

- a deterioration in the mental condition of the person such that the specified hospital would no longer be an appropriate placement
- a bed being unavailable in the specified hospital due to emergency circumstances

122. When such change of circumstances is intimated to the court or the Scottish Ministers, a medical practitioner should make a recommendation for an alternative hospital after making arrangements with this hospital for the person to be admitted there. The medical practitioner would usually be one of the medical practitioners who had recommended the treatment order, or the doctor who would have been the RMO, or a doctor from the alternative hospital, but may be another AMP depending on the circumstances

Review of a treatment order (section 52Q)

123. Under section 52Q(1), at any point during the treatment order the RMO may submit a report to the court seeking to have the order varied or revoked. Circumstances in which such a report may be submitted include:

- it has become clear during the treatment order that:
  - the person does not suffer from mental disorder
  - treatment in hospital is unlikely to alleviate or prevent a worsening in the mental disorder
  - there would not be a significant risk to the person’s health, safety or welfare, or to the safety of another person if they were not treated in hospital

- it is apparent that the risk the person poses is such that he/she requires a higher or lower level of security than that provided at the hospital where the person is currently detained

124. It would be expected that where the RMO is considering making a recommendation for the variation or revocation of the order, he/she would consult with the designated MHO. A recommendation for the revocation of the order may have consequences for the need to provide community care services, criminal justice social work services, or the provision of

local authority services in general, or have implications for matters of community or public safety.

125. In his/her report the RMO should set out the grounds for requesting variation or revocation of the treatment order, and specify the variation. If admission to a different hospital is proposed then arrangements should be made with that hospital for the person to be admitted there following the variation of the treatment order by the court. This would be done by the RMO who should contact the other hospital and receive an agreement from an RMO there to admit the patient.

126. The court may in terms of section 52Q(2) confirm, vary or revoke the treatment order.

What should happen during a treatment order?

127. Where an RMO and MHO have not previously been allocated responsibility for the patient's case under sections 230 and 229 of the 2003 Act respectively (see paragraph 87), this should now be done. A multi-disciplinary assessment should be undertaken to address the issues set out in paragraphs 123 to 126 under 'Review of a treatment order'.

128. It would be expected that the designated MHO would work in close collaboration with the RMO and other members of the multi-disciplinary team. He/she must prepare a Social Circumstances Report in terms of section 231 of the 2003 Act (unless he/she considers that to do so would serve little or no purpose) and send a copy to the RMO and MWC. However, even where the MHO considers that an SCR would serve little or no purpose, the MHO will still require to comply with the duties in section 231(2)(b).

129. In most cases, whether at the pre-trial or post-conviction stage, it would be expected that the RMO, the designated MHO, and the multi-disciplinary team would require to consider during the treatment order which recommendation should be made following conviction or at sentencing. At the post-conviction stage a Social Enquiry Report (SER) in terms of section 204(2) of the 1995 Act may be available and provide useful information.

130. Thus during the treatment order the RMO, in consultation with the designated MHO, will usually be responsible for assessing the relevant issues and preparing a non-statutory report at the request of the prosecutor or the court which would address statutory issues relating to the various orders that are available at that stage.

131. Issues that would be expected to be considered in this report if the treatment order is at the pre-trial stage are:

- insanity in bar of trial (see chapter 3)
- insanity at the time of the offence (see chapter 3)
- diminished responsibility (where the charge is murder; see chapter 3)
- the appropriate disposal if the person is found to have been insane at the time of the offence (see chapter 3)
- the appropriate disposal if the person is convicted (see chapters 4 and 5)

132. Other issues that may require to be considered in the report if the treatment order is at the post-conviction stage are:

- whether an interim compulsion order should be made (this would be expected to be made in almost all cases where a hospital direction or compulsion order with a restriction order is being considered; see chapter 5)

- whether a final mental health disposal should be made (see chapter 5):
  - compulsion order
  - compulsion order and a restriction order
  - hospital direction
  - guardianship order
  - probation order with a requirement for treatment

133. Where the RMO is considering recommending a final mental health disposal, it would be expected that he/she would consult the designated MHO (in the case of a proposed compulsion order, hospital direction or guardianship) or potential supervising officer (in the case of a proposed probation order with a requirement for treatment of mental condition), well in advance of making such a recommendation to ensure that the MHO or proposed supervising officer supports the recommendation and that any necessary services will be made available by the local authority.

134. This is of particular relevance where the RMO is considering making a recommendation for a compulsion order (with or without a restriction order) because the court, upon receipt of the RMO's evidence, will request a report from the MHO under section 57C, the purpose of which is to assist the court in considering whether a compulsion order is an appropriate and feasible disposal.

135. Late or ineffective consultation between the RMO and MHO may result in undue delay in disposal, or contradictory recommendations being presented to the court. For further information on the making of a compulsion order see chapter 5.

Suspension of detention

39. Suspension of detention was called "leave of absence" under the 1984 Act. Part 13 of the 2003 Act sets out the statutory procedures for the suspension of the measure in a treatment order specifying detention of the patient. These procedures are the same for an interim compulsion order (section 53), a compulsion order with a restriction order (sections 57A and 59), a hospital direction (section 59A) and a transfer for treatment direction (section 136 of the 2003 Act). For further information on these procedures refer to Part 2, Chapter 5 of this part of the Code of Practice.

End of a treatment order

137. If the person is on a treatment order pre-trial, the order ends if:

- he/she is liberated in due course of law
- summary proceedings are deserted
- solemn proceedings are deserted *simpliciter* (but not *pro loco et tempore*)
- he/she is acquitted
- he/she is convicted

- he/she is found insane in bar of trial (a treatment order is not available in cases of insanity, a temporary compulsion order in terms of section 54(1)(c) may be used.)

138. If the person is on a treatment order post-conviction but pre-sentence, the order ends if:

- sentence is deferred
- a sentence is imposed
- one of the following mental health disposals is made:
    - interim compulsion order
    - compulsion order
    - guardianship order
    - hospital direction
    - any disposal under section 57
    - probation order with a requirement of treatment

CHAPTER 3: INSANITY

Introduction

This chapter begins by providing an overview of the relevant psychiatric issues at trial in relation to insanity. It then sets out the legal criteria and clinical assessment of insanity in bar of trial, insanity at the time of the offence and diminished responsibility. The chapter goes on to describe how these should be addressed in pre-trial reports.

The chapter then provides detailed information about the relevant 'insanity' sections of the 1995 Act including the imposition of a temporary compulsion order.

Finally the chapter sets down the procedures involved in the imposition of a supervision and treatment order and its effect.

OVERVIEW OF PSYCHIATRIC ISSUES OF RELEVANCE AT TRIAL

1. At the trial a sheriff (in summary cases) or a jury (in solemn cases) decides a verdict. Most criminal cases do not go to trial as the accused usually pleads guilty and the process moves on to the sentencing stage. However if a trial is to proceed there are three scenarios in which mental disorder may be pertinent. These are:

<u>Insanity in bar of trial</u>

2. If a person's mental disorder is such that they cannot participate adequately in the court process, (i.e. cannot understand the proceedings or instruct a legal representative as to a defence), then it has long been held that it is unfair for the person to be tried. If this is the case the court may find the person insane in bar of trial (or insane and unfit to plead) and there is no trial, or where the trial has commenced, it will be discharged (section 54(1)(a)).

<u>Insanity at time of offence</u>

3. If a person was mentally disordered at the time of the offence then this may affect his/her legal responsibility for his/her actions. In some cases the court may find that the person's mental condition was such that he/she cannot be held responsible for his/her actions; he/she is then acquitted on account of insanity in terms of section 54(6) (also known as insanity at the time of the offence or not guilty by reason of insanity). A person may also be acquitted on the ground of insanity in terms of section 55(3) and (4), where the trial diet has been discharged and an Examination of Facts has taken place.

<u>Diminished responsibility</u>

4. In murder cases, a person's mental condition may be such that although he/she cannot be acquitted on account of insanity, he/she may be found to be of diminished responsibility. The latter is a mitigating plea as opposed to a defence and therefore does not result in acquittal, but in conviction for the lesser offence of culpable homicide. Diminished responsibility, unlike insanity, does not have any specific procedures attached to it, but is conveniently described here because, like acquittal on the ground of insanity, it is concerned with the impact of mental disorder on a person's responsibility for an offence.

5. The legal criteria for insanity in bar of trial, acquittal on account of insanity and for diminished responsibility are set out in common law. It should be noted that insanity in bar of trial and insanity at the time of the offence are separate issues with different legal criteria. They are also distinct from whether a person has mental disorder in terms of the 2003 Act.

6. A person may have been insane at the time of an offence (section 54(6)), and although currently mentally disordered within the meaning of the 2003 Act, he/she may nevertheless be fit to plead.

7. A person may not have been insane at the time of the offence, but may later be found unfit to plead (section 54(1)(a)) and mentally disordered within the terms of the 2003 Act.

8. Generally insanity, both in bar of trial and at the time of an offence, has a higher threshold than that for mental disorder under the 2003 Act. This is clarified in later in this chapter where the common law basis for these two forms of legal insanity are set out.

9. Insanity (in bar of trial in terms of section 54(1)(a) or at the time of the offence in terms of section 54(6) accounts for a tiny minority of mentally disordered offenders who are processed by the criminal justice system. Where offences are relatively minor, charges may be dropped and the case dealt with informally or through civil procedures (covered by Parts 5 to 7 of the 2003 Act; for information about these procedures refer to Volume 1 of this Code of Practice).

10. In more serious cases, if criminal proceedings are raised, and the person is found to be insane in bar of trial the court will order an Examination of Facts ("EOF") (section 54(1)(b)) to be held in terms of section 55. If it is established in the course of an ordinary trial or in an EOF that the person was insane at the time of the offence, he/she will be acquitted on the grounds of insanity (in terms of section 54(6) and section 55(4) respectively). The disposals available following the conviction of a mentally disordered offender are almost identical to those available if a mentally disordered offender is found to be insane in bar of trial and/or was insane at the time of the offence (section 57(2)).

11. In cases where insanity or diminished responsibility is an issue, it is possible for parties to be in agreement about the expert evidence. However, this is less common in cases where the defence of diminished responsibility is advanced. Therefore where a person is insane in bar of trial the court makes this finding based on medical evidence usually in the form of a written report, without the need to lead evidence and allow for cross examination.

LEGAL CRITERIA AND CLINICAL ASSESSMENT

12. The legal criteria for insanity in bar of trial, insanity at the time of the offence and diminished responsibility are derived from common law. The current legal criteria are set out in paragraphs 16 to 18, 21 to 22, and 26 to 27 respectively on the basis of the most recent case law, however it is always possible the law will change.

13. When medical practitioners are requested to assess a person pre-trial, the current legal criteria for insanity and, in murder cases, diminished responsibility, should be set out in the letter requesting the assessment. **Medical practitioners should ensure that they are up-to-date with the current legal criteria before they give any opinion as to insanity or diminished responsibility**, although it is the responsibility of the commissioning agent to ensure that the medical practitioner is provided with the relevant information.

14. It is a matter for the court to make a finding in law as to whether the person is insane in bar of trial and/or was at the time of the offence.

15. The legal criteria do not translate easily into clinical terms. Some guidance is given in paragraphs 19 to 20, 23 to 25, and 28 to 29 on the issues to be addressed in the clinical assessment of a person to determine whether insanity in bar of trial, insanity at the time of the offence or diminished responsibility apply. Medical practitioners should give opinions on these matters, but the court will make the appropriate finding in law.

INSANITY IN BAR OF TRIAL

Legal criteria

16. In *H. M. Advocate v. Wilson* 1942 JC 75 (at page 79) the court set out that there had to be:

> *a mental alienation of some kind which prevents the accused giving the instruction which a sane man would give for his defence or from following the evidence as a sane man would follow it and instructing his counsel as the case goes, along any point that arises*

17. Similar criteria were set out in *Stewart v H. M. Advocate* (No. 1) 1997 JC 183 (at page 183):

> *The question for* [the trial judge] *was whether the appellant, by reason of his mental handicap, would be unable to instruct his legal representatives as to his defence or to follow what went on at his trial. Without such ability he could not receive a fair trial.*

18. The test excludes amnesia for the circumstances of the alleged offence in itself, but inability to give instruction due to physical defects may be accepted with the exception of deaf mutism (HMA v Wilson 1942 SLT 194).

Clinical assessment

19. The assessment of fitness to plead is concerned with the mental state and ability of an accused at the time of the trial. This involves making a diagnosis of mental disorder, and determining the impact of this disorder on the ability of the accused to give instructions for his defence and follow proceedings in court. As the mental state of a person may change, if some time has elapsed between a clinical examination and the person's appearance in court a brief re-examination may be necessary.

20. Medical practitioners usually also consider whether the person understands the charge they are facing and the pleas available to them (although these are not specifically mentioned in the case law).

INSANITY AT THE TIME OF THE OFFENCE

Legal criteria

21. *H. M. Advocate v Kidd* 1960 JC 61 (at page 70) is currently generally accepted and used as the basis of the insanity defence:

> *... in order to excuse a person from responsibility on the grounds of insanity, there must have been an alienation of reason in relation to the act committed. There must have been some mental defect ... by which his reason was overpowered, and he was thereby rendered incapable of exerting his reason to control his conduct and reactions. If his reason was alienated in relation to the act committed, he was not responsible for the act, even although otherwise he may have been apparently quite rational.*

22. Self-induced intoxication does not provide grounds for a defence of insanity.

Clinical assessment

23. The task of the medical practitioner is to assess the mental state of the person at the time of the offence, and its relative contribution to the offence, taking into account the wider circumstances.

24. The nature and degree of any mental disorder should be such that the person's reason was alienated. It is difficult to translate the terminology of legal judgments into clinical corollaries but the mental disorder should be such that it played an overwhelming role in determining the occurrence of the offence. In most cases the person is suffering from a psychotic illness and there is a direct link between positive psychotic symptoms (delusions and hallucinations) and the act committed.

25. If an SCR has been prepared in terms of section 231 of the 2003 Act, it would be expected that this would provide information that will contribute to this area of assessment, as it should address aspects of personal history, (including social work records), family or carer accounts, and circumstances leading up to the event.

DIMINISHED RESPONSIBILITY

Legal criteria

26. These were set out in *Galbraith v H. M. Advocate* 2001 SCCR 551 (2001 SLT 953 at page 966). The conclusions of the court were:

> *In essence, the judge must decide whether there is evidence that, at the relevant time, the accused was suffering from an abnormality of mind which substantially impaired the ability of the accused, as compared with a normal person, to determine or control his acts.*

27. 'Psychopathic personality disorder' (Carraher v HMA 1946 SLT 225 and Kennedy v HMA 1944 JC 171 both refer) and voluntary intoxication (Brennan v HMA 1977 JC 3 refers) are excluded.

Clinical assessment

28. Diminished responsibility is concerned with the mental state of the person at the time of the offence, as with insanity at the time of the offence. Therefore the clinical approach to assessment is identical to that outlined above, including reference to the SCR where one is available.

29. The clinical corollaries of the *Galbraith* judgment are difficult to determine, because at the time of writing the judgment was relatively recent. The conditions that come within the scope of diminished responsibility are broader that those for insanity. It would be expected that the medical practitioner would comment on the mental condition of the person at the time of the homicide and the relative contribution of any mental disorder to the occurrence of the killing. The medical practitioner should not state if the person's responsibility was diminished; this is an issue for the jury.

ADDRESSING INSANITY IN PRE-TRIAL REPORTS

Insanity in bar of trial

30. *In every pre-trial psychiatric report the issue of insanity in bar of trial should be addressed.* In most cases where a person appears insane in bar of trial (section 54(1)(a)) or there is uncertainty, the most appropriate next step may be to recommend an assessment order or a treatment order under section 52D or section 52M of the 2003 Act. This allows for a period of in-patient assessment and treatment to clarify the person's mental state and for diversion for care and treatment by mental health services.

31. If the offence is relatively minor and the prosecutor decides not to proceed with a prosecution, the most appropriate course may be either informal treatment or compulsory treatment under civil procedures (covered by Parts 5 to 7 of the 2003 Act; for information about these procedures refer to Volume 1 of this Code of Practice).

32. If a person is assessed by a medical practitioner to be insane in bar of trial (section 54(1)(a)), then the court will make a determination on this issue either at a specific preliminary hearing (sometimes called a 'mental health proof') or at the trial diet, where the necessary medical evidence (from two medical practitioners, one of whom is approved in terms of section 22 of the 2003 Act) would be considered.

33. The importance of this is that if one medical practitioner prepares a report stating that a person is insane in bar of trial at an early stage in the pre-trial process, then this cannot be turned into a legal finding of insanity in bar of trial at the next scheduled court appearance because evidence is required from two medical practitioners. There would therefore need to be a specific hearing with the necessary medical evidence from two medical practitioners in terms of section 54(1).

34. Having assessed a person who appears to be insane in bar of trial, it may be that with treatment (by way of a temporary compulsion order under section 54(1)(c)(ii), (see paragraphs 54 to 62), or the natural course of the mental disorder, there is an improvement in mental state over a period of time such that the person becomes fit to plead. On the other hand a person who initially appears fit to plead, may experience a deterioration in mental state prior to trial and appear to be insane in bar of trial.

35. If the court finds a person insane in bar of trial, then there will be an Examination of Facts in terms of section 55 to determine whether the person committed the offence(s). Whilst awaiting the Examination of Facts the person may be detained in hospital on a temporary compulsion order (section 54(1)(c)(ii)). Therefore in any report stating that a person is insane in bar of trial, which is likely to be the final report submitted for the hearing to determine whether the person is insane in bar of trial, consideration should be given to whether the person meets the criteria for a temporary compulsion order (see paragraph 54).

Insanity at the time of the offence

36. At the very early stages of the pre-trial process (police custody and first court appearance, (see chapter 2 of this part of the Code of Practice), the issue of insanity at the

time of the offence is not usually important, the main issues being fitness to plead and whether the person needs immediate psychiatric care and/or treatment.

37. *In all other pre-trial reports the issue of insanity at the time of the offence would be expected to be considered.* In most cases where this is an issue it may be appropriate to recommend an assessment order under section 52D if the person continues to be unwell.

RECOMMENDATION OF DISPOSAL IN INSANITY CASES

38. *In any case where it is likely that a person may be found insane in bar of trial (section 54(1)(a)) or acquitted on the ground of insanity by the court (section 54(6) or 55 (4))), a medical practitioner preparing a report should address the most appropriate mental health disposal, if any, to be made if the person is found insane (section 57(2)), and also the most appropriate disposal if the person is not found insane but is convicted (see chapter 4 of this volume).* The mental health disposals available in both circumstances are very similar, but not identical, so by covering both eventualities an appropriate disposal may be achieved whether the person is found insane or not.

39. The recommended disposal will depend on the nature of the person's mental disorder, their needs and the risk they pose to others. The issues here are identical to those at the post-conviction stage for persons who are convicted (see chapters 4 and 5 of this part of the Code of Practice). The options as set out under section 57(2) are:

- a compulsion order
- a compulsion order and a restriction order
- a guardianship order
- a supervision and treatment order
- no order

40. The assessment as to the appropriateness of each of the options in paragraph 39 is identical to that set out in chapters 4 and 5 of this volume, with the exception of the supervision and treatment order (section 57(2)(d)) which is unique to insanity procedure and so is included in this chapter.

INSANITY IN BAR OF TRIAL
INSANITY AT THE TIME OF THE OFFENCE

Background

41. If a person was found insane prior to 1996, disposal was inflexible. In solemn cases there was automatic detention at a state hospital under a restriction order without limit of time. The Criminal Justice (Scotland) Act 1995 introduced an Examination of Facts ("EOF") following a finding of insanity in bar of trial, and flexible disposals following a finding of insanity (either in bar of trial with the facts found and/or at the time of the offence). These are set out under sections 54 to 57.

Purpose

42. Sections 54 to 57 set out the procedures to be followed when a person is found insane in bar of trial (section 54(1)(a)) or acquitted on account of insanity (section 54(6) or section 55(4)). The criteria for these two findings are not set out here as they are not statutory, but are set out in common law.

43. Following a finding of insanity in bar of trial, an EOF allows the court to determine whether the person committed the offence(s) libelled before imposing an appropriate disposal. Section 57(2) provides a flexible range of disposals in insanity cases allowing the nature of the person's mental disorder, their needs and the risk they pose to themselves or others to be taken into account.

Overview

44. For a finding of insanity in bar of trial, the court must make a determination on the basis of evidence from at least two medical practitioners (section 54(1)). Usually, the issue is determined before trial commences, but it may become apparent after the trial has started.

45. If the person is found insane in bar of trial, he/she may be placed on a temporary compulsion order or remanded in custody or on bail (section 54(1)(c)). Next there is an EOF at which the court determines whether the person committed the offence(s). The court will also consider whether or not there are any grounds for acquittal and if any ground is established the accused person will be acquitted (section 55(3)). The exception to this as already mentioned, is an acquittal on the grounds of insanity at the time of the offence (section 54(6)).

46. A defence of insanity at the time of the offence may be put forward whether the person has been found insane in bar of trial or not.

47. If a person is found:

- insane in bar of trial and it is proven beyond reasonable doubt that the he/she committed the offence and that there are no grounds for acquitting him/her at an EOF; and/or
- insane at the time of the offence and therefore acquitted on the grounds of insanity;

the following disposals under section 57 of the 1995 Act are available:

- compulsion order (section 57(2)(a))
- compulsion order and a restriction order (section 57(2)(b))
- guardianship order (section 57(2)(c))
- supervision and treatment order (section 57(2)(d))
- no order (section 57(2)(e)

INSANITY IN BAR OF TRIAL

General: section 54

The court's finding as to insanity in bar of trial

48. *Section 54 sets out procedures relating to a court's finding of insanity in bar of trial or at the time of the offence.* Section 54(1) sets out the medical evidence necessary for a finding of insanity in bar of trial, and the procedures to be followed following such a finding (including making a temporary compulsion order). Section 54(3) allows for adjournment of a case where the person appears to be insane in bar of trial in order that investigation of his/her mental condition may be carried out. Section 54(5) allows for the hearing regarding insanity in bar of trial to proceed in the person's absence. Section 54(2A), section 54(2B) and section 54(4) set out procedures related to the temporary compulsion order. Section 54(7) sets out requirements for the notice to be given if insanity in bar of trial is to be put forward. Section 54(8) defines terms used in section 54.

49. If a court is presented with evidence from two medical practitioners (at least one of whom is an AMP in terms of section 61) that a person is not in their opinion sane and fit to plead, either before the trial has commenced or during a trial (section 54(1)), the court may find the person insane in bar of trial. This may occur in the person's absence if it is not practicable or appropriate for them to appear, and he/she (or the person acting on his/her behalf) has no objection (section 54(5)).

50. Before making a finding of insanity in bar of trial the court may adjourn the case for investigation into the person's mental condition (section 54(3)). This may occur if the court does not have the necessary medical evidence or if there is conflicting evidence.

51. If the question of insanity in bar of trial arises in a jury trial, the judge may adjourn the case, without having to dismiss the jury until the question is decided one way or another – whereupon the trial would either continue (with the same jury) or be discharged.

52. If an accused person intends to intimate a plea of insanity in bar of trial in a summary case, he/she must give notice of the plea and relevant witnesses to the prosecutor before the first prosecution witness is sworn (section 54(7)).

53. Following the finding in terms of section 54(1)(a) that the accused is insane in bar of trial the court discharges the trial diet and orders an EOF (section 54(1)(b)). Whilst awaiting the EOF the person may be remanded on bail or in custody, or may be placed on a temporary compulsion order (section 54(1)(c)). The court may also desert the diet *pro loco et tempore* on the application of the prosecutor (section 54(2)).

Criteria for making a temporary compulsion order

54. To make a temporary compulsion order, in accordance with section 54(2A), the court must be satisfied on the evidence from two medical practitioners that:

- the person has a mental disorder
- medical treatment is available which would be likely to prevent the mental disorder worsening, or alleviate any of the symptoms or effects of the disorder

- if such medical treatment were not provided there would be a significant risk to the person's health, safety or welfare, or to the safety of any other person
- a hospital is available and suitable for the person's detention (this hospital will be specified in the order).

Effects of a temporary compulsion order

55. The measures that may be authorised in accordance with section 54(2B) are that the person shall be:

- conveyed to the specified hospital within 7 days of the making of the order by a constable, a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the managers of that hospital to remove persons to hospital for the purposes of that section, or another specified person
- detained at the specified hospital
- given medical treatment under Part 16 of the 2003 Act.

What should happen during a temporary compulsion order?

56. Although a temporary compulsion order does not qualify as a 'relevant event' in terms of section 232 of the 2003 Act (see Chapter 6), best practice would suggest that in those cases where a temporary compulsion order is made and an RMO and an MHO have not previously been allocated for the patient, this action should be considered by the hospital managers and the local authority respectively.

57. It would be expected that the designated MHO would work in close collaboration with the RMO and other members of the team and would prepare an SCR (unless he/she considers it would serve little or no practical purpose to do so) which would be used by the RMO to inform his/her assessment.

58. It would be expected that in all cases the most appropriate disposal under section 57(2) should already have been recommended to the court in the reports that were given in evidence regarding insanity in bar of trial. These recommendations should be reviewed during the temporary compulsion order by the RMO and the MHO and the rest of the multi-disciplinary team where relevant and appropriate.

59. The length of time on a temporary compulsion order will not usually be sufficient to undertake a thorough multi-disciplinary assessment, particularly in more complex or serious cases. No further reports need to be submitted unless these are requested by the court or the initial recommendations are no longer appropriate.

Revocation or variation of temporary compulsion order

60. Under section 54(4), the court may review the order at any point and take into consideration any changes in circumstances. If there is a change in circumstances at any point during the temporary compulsion order the RMO would be expected to report this to the prosecutor and have them seek to have the order varied or revoked. Such circumstances may include the following:

- it has become clear during the temporary compulsion order that the person does not suffer from mental disorder

- it is apparent that the risk the person poses is such that they require a higher or lower level of security than that provided at the hospital where the person is currently detained. This decision would be made by the RMO in consultation with the MHO and the rest of the multi-disciplinary team where relevant and appropriate.

61. The RMO's report to the prosecutor should set out the grounds for requesting the variation or revocation of the temporary compulsion order, and if recommending variation, should set out the recommendation.

62. If the variation proposed is that the person be admitted to a different hospital then arrangements should be made with that hospital for the person to be admitted there following the variation of the temporary compulsion order by the court. The court may then:

- revoke the order, and remand the person on bail or in custody (section 54(4)(a);
- confirm or vary the order (section 54(4)(b)(i)); or
- revoke the order and make such other order under section 54(4)(1)(c) or any other provision of the 1995 Act as the court considers appropriate

INSANITY AT THE TIME OF THE OFFENCE

General : sections 54 and 55

63. Section 54(6) allows the court to acquit a person on account of insanity at the time of the offence. If a court finds that a person was insane at the time of an offence it must then declare whether the person is acquitted on the ground of insanity, given that even though the person was insane the acquittal may also be on other grounds. Acquittal on account of insanity is available under both solemn and summary procedure.

Examination of facts

64. *Section 55 sets out the procedures for an EOF following a finding of insanity in bar of trial.* The court determines whether the person committed the offence(s) (subsection (1)) and makes a finding to this effect (subsection (2)). If the court finds that it is not established beyond reasonable doubt that the accused committed the offence(s), he/she will be acquitted (subsection (3)). If the court finds that the accused did commit the offence(s), the court will also consider whether on the balance of probabilities there are any grounds for acquittal, which includes insanity (subsection (4)). Subsection (5) allows for the EOF to proceed in the person's absence, and subsections (6) and (7) set out the rules of evidence and their duration.

65. *Section 56 sets out supplementary procedures* to be followed: if an accused is found insane in bar of trial after the trial has commenced (subsection (1)); in relation to witness citation (subsection (2)), legal representation (subsection (3)) and charge to be dealt with at the EOF (subsection (4)); if an EOF is deserted *pro loco et tempore* (subsection (5)); and if a person is subsequently charged with an offence which it has been established they committed at an EOF (subsection (7)).

66. The primary purpose of the EOF is to examine available evidence in order to determine beyond reasonable doubt, whether the person committed the offence(s) and whether, on the balance of probabilities, there are no grounds for acquitting him/her.

67. An EOF shall consider any evidence already given in a trial (i.e. where the finding of insanity in bar arises part way through a trial) and any evidence led by any party at the EOF itself (section 55(1)).

68. The secondary purpose of the EOF is to identify the appropriate disposal for the person. However, where the court on examining the relevant facts, is not satisfied beyond reasonable doubt that the accused person is responsible for the offence(s) libelled it must acquit him/her of the charge(s). In such circumstances the court may detain the person for a medical examination under section 60C (see chapter 6).

69. The diagram on page 74 shows the different findings that a court may make at an EOF.

70. The EOF can take place directly after the trial has been discharged. The citation of the person and witnesses to appear at the trial is also valid for them to appear at the EOF (section 56(1) and (2)).

Disposal of case where an accused found to be insane

71. Where a person has been acquitted on account of insanity or has been found insane in bar of trial and the court has found beyond reasonable doubt that he/she committed the offence then the following disposals are available under section 57(2):

(a) a compulsion order
(b) a restriction order in addition to the compulsion order under (a)
(bb) an interim compulsion order
(c) a guardianship order
(d) a supervision and treatment order
(e) no order

72. The diagram on page 75 illustrates the range of disposals in the case of insanity. All of these disposals, except (d) are almost identical to options available for mentally disordered offenders following conviction, and the same issues are pertinent in both circumstances. For information on assessing the most appropriate disposal under section 57 medical practitioners should refer to chapters 4 and 5 of this part of the Code of Practice regarding (a), (b), (bb) and (c) above.

73. Sections 57(3A),(4),(4A),(4B),(4C) and (6) relate these disposals to those available following conviction making appropriate changes in the wording and process of the latter, to take into account that following a finding of insanity the person has not been convicted of an offence and therefore could not be subject to criminal justice sanctions.

74. Therefore, for example, reference to the terms 'offence' and 'offender' are removed from the wording of the paragraphs dealing with these disposals; and an interim compulsion order ceases to have effect if the court makes an order under section 57(2)(a), (b), (c) or (d), or decides under 57(2)(e) to make no order. (i.e. the final disposal at the end of the interim compulsion order cannot be a penal disposal).

75. If a compulsion order with a restriction order is being considered as the final disposal, then it would be expected that, as with cases following conviction, an interim compulsion order would be made first, to allow for a period of assessment and treatment.

76. A compulsion order authorising detention in hospital or compulsory measures in the community would be made according to the same criteria as set out under section 57A for convicted persons.

77. A guardianship order would be made according to the same criteria as set out under section 58 for convicted persons.

78. Section 57(5) refers to Schedule 4 of the 1995 Act, which sets out procedures relating to the supervision and treatment order ("STO"). Information on the STO is set out in paragraphs 79 to 123 below, as there is no analogous order following conviction.

SUPERVISION AND TREATMENT ORDER

Overview

79. In general terms an STO may be used where the court is of the view that the person, whilst in need of treatment, will be able to live in the community with the supervision and support of health and social services.

80. The aim is to ensure that such persons receive medical treatment, either as out-patients or under a GP, and social work supervision and support. The local authority responsible for overseeing the STO will have the lead role and must be fully consulted before this recommendation is proposed.

81. The requires the person to be under the supervision of a social worker who is an officer of the local authority for the area where the supervised person resides or is to reside (Part I of Schedule 4, paragraph 1(1)(a)).

82. The duties undertaken depend on the person's circumstances and require the prior assessment and agreement of the local authority concerned. The local authority is required to confirm to the court that there is a supervising officer willing to undertake the supervision under Part II of Schedule 4, paragraph 2(2)(a). In effect the local authority must be satisfied that the proposed supervision in the community is both viable and available.

83. It would be expected that the proposed supervising officer would be an MHO wherever possible. The designated MHO for the case (where one has been appointed under section 229 of the 2003 Act) should always contribute to the formulation of this recommendation.

84. The supervised person must comply with the instructions of the supervising officer (Part I of Schedule 4, paragraph 1(1)(b)) and submit to treatment under the direction of the medical practitioner with a view to the improvement of his/her mental condition (Part I of Schedule 4, paragraph 1(1)(c)).

85. It would be expected that there would be close liaison between the medical practitioner and the supervising officer to ensure that the supervised person is complying with the requirements of the order and is benefiting from the care and treatment that has been recommended.

86. The order not only provides requirements in relation to treatment (Part II of Schedule 4, paragraph 4), it can also provide a requirement of residency in respect of the supervised person (Part II of Schedule 4, paragraph 5).

87. Where the medical practitioner is of the opinion that part of the treatment can be better or more conveniently given at an institution or place which is not specified in the order; and is one at which the treatment of the supervised person will be given by or under the direction of a medical practitioner, he/she may, with the consent of the supervised person, make arrangements for the person to be treated accordingly. (Part II of Schedule 4, paragraph 4(3).

88. Where any such arrangements are made, the medical practitioner who made the arrangements must notify the supervising officer in writing, specifying the institution or place at which the treatment is to be carried out; and the treatment at that place is deemed to be treatment to which the supervised person is required to submit in pursuance of the supervision and treatment order. (Part II of Schedule 4, paragraph 4(4)).

89. When an order is made, amended or revoked, the supervising officer must give a copy of the order to the supervised person, the person in charge of any institution in which the supervised person is or was required to reside and the MWC.

90. To make an STO the court must be satisfied on the evidence of two AMPs that the mental condition of a person does not warrant a compulsion order (with or without a restriction order) or a guardianship order, but requires or may be susceptible to treatment directed by a medical practitioner (Part II of Schedule 4, section 2(1)(b)).

91. The order allows treatment by a medical practitioner as an out-patient and may also specify where a person should reside.

SUPERVISION AND TREATMENT ORDER

General : schedule 4

92. It would be expected that any consideration of an STO as a possible disposal would require close liaison between the RMO and the intended supervising officer, prior to formulating, and recommending such a disposal. Procedures relating to an STO are set out in Schedule 4.

Criteria

93. In accordance with Part II of Schedule 4, paragraph 2, before making an STO the court must be satisfied:

- that, having regard to all the circumstances of the case, the making of such an order is the most suitable means of dealing with the person;
- on the written or oral evidence of two AMPs that:
  - the person has a mental condition which requires and may be susceptible to treatment
  - but this mental condition is not such as to warrant a compulsion order (with or without a restriction order) or a guardianship order;
- that the supervising officer intended to be specified in the order is willing to undertake the supervision;
- that arrangements have been made for the treatment intended to be specified in the order.

94. The court must also, in terms of section 203(1), instruct a Social Enquiry Report from a criminal justice social worker prior to considering a recommendation for an STO which would ensure that a full social work assessment has been carried out.

Treatment

95. Part II of Schedule 4, paragraph 4(2) sets out the alternative types of treatment which may be specified in the order:

- treatment as a non-resident patient at a specified institution or place;
- treatment by or under the direction of a specified medical practitioner.

96. Other aspects of the treatment need not be specified. Note that, unlike a probation order with a requirement for the treatment of mental condition (section 230), in-patient treatment may not be given under an STO.

Medical evidence

97. In all cases two AMPs must give evidence addressing the issues in paragraph 2(1)(b of Part I of Schedule 4. If the treatment is to be given by or under the direction of an approved medical practitioner then it would be expected that this medical practitioner would be one of the two on whose evidence the court decides to make the order. But where the treatment is to be by or under another medical practitioner then the agreement of this medical

practitioner should be sought and received by the two medical practitioners recommending the STO before the recommendations are made. A recommendation for an STO should never be made without the prior agreement of the person who will be responsible for the treatment.

98. Evidence for the court would usually be given by way of written reports, but under some circumstances oral evidence may be required (Part II of Schedule 4, paragraph 2(3)).

99. It would be expected that when assessing the person for the purpose of Part II of Schedule 4, section 2(1)(b), the approved medical practitioners should consider the following:

- the diagnosis of a *mental condition* – the definition of a mental condition would be expected to be broader than the definition of mental disorder under section 328 of the 2003 Act, and would include both conditions that are included and excluded under that section.
- is the mental condition a type (or types) of mental disorder which warrants a compulsion order (with or without a restriction order) or a guardianship order under section 57(2)?
- does the mental condition require or may be susceptible to treatment? It would be expected that the definition of "susceptible to treatment" would be broader than the 'treatability criterion' for a compulsion order as set down in section 57A(3). This treatment may be given by or under the direction of a medical practitioner and may be as day-patient or out-patient.
- will the treatment be given to the person as a day-patient or an out-patient by reference to the relevant section (Part II of Schedule 4, paragraph 4(2)(a) or paragraph 4(2)(b))? The exact nature of the treatment in terms of medication, psychological treatment or input from particular staff or services, may be included, but is not required, and such details are not to be specified in the order.

100. It would be expected that those preparing medical reports would not make a recommendation for a STO without consulting the potential supervising officer; there should be agreement from both the potential supervising officer and the person who may be made subject to the order to the making of the order before a recommendation is made for such an order.

101. The duration of the requirement of treatment should be specified in the evidence of the medical practitioners. This may be for a period of up to 3 years (Part II of Schedule 4, paragraph 1(1)(a)).

Effects of a supervision and treatment order

102. The supervised person will be under the supervision of a social worker who is an officer of the local authority for the area where the person resides or is to reside. The supervised person must comply with the instructions of the supervising officer and submit to treatment by or under the direction of a medical practitioner with a view to the improvement of his/her mental condition (Part I of Schedule 4, paragraph 1(1)(b) and (c)).

103. An STO may include a condition of residence (although not as a resident patient in a hospital) (Part II of Schedule 4, paragraph 5(1) and (2)).

104. The person should attend for treatment specified in terms of Part II of Schedule 4, paragraph 4(2). However, the order does not give the power to convey the person forcibly to a hospital or clinic and does not give the power to compel a person to take medication. Part 16 of the 2003 Act concerning medical treatment does not apply to persons made subject to an STO.

Non-compliance with the conditions of the order

105. As the person has not been convicted, this order is not a sentence and therefore the order cannot be 'breached' in the same way as a probation order can. If a person fails to comply with the treatment specified in the order by, for example, failing to attend appointments, then it would be expected that this would be reported in writing by the medical practitioner to the supervising officer. The medical practitioner, supervising officer and any other relevant staff, along with the person subject to the STO and, where appropriate relatives/carers, should then decide on the course of action.

106. If the person's mental condition deteriorates so that he/she requires treatment in hospital then this may be given informally with the person's consent or by using compulsory measures under the 2003 Act (emergency detention under section 36, short-term detention under section 44 or a compulsory treatment order under section 63) if there has been sufficient change in the mental condition of the person so that such a measure is warranted.

107. In-patient treatment as a resident patient in hospital with or without the person's consent cannot be given under an STO. Alternatively, a compulsory treatment order authorising compulsory powers in the community may be applied for if the circumstances warrant this. If a person is admitted to hospital or placed on a compulsory treatment order in the community it would be expected that the STO would be revoked.

Variation of the conditions specified in the order

108. Under Part II of Schedule 4, paragraph 4(3), if the medical practitioner by or under whom the treatment will be given is of the opinion that the person requires treatment at a different place or institution, or under the supervision of a different medical practitioner, then he/she may, with the consent of the supervised person, make such alternative arrangements for the treatment of the person.

109. It would be expected that the medical practitioner would consult with the supervising officer who would contribute to this decision. When the decision has been made the medical practitioner must confirm this in writing to the supervising officer (Part II of Schedule 4, paragraph 4(4)(a)).

110. Such alternative arrangements may only be made if the person consents (Part II of Schedule 4, paragraph 4(3). It would be expected that the medical practitioner would also seek the agreement of the supervising officer, and this would be done prior to varying any of the conditions.

111. When such alternative arrangements are made the alternative treatment is deemed to be treatment to which the person should submit in pursuance of the order (Part II of Schedule 4, paragraph 4(4)(b)).

Residence

112. In accordance with paragraph 5 of Part II of Schedule 4, an STO may require that a person reside at a specific place, but not a hospital. It would be expected that the two medical practitioners recommending the STO, the designated MHO (where there is one) and the potential supervising officer, would assess collaboratively whether this is required in the particular case so that the court is able to consider the home surroundings of the supervised person in terms of Part II of Schedule 4, paragraph 5(3).

Changes to requirements

113. Under the following circumstances, or a combination of the following circumstances, it may be necessary to consider changing the requirements in a STO:

- the person moves to a new local authority area
- it appears that the person no longer requires to be subject to a STO
- the person requires different treatment
- the person requires to be treated by a different medical practitioner
- the person requires treatment beyond the period specified in the STO.

114. For example:

- if the person moves they may need to be supervised by a new local authority and to have their treatment under a new psychiatrist
- the treatment and support may lead to an improvement that means that the order is no longer necessary
- the initial order may have only been for one year but it may appear that further supervision and treatment is necessary
- it may become clear that treatment is not required.

115. Part III of Schedule 4, paragraphs 6 to 9 set out the procedures relating to the revocation and amendment of STOs under such circumstances.

Revocation of STO in interests of health or welfare (paragraph 6)

116. If it appears to the medical practitioner that the order should be revoked, he/she must report this in writing to the supervising officer. Both the supervised person and the supervising officer may apply to the sheriff court for the revocation of the order.

117. The court may revoke the order where it considers that the circumstances are such that it would be in the interests of the health or welfare of the person to do this. It would be expected that if the medical practitioner or the supervising officer changes, he/she should inform the other of the change.

Change of residence (paragraph 7)

118. If the person is proposing to move to a different local authority area, the supervising officer should apply to the court for the STO to be amended. There should be an agreement from another social worker that he/she will take over as the new supervising officer and that the treatment requirements continue to be feasible (Part III of Schedule 4, paragraph 7(1)).

119. If aspects of the treatment requirements are no longer feasible then the court may revoke these or substitute these with ones that will be feasible in the new area (for example if the person would not be able to attend the same psychiatrist as previously then this may be changed to a psychiatrist in the new area)(Part III of Schedule 4, paragraph 7(3)).

Change in treatment requirements (paragraph 9)

120. If it appears that amendments should be made to the treatment requirement of any supervised person, then it would be expected that the medical practitioner would consult with the supervising officer who would contribute to this decision.

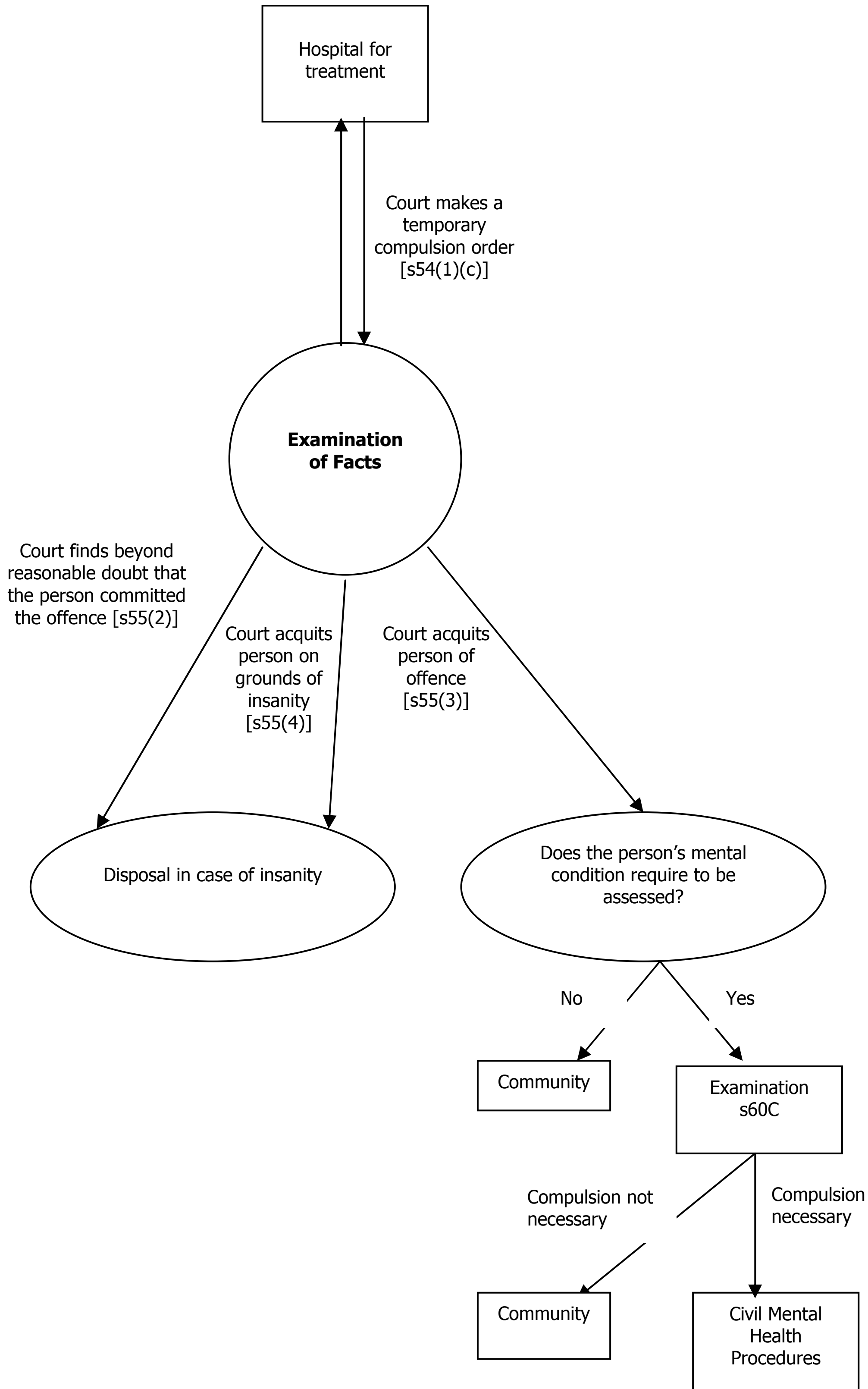
121. When the decision has been made the medical practitioner must confirm this in writing to the supervising officer, who will apply to the sheriff court for the variation or cancellation of the requirement (Part III of Schedule 4, paragraph 9(1)). This applies whether the supervised person is moving area or not (see paragraph 118).

122. It may be the opinion of the medical practitioner that any of the following is the case: the treatment should continue beyond the previously specified time-limit specified in the STO (paragraph 9(2)(a)); the person needs different treatment (paragraph 9(2)(b)) which may perhaps be under a different doctor; the person is not susceptible to treatment (paragraph 9(2)(c)); or the person does not require treatment (paragraph 9(2)(d)).

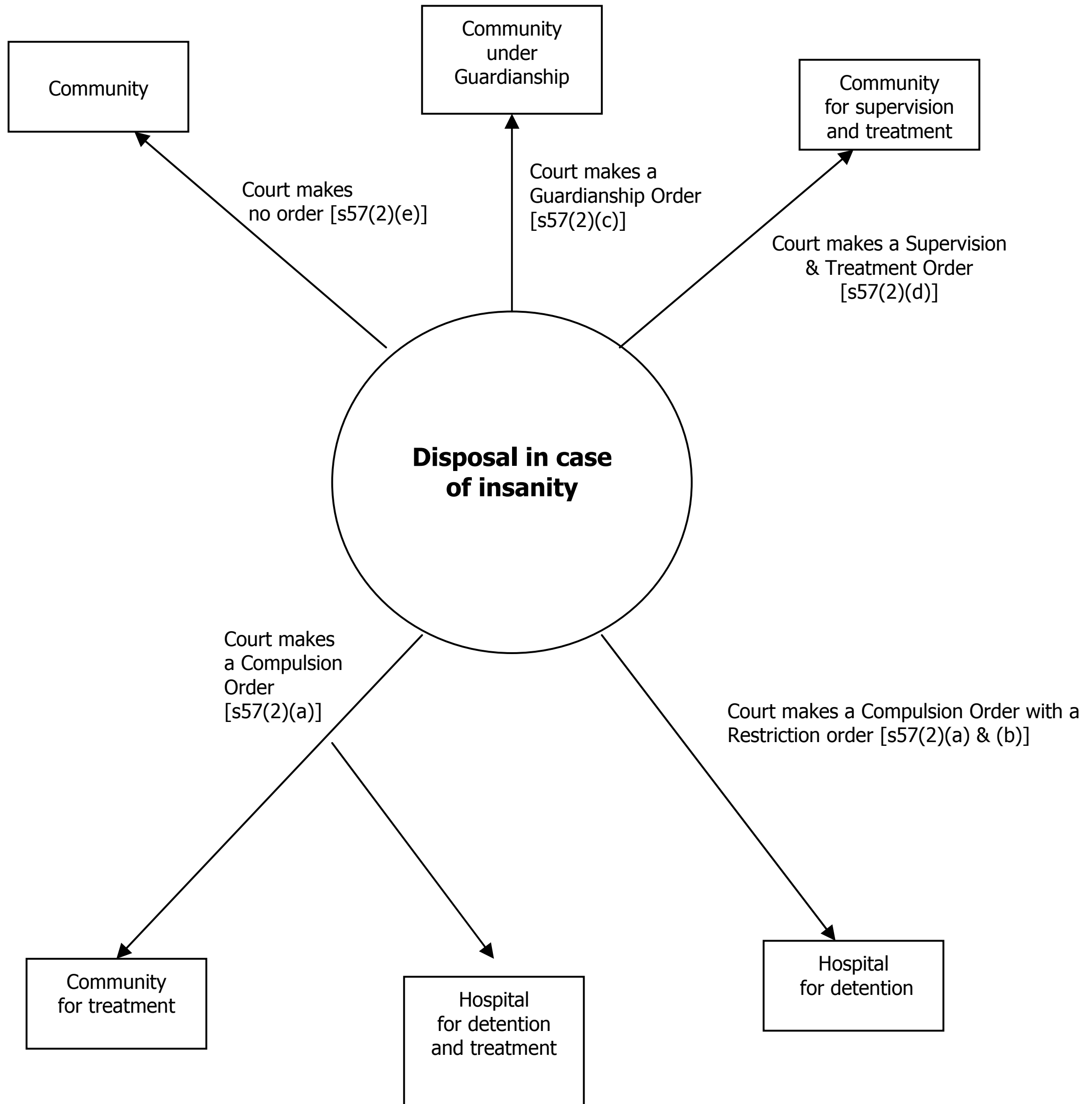
Duty of supervising officer to give copy of order to supervised person and MWC (paragraphs 10 and 11)

123. Where a STO is made, amended or revoked, the supervising officer will receive a copy of the relevant order from the sheriff clerk and must give a copy of the order to the supervised person and to the person in charge of any institution in which the person is or was required to reside. The supervising officer must also send a copy of the order to the MWC.

EXAMINATION OF FACTS



INSANITY DISPOSAL



CHAPTER 4: POST CONVICTION, PRE-DISPOSAL

Introduction

This chapter begins with an overview of the orders that are available post-conviction which allow for the assessment and/or treatment of a mentally disordered offender before a final disposal is made.

It then describes the procedures surrounding the imposition of an interim compulsion order under section 53 and the effect of this order.

The chapter goes on to provide detailed information about assessment orders and treatment orders made post-conviction, and remand for enquiry into mental condition under section 200.

OVERVIEW

1. Orders are available post-conviction to allow for the assessment and/or treatment of a mentally disordered offender before a final disposal is made. These orders are:

- interim compulsion order (section 53)
- assessment order (section 52D)
- treatment order (section 52M)
- committal to hospital (section 200)

2. The diagram on page 79 illustrates the range of orders.

3. It would be expected that further assessment at the post-conviction stage may help to clarify:

- diagnosis
- the relationship between the mental disorder and the offence (although legal responsibility will no longer be an issue as the person has been convicted)
- the response of the mental disorder to treatment
- the risk that the person poses
- the contribution made to this risk by mental disorder
- ongoing mental health and care needs and how these might best be met

4. Clarification of these issues will inform the ultimate disposal of the case (see chapter 5 of this part of the Code of Practice).

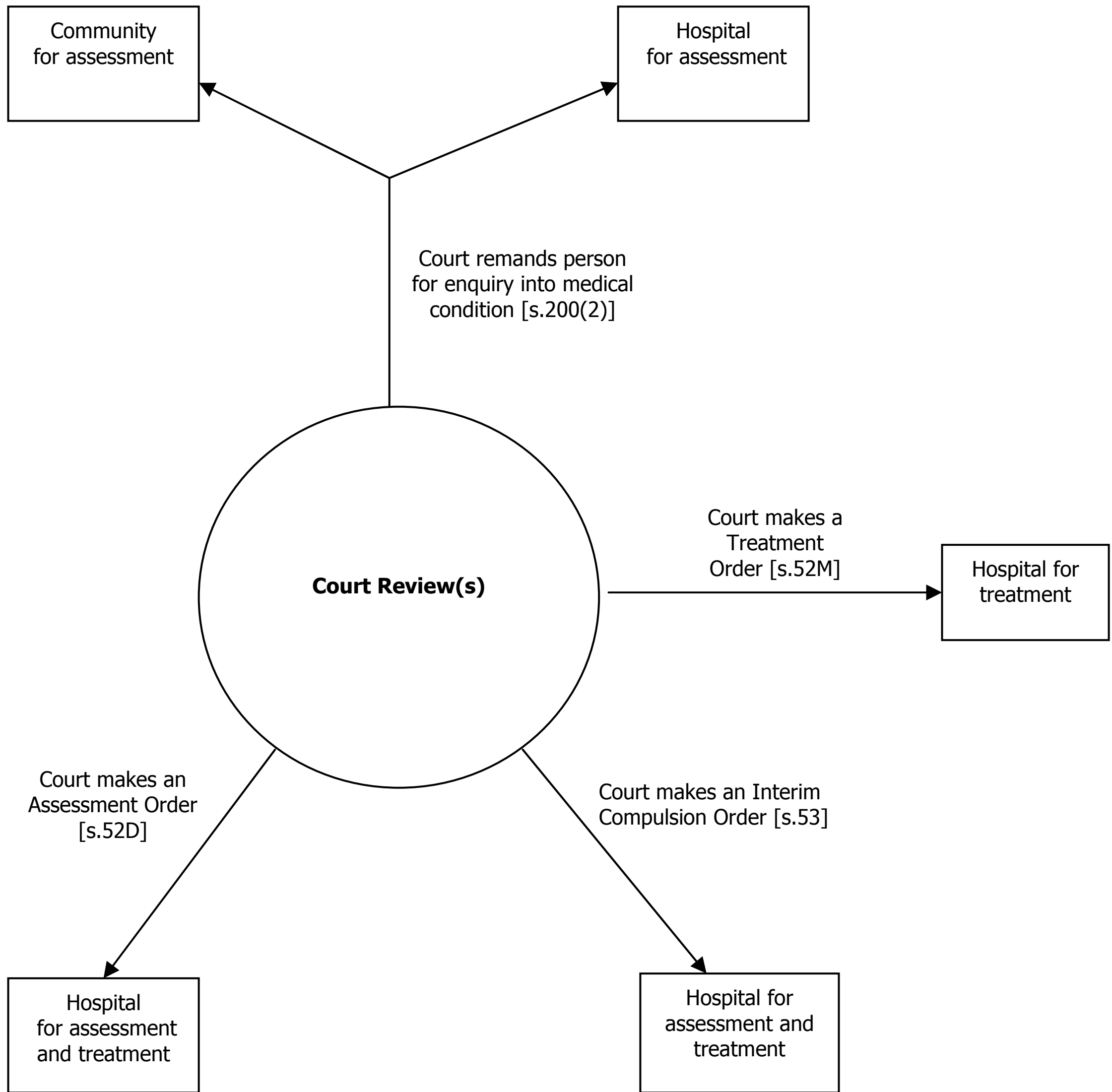
5. In cases where offences are minor and offenders are clearly mentally disordered a prolonged period of in-patient assessment may be neither necessary nor appropriate. In some cases there may have already been a period of in-patient assessment at the pre-trial stage under an assessment order (section 52D), and further assessment may not be necessary. In other cases the issues listed above may need further clarification or there may not have been a period of in-patient assessment already.

6. In all serious cases (certainly all cases under solemn procedure) it would be expected that there would be a period of in-patient assessment (before and/or after trial) to clarify the issues in paragraph 3 before a final disposal is made.

7. In all of the most serious cases, where a restriction order added to a compulsion order (section 59 and section 57A respectively) or hospital direction (section 59A) is being considered, it would be expected that there would be a period of assessment and treatment on an interim compulsion order (section 53), unless there are good reasons for this not being the case. The interim compulsion order cannot be used unless either of these disposals is being considered.

8. Assessment orders (section 52D) and treatment orders (section 52M) are available at this stage as well as at the pre-trial stage, in contrast to previously when orders under section 52 only applied pre-trial. Where an assessment order or a treatment order has been made pre-trial, these orders may also be made post-trial.

POST CONVICTION ASSESSMENT and/or TREATMENT



INTERIM COMPULSION ORDER

Background

9. The interim compulsion order replaces the interim hospital order under section 53 of the 1995 Act. The main changes to the legislation are:

- the order may be renewed for up to 12 weeks at a time rather than 4 weeks (section 53B(4))
- it is no longer specified that the order is to be made in cases where a final disposal to a state hospital is being considered
- previously, except under special circumstances, a state hospital had to be the hospital specified for detention under an interim hospital order; this is no longer the case
- rather than the order being linked to a state hospital disposal, it is now specified as being only for cases where the final disposals being considered are a compulsion order with a restriction order or a hospital direction (section 53(3)(a)(ii) and (6))
- it would be expected that a compulsion order with a restriction order or a hospital direction would not be made unless the person has been on an interim compulsion order first, except in exceptional cases.
- in line with other orders the criteria for making the order have been brought in line with the criteria for compulsory powers under the 2003 Act.

Purpose

10. The purpose of the interim compulsion order in general terms is to allow a prolonged period of in-patient assessment and assessment before a final disposal is made for mentally disordered offenders who have been convicted of serious offences and/or appear to pose a considerable risk to themselves or others. It would be expected that this would enable the court to make the most appropriate final disposal.

Overview

11. An interim compulsion order may only be made where a compulsion order with a restriction order or a hospital direction is being considered as a final disposal (section 53(3)(a)(ii) and (6)).

12. Two medical recommendations are required and the criteria for making the order (section 53(2)) are similar to, but less stringent than, those for a compulsion order.

13. Unlike a compulsion order, an interim compulsion order only allows compulsion and treatment in hospital, not in the community. The order allows detention in hospital for assessment and treatment for up to 12 weeks (section 53(8)(b)), which can be renewed every 12 weeks up to a total of 12 months (section 53(8)(c) and 53B(5)). At the end of an interim compulsion order the court may make any disposal it sees fit (mental health or penal).

14. Compulsory medical treatment in terms of Part 16 of the 2003 Act may be given under this order (section 53(8)(c)). A flowchart setting out court procedures relating to interim compulsion orders is on page 90.

GENERAL: SECTIONS 53 AND 53A TO D

Criteria for making an interim compulsion order

15. For an interim compulsion order to be made:

- a person must have been convicted of an offence punishable by imprisonment, (section 53(1)), (excluding an offence where the sentence is fixed by law, i.e. murder)

- the court must be satisfied in terms of section 53(2) that it is appropriate to make an interim compulsion order, having regard to all the circumstances (including the nature of the offence) and any alternative disposal available (sections 53(2)(b) and 53(4))

- there must be written or oral evidence from two medical practitioners (section 53(2)(a)), one of whom is approved under section 22 of the 2003 Act (section 61), satisfying the court that:

    - the offender has a mental disorder (section 53(2)(a)(i))

    - there are reasonable grounds for believing that it is likely that:
        - medical treatment which would be likely to prevent the mental disorder deteriorating, or which would be likely to alleviate any of the symptoms or effects of the disorder (“the treatability criteria”) is available for the offender
        - if the offender were not provided with such treatment there would be a significant risk to the offender’s health, safety or welfare; or to the safety of any other person (“the risk criteria”)
        - the making of an interim compulsion order is necessary (sections 53(2)(a)(ii), 53(3)(a)(i) and 53(5))

    - there are reasonable grounds for believing that the person’s mental disorder is such that it would be appropriate to make one of the following final disposals in relation to the offender:
        - a compulsion order with a restriction order
        - a hospital direction

        (sections 53(2)(a)(ii), 53(3)(a)(ii) and 53(6))

    - to assess these issues a suitable, specified hospital placement is available within 7 days (sections 53(2)(a)(ii), 53(3)(b) and 53(3)(c)). A state hospital may be specified if the offender requires conditions of special security that can only be provided by a state hospital (section 53(7)).

Medical recommendations

16. In terms of section 52(2) and 52(3) the medical recommendations must address the issues set out above in paragraph 15:

- does the offender suffer from mental disorder?

- are there reasonable grounds for believing it is likely that:
  - the treatability criteria are met? (see paragraph 15)
  - the risk criteria are met? (see paragraph 15)

  Note: the criteria for the above two issues are as for compulsion under civil procedures, but rather than being certain about them being met the medical practitioners must be of the opinion that there are reasonable grounds for believing it is likely that these criteria are satisfied.

- is the final mental health disposal, if one is made, likely to be a compulsion order with a restriction order or a hospital direction? This would be expected to be the case if the offender poses a significant risk to his/her own health, safety or welfare or to the safety of any other person (the 'risk criteria' for a hospital direction) or as a result of his/her mental disorder he/she poses a serious harm to the public if set at large (the 'risk criteria' for a restriction order); consideration would need to be given to the nature of the index offence, the nature of previous offences, the background of the offender, and the nature of the mental disorder. The medical practitioner would be expected to contact the MHO (designated under section 229 of the 2003 Act) to assist in the assessment and decision making process. A Social Circumstances Report, (SCR), may have previously been prepared (under section 231 of the 2003 Act) and would be expected to be used by the RMO to inform the assessment.

- is a suitable hospital placement available within 7 days of the order being made? It would be expected that the medical practitioner would make arrangements with a specific hospital unit taking into consideration the nature of the person's mental condition and the risk they may pose. One of the recommendations for an interim compulsion order must be made by a medical practitioner working at the specified hospital (section 61(1A)).

- is there a reasonable alternative to enable the assessment to be undertaken rather than by making an interim compulsion order?

Appearance of the person at court when an interim compulsion order is made

17. It would be expected that the person would attend the initial court hearing at which the court decides whether to make an interim compulsion order. However, if a person's mental condition is such that it may be detrimental to his/her health to appear in court, or he/she may pose a significant risk in court, then the medical practitioner should inform the court, giving reasons for this opinion. The court may then, if it is satisfied that it is inappropriate or impractical for the person to be brought before it, make an interim compulsion order in the absence of the person (section 53(10)). Under such circumstances the person's legal representative must be present and have an opportunity to be heard.

18. When an interim compulsion order is extended under section 53B(5) it would be expected that the person would attend court, unless the court is satisfied in terms of section 53B(6) that it is impracticable or inappropriate for the person to be brought before it. In these circumstances the person must be represented by counsel or a solicitor who must be given the opportunity of being heard.

Notification by the court of the order being made

19. As soon as is reasonably practicable after an interim compulsion order has been made, the court must in terms of section 53(11) inform the following parties of the making of the order:

- the person subject to the order
- any solicitor acting for that person
- the Scottish Ministers
- the Mental Welfare Commission

Duty of a local authority to appoint an MHO

20. A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is practicable after an interim compulsion order has been made in accordance with section 229 of the 2003 Act. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless the MHO records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the MWC within 21 days of the order being made. (For further information about SCRs please see section 231 of the 2003 Act or chapter 11 of the Code of Practice: Volume 1).

21. It would be expected that the medical records office of the hospital to which the person is admitted would ensure that the local authority is notified and sent a copy of the order. The notification would be sent to the Chief Social Work Officer for the relevant local authority. Hospital managers would be required to ensure that this is done speedily and, if possible, within 2 working days. Best practice would suggest that the relevant local authority should designate an MHO responsible for the patient's case within 2 working days of receiving notification. It would be expected that procedures would be developed to ensure that there is no undue delay in this process.

Effect of an interim compulsion order

22. An interim compulsion order allows the person:

- to be detained in hospital for up to 12 weeks initially (section 53(8)(b)).
- to be conveyed to the specified hospital within 7 days by a constable, a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the managers of that hospital to remove persons for the purpose of section 53; or a specified person (section 53(8)(a)).
- to be removed to and held in a place of safety pending admission to the specified hospital (section 53(9)).
- to be given medical treatment in accordance with Part 16 of the 2003 Act (section 53(8)(c)).

What should happen during an interim compulsion order?

23. An RMO and an MHO should be allocated as responsible for the person's case by the hospital managers and the local authority respectively, if this has not already been done

(section 230 and section 229 of the 2003 Act). The patient should receive appropriate treatment for the mental disorder in terms of Part 16 of the 2003 Act. It would be expected that a multi-disciplinary assessment would be undertaken to address the issues set out in paragraph 25 below and inform the RMO's report to the court under section 53B(1).

24. It would be expected that the designated MHO would work in close collaboration with the RMO and other members of the multi-disciplinary team, and inform and assist in this assessment. The MHO must prepare an SCR in accordance with section 231 (unless he/she considers that to do so would serve little or no purpose) and send a copy to the RMO and MWC. However, even where the MHO considers that a SCR would serve little or no purpose, the MHO will still require to comply with the duties in section 231(2)(b).

Assessment during an interim compulsion order

25. Assessment of the person should be undertaken so that a written report can be prepared for the court by the responsible medical officer before the expiry of the order (section 53B(1)). Issues to be addressed in the assessment will vary from case to case but would usually be expected to include some or all of the following:

- what is the nature of the persons's mental disorder?
- what is the prognosis of the mental disorder and what will be the response to treatment?
- what is the relationship between the mental disorder and the offence?
- what risk does the person pose and what is the contribution to this risk of mental disorder?
- what are the person's social circumstances and personal history, relevant to understanding their mental health and social care needs and the assessment of risk?

The written report under section 53B(1)

26. This report must be submitted to the court before the expiry of the interim compulsion order (i.e. within 12 weeks). If no mental health disposal or extension of the interim compulsion order is recommended, then one report would be expected to be provided by the RMO.

27. If a compulsion order and a restriction order, or a hospital direction is being recommended, two reports would be expected, as is the requirement under sections 57A(2)(a) or 59A(2)(a) respectively.

28. Section 53B(2) requires that the report must address:

- whether the treatability and risk criteria are met (see paragraph 15)
- the type(s) of mental disorder present
- whether an extension of the interim compulsion order is necessary

29. However, it would be expected that the report would also address the issues outlined in 'Assessment during an interim compulsion order' in paragraph 25 above, particularly if it is not recommending an extension to the interim compulsion order and is therefore the final report whilst the person is detained under an interim compulsion order.

30. In addition, the recommendations in the report would be expected to address the specific issues relevant to appropriate disposal at the end of the interim compulsion order (see paragraph 32 below).

31. The RMO must send a copy of his/her report under section 53B(1) to the person and to the person's solicitor (section 53B(3)). It would be expected that a copy would also be sent to the designated MHO.

Options for disposal at the end of an interim compulsion order

32. These are:

- an extension to the interim compulsion order (by 12 weeks at a time up to a maximum of 12 months) (sections 53B(4) and (5)). An extension would be expected to be recommended if there has been insufficient time to address the relevant issues.
- a compulsion order with a restriction order (sections 57A and 59)
- a hospital direction (section 59A)
- another mental health disposal (although the interim compulsion order is for cases where a compulsion order with a restriction order or a hospital direction is seen as the most appropriate ultimate disposal, in some cases it may become apparent that although a mental health disposal is appropriate, the risk posed is such that neither of these measures is warranted)
- a non-mental health disposal, which may be a prison sentence.

33. Refer to chapter 5 of this part of the Code of Practice for information regarding the various mental health disposals available at sentencing.

Change to the hospital specified in the order

34. After the court has made an interim compulsion order it may become apparent that either the hospital specified is unsuitable or that the person no longer requires to be on an interim compulsion order. Usually this would be expected to be addressed when the order is due for renewal but under certain circumstances this may not be feasible.

35. Under section 53A, if within 7 days of the interim compulsion order being made it is apparent that the hospital specified in the interim compulsion order is unable to admit or inappropriate for the person, then this should be notified to the court or the Scottish Ministers, and they may direct that the person be admitted to an alternative hospital.

36. It would usually be the medical practitioner who recommended the interim compulsion order, or the prospective RMO, who would inform the court or the Scottish Ministers that another hospital needs to be specified but it may be another doctor or someone else (e,g, hospital manager) depending on the circumstances.

37. This alternative should only be made because of emergency or other special circumstances. For example:

- a deterioration in the mental condition of the person such that the specified hospital would no longer be an appropriate placement
- a bed being unavailable in the specified hospital due to emergency circumstances

38. When such circumstances are alerted to the court or the Scottish Ministers, it would be expected that a medical practitioner should make a recommendation as to the alternative hospital after making arrangements with this hospital for the person to be admitted there.

Suspension of detention

39. Suspension of detention was called "leave of absence" under the 1984 Act. Part 13 of the 2003 Act sets out the statutory procedures for the suspension of the measure in an interim compulsion order specifying detention of the patient. These procedures are the same for a treatment order (section 52M), a compulsion order with a restriction order (sections 57A and 59), a hospital direction (section 59A) and a transfer for treatment direction (section 136 of the 2003 Act). For further information on these procedures refer to Part 2, Chapter 5 of this Code of Practice.

Revocation of an interim compulsion order

40. At any point during the interim compulsion order the RMO may submit a report (under section 53B(1)) to the court seeking to have the order revoked. In considering a recommendation to revoke an interim compulsion order, it would be expected that the RMO would consult with the designated MHO, and take into consideration the SCR provided under section 231 of the 2003 Act.

41. Circumstances in which such a report may be submitted include:

- it has become clear during the interim compulsion order that the person no longer suffers from mental disorder
- it is apparent that the risk the person poses is such that he/she requires a higher or lower level of security than that provided at the hospital where the person is currently detained.

Section 53B(1) sets out the matters that must be addressed in the RMO's report to the court.

Renewal of interim compulsion order

42. An interim compulsion order may be renewed by the court for up to 12 weeks at a time up to a maximum of 12 months in total (sections 53B(4) and 53B(5)). A report recommending an extension of an interim compulsion order must be submitted by the RMO under section 53B(1) and should address the issues relevant to making an interim compulsion order as set out in that section. These are:

- whether the conditions mentioned in section 53(5) of the Act are met in respect of the offender;
- the type (or types) of mental disorder that the offender has; and
- whether it is necessary to extend the interim compulsion order to allow further time for the assessment mentioned in section 53(3)(b) of the Act.
- any matters specified by the court under section 53(2)

43. It would be expected that the RMO would consult with the designated MHO to inform the assessment and decision making process.

End of interim compulsion order (section 53C)

44. An interim compulsion order ends when the court makes:

- a compulsion order (with or without a restriction order)
- a hospital direction
- any other final mental health disposal
- any penal disposal (including imprisonment)

ASSESSMENT ORDERS AND TREATMENT ORDERS POST-CONVICTION

45. Assessment orders (section 52D) and treatment orders (section 52M) are described in detail in chapter 2 of this volume for the pre-trial stage. These orders may also be applied post-conviction in the same way, with exceptions as stated below:

- as the prosecutor is no longer involved, the prosecutor cannot apply for an assessment order or a treatment order post-conviction. Sections 52B and 52K do not therefore apply at this stage. The applications must be made by the Scottish Ministers (if the person has been remanded in custody) under sections 52C or 52L, or at the initiative of the court under sections 52E or 52N.

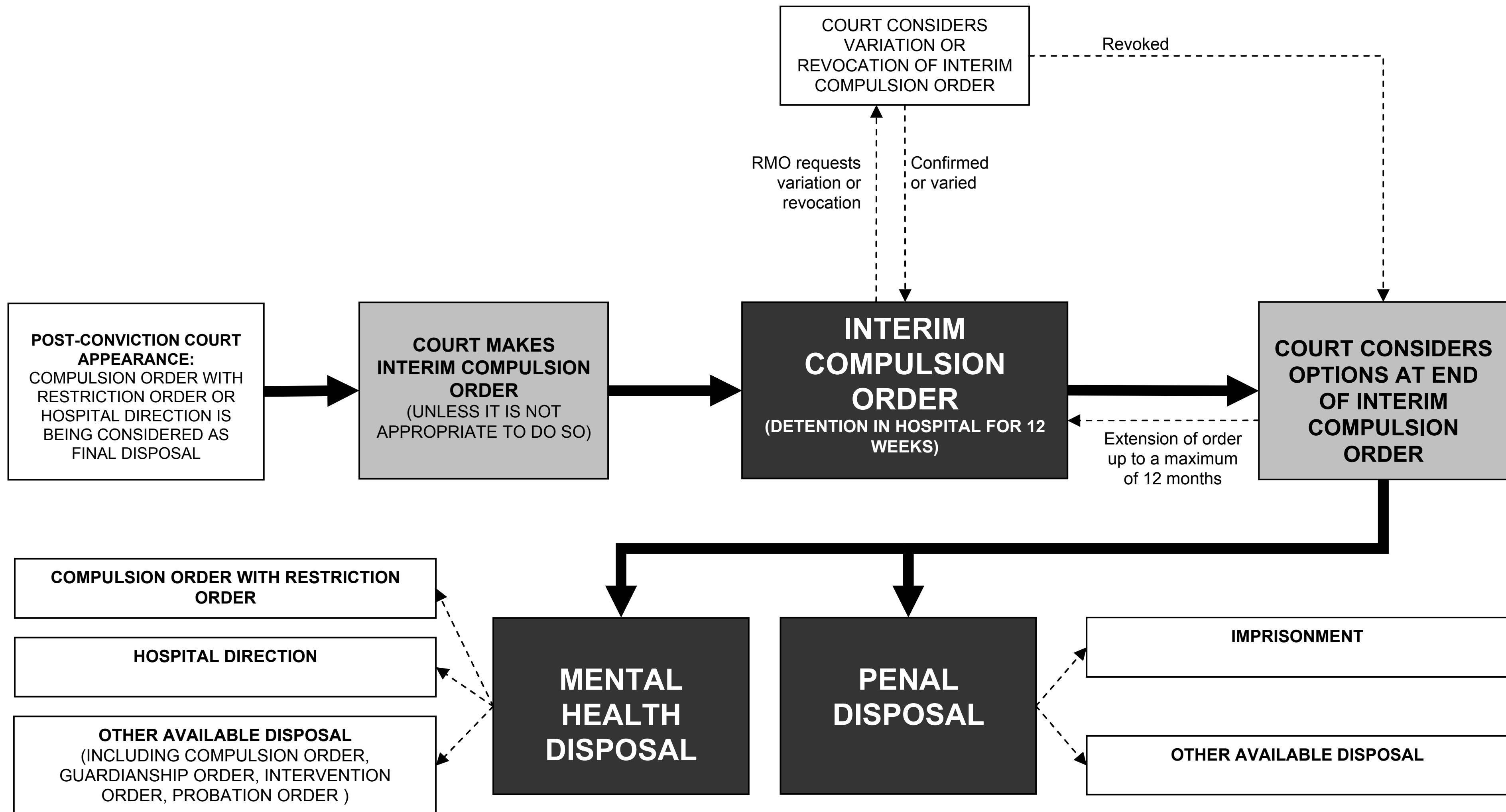
- an assessment order may last up to 28 days and may be extended further by 7 days on one occasion (sections 52G(1) and 52G(4)); a treatment order has no specified duration, as at the pre-trial stage. Either type of order ends when one of the following disposals is made:

    - deferral of sentence by the court under section 202(1)
    - the imposition of any sentence (whether in prison or the community)
    - the making of one of the following mental health disposals:
        - interim compulsion order (section 53)
        - compulsion order (section 57A)
        - guardianship order (section 58(1A))
        - hospital direction (section 59A)
        - probation order with requirement of treatment (section 230)

46. An assessment order or a treatment order may still be made post-conviction in cases where either or both of these orders has already been applied pre-conviction.

47. The flowchart on page 91 summarises the operation of the assessment order and the treatment order at the post-conviction stage.

INTERIM COMPULSION ORDER



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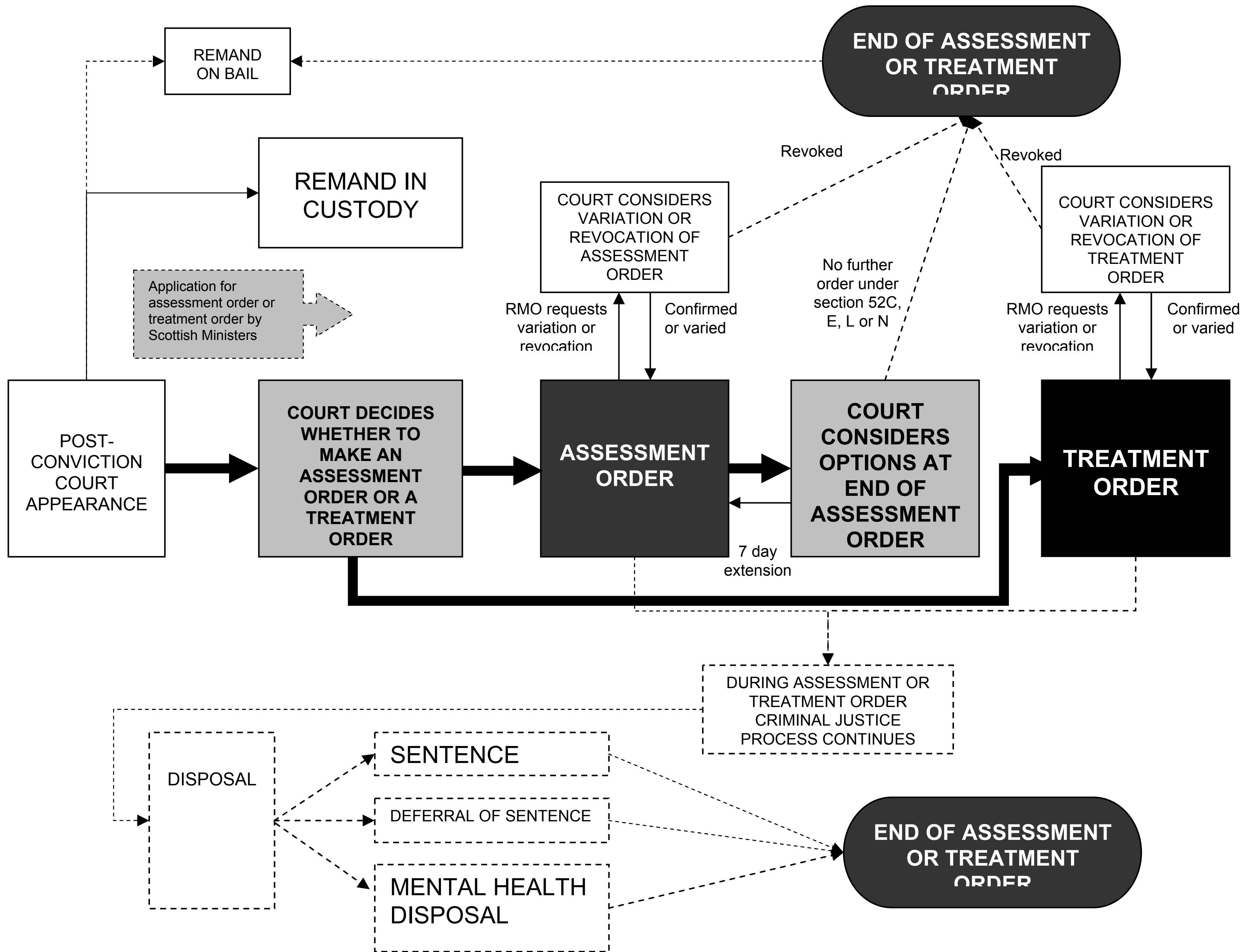
POST-CONVICTION ASSESSMENT AND TREATMENT ORDERS



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REMAND FOR ENQUIRY INTO MENTAL CONDITION

Background

48. Section 200, which allows for a person to be remanded for inquiry into his/her mental or physical condition post-conviction, is changed very little by the 2003 Act. Previously section 200 was applied post-conviction to allow hospital assessment in the same way as orders under section 52 were applied pre-trial. However, now that assessment orders (section 52D) and treatment orders (section 52M) may be applied for post-conviction, there is an overlap between the functions of section 200 and sections 52D and 52M.

Purpose

49. In general terms, for offenders who appear to be suffering from a mental disorder, section 200 allows a period of assessment in hospital (or on bail or in custody) prior to disposal, and is particularly useful in cases where mental disorder has not so far been raised, or sufficiently addressed, as an issue in court.

Overview

50. Section 200 allows remand on bail or in custody for further inquiry into a person's physical or mental condition (section 200(2)). If the purpose of the inquiry is to address an offender's mental condition then the remand may be on bail, in custody or in hospital for up to 3 weeks which may be renewed for a further 3 weeks. The criteria to be applied for detention in hospital are less stringent than those to be applied for an assessment order, a treatment order or an interim compulsion order.

GENERAL: SECTION 200

Criteria for application of section 200

51. For a person to be remanded for inquiry into their mental condition under section 200:

- he/she must have been convicted of an offence punishable with imprisonment (section 200(1)(a)); and
- it must appear to the court that inquiry should be made into their mental condition (section 200(1)(b)) before the method of dealing with him is determined.

52. Then he/she may be remanded on bail or in custody.

53. To be committed to hospital, in addition:

- the person must appear to be suffering from mental disorder according to evidence from a medical practitioner (section 200(2)(b)(i))
- there must be a suitable hospital placement available for that person's detention (section 200(2)(b)(ii))

54. The medical practitioner need not be an AMP. Mental disorder has the meaning given in section 328(1) of the 2003 Act. The person need only *appear* to be suffering from mental disorder. It would be expected that the information gained from the background history, presentation at interview, details of the offence or presentation in court there would be reasonable grounds for the medical practitioner to conclude that the person may be mentally disordered.

55. Although a section 200 order does not qualify as a 'relevant event' in terms of section 232 of the 2003 Act (see chapter 6 of this part of the Code of Practice), best practice would suggest that in those cases where one is made and an MHO has not previously been allocated as responsible for the person's case, this action should be considered by the local authority.

56. The medical practitioner would be expected to consult with the MHO to inform his/her assessment and the decision making process. Best practice would also suggest that the MHO would be expected to prepare an SCR (unless he/she considers it would serve little or no practical purpose to do so) which would be used by the medical practitioner to inform his/her assessment.

57. The medical practitioner must identify an appropriate hospital placement in terms of section 200(2)(b)(ii). In identifying such a placement, it is expected that the medical practitioner would take into consideration matters such as the nature of the person's mental disorder, the nature of the index offence and the risk the person poses to him/herself or others. A hospital placement must not be recommended unless there has been agreement from a doctor (usually a consultant) working at that hospital that a bed is available for the person.

Measures authorised by the making of an order under section 200

58. The court will specify the duration of the order which will not exceed three weeks (section 200(2)). In all cases of remand or committal, the court must prepare a written statement of the reasons why it considers inquiry should be made into the person's physical or mental condition (section 200(7)). It would be expected that the statement would also include any information that the court has about the person's condition.

Remand on bail (section 200(2))

59. A remand on bail under section 200 requires the person to undergo a medical examination by one (in the case of inquiry into a person's physical condition) or two (in the case of inquiry into a person's mental condition) duly qualified registered medical practitioners, that the person should attend for this (or these) and that he/she should comply with any instructions given to him/her regarding attending and undergoing examination(s) (section 200(6)).

60. It would be expected that there would be a clear procedure for how sheriff clerks or clerks of any court can request medical practitioners to carry out the medical reports in order to prepare the psychiatric reports required in terms of section 200(2)(b)(i).

61. Similarly within psychiatric services it would be expected that there would need to be clarity regarding who would provide psychiatric reports. On receipt of a request for one or two psychiatric reports from the court, psychiatric services in the relevant area would be expected to identify the medical practitioners responsible for preparing the report(s) and these practitioners would arrange for the person to be contacted (usually by post) so that the necessary examination(s) can be completed.

62. If two reports are requested, it would be expected that the two medical practitioners would examine the person separately. Reports should be provided for the court by the date of the person's next court appearance. If this is not feasible in a particular case then the medical practitioner should contact the court as soon as this becomes apparent.

63. For the avoidance of doubt, a person may only receive treatment for his/her mental disorder on a voluntary basis whilst on bail under section 200.

Remand in custody (section 200(2))

64. This provision allows a court to remand a person in custody so that a psychiatric examination may be undertaken (section 200(2)(b)). It is expected to be used in cases where the court does not have the required medical evidence for a committal to hospital or where there is conflicting evidence and further assessment is required.

65. A medical practitioner should not recommend that a person is remanded in prison. However if he/she is not recommending a committal to hospital because further assessment is required before making this decision, then he/she may suggest that a further examination is required, and it will be for the court to determine whether this is on bail or in custody.

66. When a person is remanded in custody under section 200 one or two psychiatric reports will usually be requested in the same way as set out in paragraphs 59 to 62 above for remands on bail in terms of sections 200(2)(b)(i) or 200(6)(a).

Committal to hospital (section 200(2))
67. Section 200 authorises detention in hospital for assessment and also the conveyance of the person to that hospital. The person may not be discharged or granted leave from the hospital without the permission of the court. Compulsory treatment is not permissible under section 200.

68. When a person is detained in hospital under section 200 one or two psychiatric reports will usually be requested in the same way as set out in paragraphs 59 to 62 above for remands on bail. It would be expected that one of these reports would usually be provided by the RMO.

Renewal of order

69. If the court considers that the criteria for detention in hospital still apply and the person could be admitted to a hospital that is suitable for his/her continued detention, the order may be renewed for up to 3 weeks on one occasion (section 200(3)(a)).

Revocation or variation of committal to hospital

70. Whilst a person is detained in hospital under section 200 it may become clear that they do not require assessment in hospital, or that the assessment should continue but at a different hospital. Examples of circumstances where this might occur are:

- the person does not appear to be mentally disordered
- the degree of risk posed by the person is greater than can be managed in the hospital where he/she is currently placed

71. In such circumstances the RMO should apply to the court for the order to be revoked (section 200(5)) or for an alternative hospital to be specified in the order (section 200(10)). Before an alternative hospital is recommended it would be expected that the RMO would have the agreement from a doctor (usually a consultant) working at that hospital that a bed is available for the offender.

Relationship between orders under section 200 and assessment orders, treatment orders and interim compulsion orders

72. It would be expected that committal to hospital under section 200 would only be recommended in situations where the criteria for an assessment order (section 52D) or a treatment order (section 52M) or an interim compulsion order (section 53) are not met, for example, where the necessary evidence or information is unavailable.

73. The criteria for the use of orders under section 200 are less stringent than those for the other orders and assessment under section 200 should be with a view to determining whether a further pre-sentence order (under sections 52D, 52M or 53) or a final mental health disposal (see chapter 5) should be made.

74. It would be expected that an order under section 200 would only be used to remand a person on bail for reports as an outpatient given that assessment orders and treatment orders are available post conviction.

Appeal

75. Where a person is committed to hospital, the hospital managers would be expected to ensure that he/she is informed of his/her right of appeal under section 200(9).

76. A person remanded under section 200 has a right of appeal against the Court's refusal to grant bail or against the conditions imposed by the court at any time during their period of remand.

77. A person committed to hospital under section 200 also has a right of appeal against the order of committal and against its renewal.

78. The appeal should be made by a note presented to the High Court. The High Court, whether in court or in chambers, may after hearing the parties, review the order and grant bail with such conditions as it considers appropriate; or confirm the order; or in the case of an appeal against an order of committal to hospital, revoke the order and remand the person in custody.

CHAPTER 5: FINAL DISPOSAL

Introduction

This chapter begins with an overview of the final disposals available to the court in relation to mentally disordered offenders.

The chapter goes on to describe the procedures surrounding the imposition of a compulsion order under section 57A and provides detailed information on the relevant sections of the 1995 Act.

The chapter then provides similar guidance and information in relation to the restriction order (section 59), the hospital direction (section 59A) and the probation order with requirement of treatment for mental disorder (section 230).

The chapter also provides a brief overview of the application of the Adults with Incapacity (Scotland) Act 2000 to mentally disordered offenders with respect to intervention orders (section 60B) and guardianship orders (sections 57(2) (c) or 58(1A).

INTRODUCTION

Overview

1. Most mentally disordered offenders are convicted of an offence and given the relevant disposal on sentence. A few are found insane in bar of trial or acquitted on account of insanity (see chapter 3 of this part of the Code of Practice). Following conviction there is a range of disposals available to the court depending on the nature of the person's mental disorder, needs and risk.

Sentencing

2. Sentencing is the responsibility of the sheriff in the sheriff court, or judge in the High Court. In cases where offenders are mentally disordered, medical practitioners usually provide opinions and recommendations by written reports or sometimes oral evidence. The court may request that a Social Enquiry Report is prepared by a criminal justice social worker to provide information about the offender to assist sentencing (see chapter 6 of this part of the Code of Practice).

3. The court may follow recommendations for mental health disposals, however in some cases it may not; for example, where there is conflicting medical evidence or where the court considers that other issues, such as public safety or the requirement for punishment, override the medical recommendation.

Assessment prior to making a mental health disposal

4. It would be expected that appropriate multi-disciplinary assessment would be undertaken, in all cases where a medical recommendation for a mental health disposal is under consideration. In most cases where a hospital disposal is being considered, a multi-disciplinary in-patient assessment before and/or after conviction (see chapters 2 and 4) would be expected to have been undertaken. Any issues regarding the diagnosis of the person, likely response to treatment, interaction between the mental disorder and the current and previous offences or risk which remain unclear, would be expected to be clarified through a period of assessment (on an assessment order under section 52D, a treatment order under section 52M, a section 200 committal to hospital or an interim compulsion order under section 53 - see chapter 4).

5. Where serious offences have been committed and/or the person appears to pose a considerable risk to others, it would be expected that there would be a period of in-patient assessment on an interim compulsion order (section 53) before a hospital direction (section 59A) or a compulsion order with a restriction order is made (sections 57A and 59), unless there is a good reason to do otherwise.

Mental health disposals available to the court

6. The court has the following mental health options in relation to making a disposal:

1. If further assessment is required (see chapter 4)

    (i) assessment order (section 52D)
    (ii). treatment order (section 52M)
    (iii) committal to hospital (section 200)
    (iv) interim compulsion order (section 53)

2. Final mental health disposals available are:

    (a) Hospital disposals:
        (i) compulsion order (section 57A)
        (ii) compulsion order with a restriction order (sections 57A and 59)
        (iii) hospital direction (section 59A)

    (b) Community disposals:
        (i) compulsion order (section 57A)
        (ii) guardianship order (section 58(1A)
        (iii) treatment as a condition of probation (section 230)
        (iv) voluntary treatment

3. In some cases courts may impose non-mental health disposals, such as:

    (i) prison sentence
    (ii) probation order

(iii) community service order
(iv) fine
(v) deferred sentence

4. In some cases offenders may be admonished.

7. The diagram on page 103 illustrates the range of final disposals that the court can make after conviction.

Mentally disordered offenders who may pose a risk of serious harm to the public

8. Where a compulsion order authorising detention in hospital is made in respect of a person and it appears to the court that —

(a) having regard to the nature of the offence with which the person is charged;
(b) the antecedents of the person; and
(c) the risk that as a result of his mental disorder the person would commit offences if set at large,

that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of section 59, further order that the person shall be subject to the special restrictions set out in Part 10 of the 2003 Act, without limit of time.

9. Where a restriction order is under consideration, it is very important that there is a thorough assessment of risk, diagnosis and their relationships to the offence. For a restriction order to be imposed it would be expected that there would be a link between the specified mental disorder and the offence and/or the future risk posed. Where this link is absent or small it would be expected that the appropriate disposal would be a hospital direction (section 59A).

10. In any case where a mentally disordered offender appears to pose a significant risk to others such that consideration is being given to making a restriction order with a compulsion order or a hospital direction, it would be expected that an interim compulsion order (section 53, for information see chapter 4) would be made first (unless there is a good reason for not doing so) to allow thorough assessment of:

- the risk the person poses
- the nature of the mental disorder, its prognosis and the likelihood that it would benefit from treatment
- the relationship between the mental disorder and current and previous offences
- the relationship between the mental disorder and the risk the person poses to others

11. It would be expected that the conclusion of the risk assessment would consider the nature of the risk the person might pose in the future and the circumstances that might exacerbate or mitigate that risk. Future risk management would be considered in the context of special restrictions and their possible role.

12. It would be expected that the interim compulsion order would be renewed (up to the maximum duration of 12 months) until the above issues are clarified.

13. In certain cases the imposition of an interim compulsion order prior to final disposal may be unnecessary. For example where there has already been a thorough assessment carried out under an assessment order (section 52D) and/or treatment order (section 52M), and it is clear that the risk that the offender poses of further harm to others is entirely or largely attributable to the presence of a treatable mental disorder. In such cases it would be expected that a compulsion order and a restriction order may be made without detention on an interim compulsion order.

Provisions for the assessment and disposal of "high risk" offenders, including those who are mentally disordered, are set out in the Criminal Justice (Scotland) Act 2003. These provisions have implications for the assessment and management of mentally disordered offenders who may pose a high risk of serious violent or sexual offending. These matters are not covered in this Code of Practice.

Recommendations for final disposal

14. A statutory requirement for most disposals is that one recommendation for the final disposal should be prepared by a medical practitioner working at the hospital or clinic where treatment is to be provided (section 61(1A)).

15. It would be expected that the following issues would be considered when a medical practitioner makes a recommendation for a final mental health disposal:

- has the necessary multi-disciplinary assessment been completed? Are there issues that still remain uncertain which may be important in determining whether a particular disposal is made? If so, consideration should be given to further assessment, perhaps as an in-patient (see chapter 4) before a final disposal is recommended.

- a report recommending a final mental health disposal should give explicit consideration to the legal criteria relating to the medical evidence required for that disposal. The reasons for reaching the opinion leading to the recommendations regarding disposal should be set out clearly. The following outline good practice regarding the preparation of reports:

  - in cases where the person is already under the care of a RMO (for example he/she has been in hospital on an assessment order (section 52D), a treatment order (section 52M), an interim compulsion order (section 53), or perhaps under civil proceedings (sections 36 or 44 of the 2003 Act – see volume 1 of this Code of Practice for information), then one of the reports should be prepared by this RMO, particularly if the person will remain the RMO after the final disposal.

  - where more than one report is required or is being prepared, the medical practitioners preparing the reports should consult each other regarding the appropriate disposal.

  - the medical practitioners preparing reports in a particular case should always consult the MHO who is preparing a report for the court for that case and take account of the information contained in the SCR, where provided.

  - where a final disposal to a state hospital is recommended, one of the reports should be prepared by a medical practitioner from the state hospital, and the other by a medical practitioner working for mental health services in the area where the offender lived or is likely to reside on discharge from the state hospital.

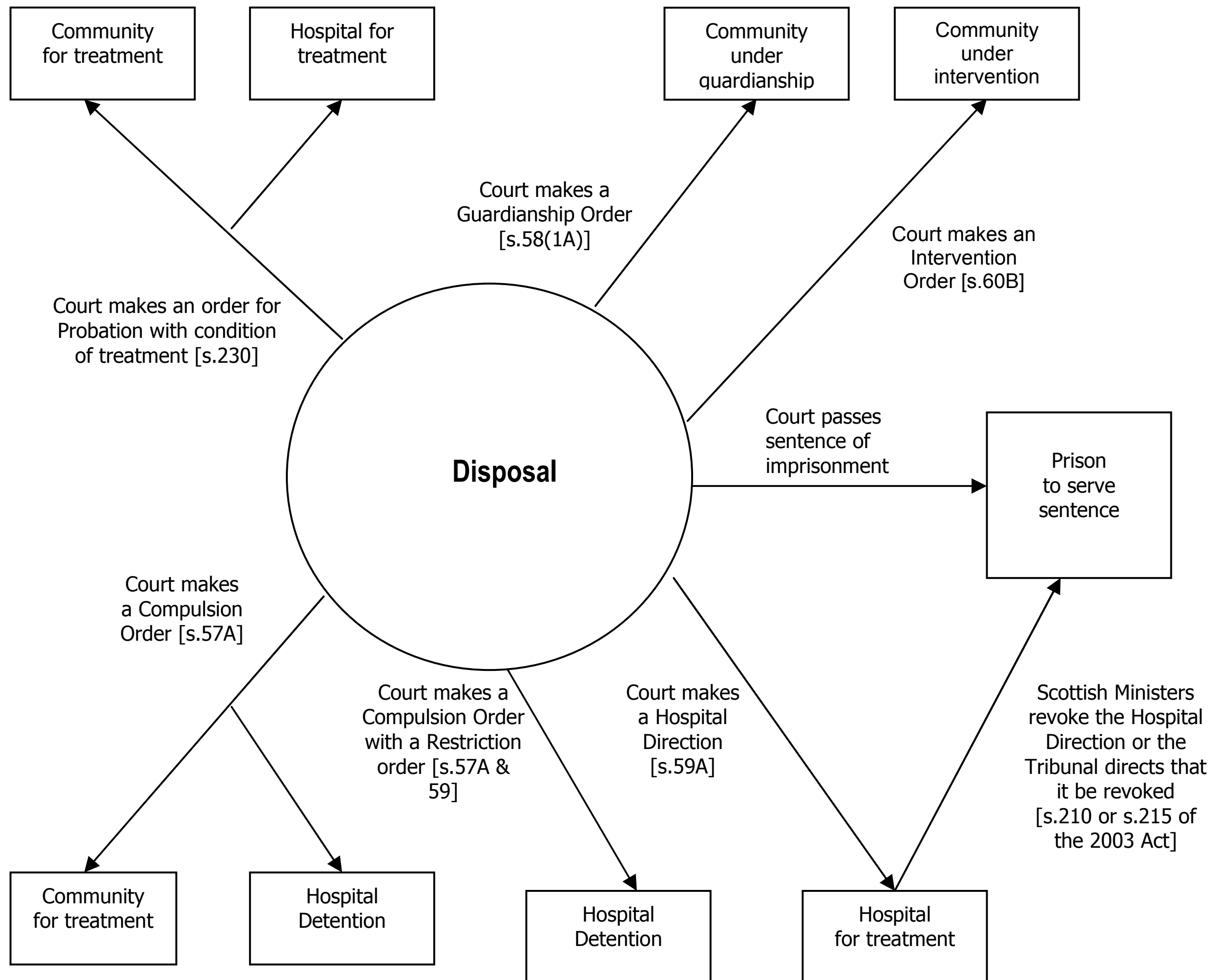
- the disposal recommended should be the <u>least restrictive</u> option necessary in the circumstances:

  - a hospital disposal should only be recommended where a community disposal is not appropriate due to the significant risk the person poses to their own health, safety or welfare or to others

  - a hospital disposal should be to a hospital or unit of no higher security than is necessary considering the risk the person poses to him/herself or others .

- when making a recommendation for a final mental health disposal a medical practitioner should ensure that his/her recommendation complies with the principles set out in section 1 of the 2003 Act.

DISPOSAL AFTER CONVICTION



COMPULSION ORDER

Background

16. The compulsion order (sections 57A to C as inserted by section 133 of the 2003 Act) replaces the hospital order. The changes mirror those for civil detention (i.e. the change from the previous long-term detention under section 18 of the 1984 Act to the new compulsory treatment order (CTO) under section 64 of the 2003 Act), in particular a compulsion order (CO) may authorise compulsory treatment either in hospital or the community, unlike its predecessor the hospital order.

Purpose

17. In general terms the purpose of the CO is to provide a disposal that is almost identical to a CTO already described above where a person has been convicted of an offence but suffers from mental disorder. The court can authorise a range of measures in a CO including detention in hospital or treatment and care in the community.

Overview

18. To make a CO there must be evidence from two medical practitioners (one of whom is approved in terms of section 22 of the 2003 Act) which satisfies the court that the person suffers from mental disorder (section 57A(2)), that medical treatment is available which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder (section 57A(3)(b)), and that if the person were not provided with such treatment there would be a significant risk to the health, safety or welfare of the person or to the safety of any other person (section 57(3)(c)). There must also be a mental health officer's report in accordance with section 57C. In terms of section 57A(3)(d), the court must also be satisfied that the making of the compulsion order is necessary.

19. The main differences in general terms between the criteria for a CO and those for a CTO are that for a compulsion order there is no criterion relating to the person's ability to make decisions about medical treatment (see section 64(5)(d) in relation to a CTO), the person needs to have been convicted of an offence punishable by imprisonment other than murder (section 57A(1)(a)), and the sentencing court should be satisfied that a CO is appropriate taking into consideration the circumstances of the case (ie the nature of the offence and the antecedents of the offender) (section 57A(4)(b)) and the other sentencing options available (section 57A(4)(c)).

20. In certain cases the CO may authorise detention at a state hospital and may have a restriction order (section 59, see paragraphs 68 to 72) added to it. A CO allows a person to be given medical treatment under Part 16 of the 2003 Act (section 57A(8)(b)) and may authorise detention in hospital (section 57A(8)(a)) or compulsory measures in the community (section 57A(8)(c) to (h)).

21. The order can be renewed after the first 6 months for a further 6 months and annually thereafter (as set out in Part 9 of the 2003 Act – for information about the renewal procedures see Part 2, Chapter 2 of this Code of Practice.

22. The person has the right of appeal to the court under section 60 against the order initially being made and then he/she may appeal to the Tribunal against it subsequently being renewed or varied in any way (see Part 9 of the 2003 Act).

GENERAL: SECTIONS 57A to D

Criteria for making a compulsion order

23. A court may make a CO under section 57A(1) where a person:

- is convicted in the High Court or the sheriff court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law, i.e. murder); or
- is remitted to the High Court by the sheriff under any enactment for sentence for such an offence.

24. There must be medical evidence from two medical practitioners (one of whom is approved in terms of section 22 of the 2003 Act) satisfying the court that:

- the person has a mental disorder as defined by section 328 of the 2003 Act (section 57A(3)(a))
- medical treatment which would be likely to
  - prevent the mental disorder worsening; or
  - alleviate any of the symptoms, or effects, of the disorder

  is available for the person (section 57A(3)(b)
- if such treatment were not provided there would be a significant risk
  - to the health, safety or welfare of the person; or
  - to the safety of any other person (section 57A(3)(c))
- the making of a CO is necessary (section 57A(3)(d))
- in a case where detention at a state hospital is to be authorised:
  - the person requires to be detained in hospital under conditions of special security; and
  - that such conditions of special security can be provided only in a state hospital (section 57(3)(6))

25. It would be expected that these issues would be addressed in the same way as they would be addressed in determining the appropriateness of a CTO under civil procedure (see Volume 1, chapter 5 of this Code of Practice). It would be expected that the medical recommendations would state that the giving of medical treatment in accordance with Part 16 of the 2003 Act should be made a requirement of the CO under section 57(8).

26. In accordance with section 57A(4) before making the order the court must have regard to:

- the MHO report prepared in accordance with section 57C
- all the circumstances of the case, including:
  - the nature of the offence of which the person was convicted
  - the antecedents of the person, and
- any alternative means of dealing with the person

MEDICAL EVIDENCE

27. It would be expected that in the majority of cases the medical evidence would be in the form of written reports; oral evidence without the preparation of a written report as the basis for making a CO should be rare.

28. At least one of the two medical practitioners must be approved under section 22 of the 2003 Act.

29. Both medical practitioners must agree that the person suffers from the same category of mental disorder (section 57A(14)(a)(i)).

30. The medical practitioners would be expected to set out in their evidence the compulsory measures in terms of section 57(8) which they consider should be authorised by the order (see paragraph 54).

31. If detention in hospital is recommended then the medical practitioners would be expected to provide the court with reasons why a community based order is not appropriate.

32. The level of security of the hospital or unit should be no more than is necessary to manage the risk the person poses to him/herself or others, and it would be expected that the reports would contain a statement that an appropriate bed is available for the person in a specified hospital (usually also specifying the ward or unit where the person will be admitted).

33. Good practice would suggest that where a CO authorising compulsory measures in the community is being recommended this will have been a matter of close consultation between the RMO and the designated MHO, well in advance of the psychiatric reports being submitted to the court. It would be expected that the RMO would need to confirm to the court that arrangements are in place for the provision of the necessary personnel and services by the relevant health authority.

MENTAL HEALTH OFFICER'S REPORT FOR THE COURT UNDER SECTION 57C

Overview

34. Where the court is considering making a CO it must direct the MHO to prepare a report in terms of section 57C.

35. In general terms it would be expected that the MHO's report would assist the court in considering whether a CO is an appropriate and necessary disposal for the person. It may be that, prior to a recommendation for a CO being made the person will have been subject to a period of psychiatric assessment, under one of the following:

- short term detention (section 44 of the 2003 Act)
- assessment order (section 52D)
- treatment order (section 52M)
- remand for enquiry into physical or mental condition (section 200)
- interim compulsion order (section 53)

36. In all of the scenarios mentioned in paragraph 35, apart from when an order is made under section 200, a local authority will have previously designated an MHO as responsible for the patient's case. Generally it would be expected that the designated MHO will remain the same person and will provide the MHO report for the court under section 57C. For further information on the designation of an MHO refer to Volume 1, Chapter 11, paragraphs 17 - 15 of this Code of Practice.

37. As mentioned in paragraph 33, for the MHO to be able to fulfil the requirements of his/her report, it would be expected that the patient's RMO and MHO would consult closely and effectively, well in advance of any medical recommendations for a CO being submitted to the court. To aid this communication it is therefore important that at whatever stage in the process of hospital detention the MHO is designated for the patient, the MHO should make him/herself known to the RMO.

38. In terms of section 57C(2), the MHO must interview the person (unless he/she considers this impracticable (section 57C(3)) and prepare a report which must state (section 57C(4)):

- the name and address of the person
- the name and address of the person's primary carer, if known
- details of the personal circumstances of the person, relevant to the psychiatric recommendations for a CO.
- any other information the mental health officer considers relevant to the recommendations for a CO.

39. The MHO would be expected to also set out in his/her report under section 57C the compulsory measures in terms of section 57(8) which the MHO considers should be authorised by the order (see paragraph 54).

40. Best practice would suggest that the MHO's report should also consider the following matters:

- the personal circumstances of the person relevant to the recommendation for CO (see paragraphs 41 to 44 below)
- the relevant views of the primary carer and named person where known
- the MHO's opinion on the suitability and viability of the powers being sought in the CO
- a description of the proposed plan of care
- confirmation that any community services that are to form part of the CO are suitable and available.
- a description of any alternative mental health disposals that in all the circumstances of the case could be considered by the court.
- where a restriction order is being sought, an opinion on the suitability and viability of the recommendation for restriction, with particular reference to any implications associated with social work supervision in the community, in the future and possible implications for the person.
- in circumstances where the MHO is of the opinion that alternatives other than a mental health disposal may be considered by the court, the MHO may suggest that consideration is given by the court to request a Social Enquiry Report (see chapter 6 of this part of the Code of Practice), to further inform the suitability and viability of other alternatives.

Personal Circumstances

41. Although many mentally disordered offenders may be diagnosed as having more than one psychiatric condition it is often the combination of medical and social factors which leads to their offending behaviour.

42. In considering the matter of personal circumstances the MHO would be expected to identify any relevant issues in the person's personal and family history that may be significant in relation to his/her mental health and/or offending behaviour. These might include by way of example disrupted childhood; lack of parenting; experiences of 'being cared for'; pattern of relationships; significant life events.

43. Particular attention should be given to drug/alcohol use and previous offending. Comment should also be made on the person's history of compliance/non compliance with previous care and treatment plans or statutory supervision.

44. It would be expected that the report would describe the person's current social circumstances, including housing, sources of income, employment, relevant activities, social and support network and comment on any associated implications there may be in the making of a CO.

MHO opinion in relation to the recommendation for a Compulsion Order in particular

45. The MHO would be expected to provide an opinion on the appropriateness and feasibility of the powers being sought in the recommendation for a CO. Best practice would suggest that the MHO should take into account all the circumstances of the case including the person's personal history, identified mental health needs, and the nature of the offence.

46. Where the powers being sought include duties to be placed on the MHO, it would be expected that the MHO would confirm that such duties are suitable and can be met by the designated MHO.

47. If the MHO does not consider that a CO is the appropriate mental health disposal he/she would be expected to draw the court's attention to any alternative considered feasible. He/she may also wish to suggest that the court considers requesting a Social Enquiry Report to inform the consideration of other alternatives.

MHO opinion in relation to a CO which authorises hospital detention

48. Where the recommendation is for a CO which authorises hospital detention it would be expected that, in addition to the matters described in paragraphs 38 to 47 above the MHO would also include in his/her report an opinion on the appropriateness of the level of security being recommended.

MHO opinion in relation to a CO which authorises compulsory measures in the community

49. Where the recommendation is for a CO which authorises compulsory powers in the community it would be expected that, in addition to addressing the matters described in paragraphs 38 to 47 above, the MHO would also confirm the feasibility and availability of the required services.

50. The MHO report would also be expected to set out the compulsory measures in terms of section 57(8) which the MHO considers should be authorised by the order (see paragraph 54).

51. There may be an overlap in the information contained in the recommendations made by the medical practitioners and the information contained in the MHO report to the court under section 57C. It would be expected therefore that the MHO and the RMO would consult closely, well in advance of recommendations being made for a community based compulsion order to ensure that there is no delay in the court being in a position to make a disposal in the case.

52. An MHO assessment will also be required where a community base CO is being recommended. It would be expected that the report prepared by the MHO under section 57C should describe the proposed plan of care and confirm that arrangements are in place for the provision of any proposed community care services by the relevant local authority.

53. The MHO's report should also confirm that any MHO duties specified in the order are appropriate and can be fulfilled.

MEASURES WHICH MAY BE AUTHORISED IN A COMPULSION ORDER

54. Section 57A(8)sets down the measures which may be specified in a CO. Quoting from that subsection of the 1995 Act, these are:

(a) the detention of the offender in the specified hospital;

(b) the giving to the offender, in accordance with Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Act (asp13), of medical treatment;

(c) the imposition of a requirement on the offender to attend—
  (i) on specific or directed dates; or
  (ii) at specified or directed intervals,
specified or directed places with a view to receiving medical treatment;

(d) the imposition of a requirement on the offender to attend—
  (i) on specified or directed dates; or
  (ii) at specified or directed intervals,
specified or directed places with a view to receiving community care services, relevant services or any treatment, care or service;

(e) subject to subsection (9) subject to subsection (9) below, the imposition of a requirement on the offender to reside at a specified place;

(f) the imposition of a requirement on the offender to allow—
  (i) the mental health officer;
  (ii) the offender's responsible medical officer; or
  (iii) any person responsible for providing medical treatment, community care services, relevant services or any treatment, care or service to the offender who is authorised for the purposes of this paragraph by the offender's responsible medical officer,
to visit the offender in the place where the offender resides;

(g) the imposition of a requirement on the offender to obtain the approval of the mental health officer to any change of address; and

(h) the imposition of a requirement on the offender to inform the mental health officer of any change of address before the change takes effect.

55. In relation to section 57A(8)(e), if the specified place is a care service then the court must be satisfied in terms of section 57A(9) that the person providing the care home service is willing to receive the person.

56. A CO allows the court to remove the person to the hospital or place specified in the order by a constable, a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the managers of that hospital to remove persons to hospital for the purposes of section 57B, or a specified person (section 57B(2)) within 7 days of the making of the order (section 57B(1)).

57. The order may authorise any of the measures set down in section 57(8) which includes the giving of medical treatment to the person in accordance with Part 16 of the 203 Act, either in hospital or the community, for a period of 6 months beginning on the day the order was made (section 57A(2)).

58. If a restriction order is imposed in addition to the order then the measures specified in the order are authorised without limitation of time (section 57A(7)).

59. The measures that may be authorised by a CO mirror those available under civil procedure for CTOs – for further information see Volume 1, Chapter 5 of this Code of Practice.

Change of hospital prior to admission and within 7 days of order being made

60. Under section 57D, if within 7 days of the CO being made it is apparent that the hospital specified in the order is unable to admit, or inappropriate for the person, then this should be notified to the court or the Scottish Ministers, and they may direct that the person be admitted to an alternative hospital.

61. It would be usually be the medical practitioner who had recommended the compulsion order, or the prospective RMO, who would inform the court or the Scottish Ministers that another hospital needs to be specified but it may be another doctor or someone else (e.g. hospital manager) depending on the circumstances.

62. This alternative should only be made because of emergency or other special circumstances. For example:

- a deterioration in the mental condition of the person such that the specified hospital would no longer be an appropriate placement
- a bed being unavailable in the specified hospital due to emergency circumstances

63. When such circumstances are alerted to the court or the Scottish Ministers, it would be expected that a medical practitioner should make a recommendation as to the alternative hospital after making arrangements with this hospital for the person to be admitted there.

Duty of a local authority to appoint an MHO

64. A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is practicable after a CO has been made in accordance with section 229 of the 2003 Act. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless the MHO records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the MWC within 21 days of the order being made. (For further information about SCRs please see section 231 of the 2003 Act or chapter 11 of the Code of Practice: Volume 1).

65. It would be expected that the medical records office of the hospital to which the person is admitted would ensure that the local authority is notified and sent a copy of the order. The notification would be sent to the Chief Social Work Officer for the relevant local

authority. Hospital managers would be required to ensure that this is done speedily and, if possible, within 2 working days. Best practice would suggest that the relevant local authority should designate an MHO responsible for the patient's case within 2 working days of receiving notification. It would be expected that procedures would be developed to ensure that there is no undue delay in this process.

RESTRICTION ORDER

Background

66. The 2003 Act makes very little change to section 59 of the 1995 Act which allows a court to impose a restriction order on a person who has been made subject to a compulsion order.

Purpose

67. In general terms a restriction order allows additional scrutiny of a mentally disordered offender, who may potentially pose a serious risk to others, as they progress through rehabilitation, so as to protect the public from this risk.

Overview

68. To make a restriction order the court must hear oral evidence from one of the medical practitioners recommending a compulsion order (section 59(2).

69. If the person has not previously undergone a period of assessment on an interim compulsion order (section 53), then the court may make a restriction order only if satisfied that in all the circumstances it was not appropriate to make an interim compulsion order in respect of the person. (section 59(2A))

70. The court must be satisfied that the criteria for making a restriction order as set out in s.59(1) are satisfied.

71. For a restriction order to be made it would be expected that there would be **a significant link between the mental disorder specified in the compulsion order and the risk of further offending.**

72. A compulsion order with a restriction order leads to the detention of the person in hospital (a restriction order cannot be made with a community based compulsion order) and the duration of compulsion is indefinite. A restriction order cannot be made for a time limited period.

GENERAL: SECTION 59

Criteria for making a restriction order

73. For a restriction order to be added to a compulsion order authorising the detention of a person in hospital it must appear to the court in terms of section 59(1):

(a) having regard to the nature of the offence with which he is charged;
(b) the antecedents of the person; and
(c) the risk that as a result of his mental disorder he would commit offences if set at large,

that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of section 59, further order that the person shall be subject to the special restrictions set out in Part 10 of the 2003 Act 2003, without limit of time.

74. In most cases a restriction order would usually be made following recommendations by the medical practitioners giving evidence, but a court may impose a restriction order if satisfied these criteria are met even if oral medical evidence does not support a restriction order. The tests which the court requires to be satisfied of are those set out in section 59(1).

75. For the imposition of a restriction order, it would be expected that the assessment of the risk posed by the person would indicate that the restriction order is necessary to protect the public from serious harm as a result of mental disorder. The mental disorder would be expected to play a substantial part in determining risk to others, and the added scrutiny of the rehabilitation process along with the stricter conditions that can be placed on a person subject to a restriction order would be necessary to reduce the risk that the person may pose.

76. Therefore, before a compulsion order with a restriction order can be imposed it would be expected that the court would consider matters such as the following:

- has the risk the person poses been thoroughly assessed during an interim compulsion order under section 53? If not, is adequate information available to address the following questions so that an interim compulsion order is unnecessary?
- if a restriction order is not imposed may there be a serious risk to others in the future?
- does the person's specified mental disorder play a substantial part in determining this risk?

77. **If the person appears to pose a significant risk, but the specified mental disorder is not a major factor determining this risk, then it would be expected that a hospital direction (under section 59A) would be a more appropriate disposal.**

MEDICAL EVIDENCE

78. Oral evidence is required from an AMP whose evidence has been the basis for the accompanying compulsion order.

79. In all but exceptional cases, a recommendation for a restriction order with a compulsion order would be expected to follow a prolonged period of multi-disciplinary in-patient assessment under an interim compulsion order (section 53). If it then appears to the reporting medical practitioners that a restriction order with a compulsion order should be made, this recommendation should be made in the final reports with evidence as to why this conclusion has been reached, addressing the matters set out in section 59(1).

80. The SCR previously prepared by the designated MHO under section 231 of the 2003 Act following the making of the interim compulsion order would be expected to contribute to the consideration of the level of risk posed by the person and the relationship between this risk and the mental disorder.

MHO REPORT TO THE COURT UNDER SECTION 57C WHERE A RESTRICTION ORDER IS UNDER CONSIDERATION BY THE COURT

81. Reference should be made "MHO's report to the court under section 57C" in relation to compulsion orders without a restriction order in paragraphs 34 to 48.

82. In addition, where a restriction order is being considered, the MHO's report for the court would be expected to consider and reflect upon the merits or otherwise of a restriction order given the circumstances of the case. The MHO should therefore have regard to the implications of such powers of restriction for the person's future, including their care and treatment and matters relating to public safety, and be satisfied that conditions of restriction provide the most appropriate and effective way of managing the person's on-going care and treatment.

83. The MHO would also be expected to consider if there are less restrictive alternatives that might be applied safely. Matters such as how the powers of restriction may support the need for and compliance with community services, and risk management requirements in the longer term should be considered.

84. In assessing whether powers of restriction are necessary and appropriate, the MHO would be expected to bear in mind the broad range of powers that are available under a compulsion order without restriction, including powers to require treatment in the community; determination of residence; and powers of access for the purposes of supervision and treatment.

85. The MHO should consider the nature and gravity of the offence and the risks of re-offending that may be directly linked to the person's mental health and social circumstances. In particular the MHO's report would be expected to contribute to the consideration of matters detailed in b) and c) of the criteria for making a restriction order in paragraph 73 above.

EFFECT OF A RESTRICTION ORDER

86. A restriction order is made in conjunction with a compulsion order at the time of disposal and it allows the person to be detained in hospital without limit of time (section 57A(7)).

87. None of the provisions in Part 9 of the 2003 Act relating to the duration and renewal of the compulsion order apply; the person is detained in hospital until he/she is conditionally or absolutely discharged upon the direction of the Tribunal (sections 193(7), or 193(3) or (4) of the 2003 Act).

88. The approval of the Scottish Ministers is required before the person may be granted leave (section 224 of the 2003 Act) or transferred to another hospital (section 218 of the 2003 Act). This applies whether or not the person is detained in the State Hospital.

HOSPITAL DIRECTION

Background

89. The hospital direction was inserted as section 59A into the 1995 Act by amendments made by the Crime and Punishment (Scotland) Act 1997. It allows for a convicted mentally disordered offender to be given a hospital disposal along with a prison sentence.

Purpose

90. It would be expected that a hospital direction would be made in cases where persons convicted on indictment meet the criteria for a compulsion order but where **there is little relationship between the specified mental disorder and the index offence or where treating the specified mental disorder is unlikely to significantly reduce the risk the person poses to the public.**

91. In general terms the hospital direction allows the person to receive the appropriate medical treatment in hospital (in accordance with Part 16 of the 2003 Act) and then to be transferred to prison to complete the prison sentence imposed at the time of the making of the hospital direction.

Overview

92. To make a hospital direction there must be evidence from two medical practitioners (one of whom is approved (section 61(1))) which satisfies the court that the person suffers from mental disorder (section 59A(3)(a)), that medical treatment is available which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder (section 59A(3)(b)), and that if the person were not provided with such treatment there would be a significant risk to the health, safety or welfare of the person or to the safety of any other person (section 59A(3)(c)).

93. As with restriction orders (section 59), assessment of the person prior to the making of a hospital direction would expect to be undertaken during an interim compulsion order (section 53) except where this is clearly not appropriate. The hospital direction is only available for cases prosecuted on indictment (section 59A(1)) and it would be expected that it would only be used in cases where serious offences have been committed as an alternative to a compulsion order with a restriction order (sections 57A and 59).

94. The court must be satisfied that a hospital direction is appropriate taking into consideration the mental health officer's report prepared under section 59B (section 59A(5)(a), all the circumstances of the case (section 59A(5)(b)) and the alternative sentencing options available (section 59A(5)(c)).

95. If a person is convicted of murder, then the hospital direction is the only mental health disposal available to the court.

GENERAL: SECTION 59A

Criteria for making a hospital direction

96. A court may make a hospital direction where a person is convicted on indictment in the High Court or the sheriff court of an offence punishable by imprisonment (section 59A(1))

97. Unlike a compulsion order, there is no requirement that the offence is one for which the sentence is not fixed by law. Therefore the order is available where a person has been convicted of murder.

98. Before making the hospital direction under section 59A(2) the court must have regard to:

- the MHO report prepared in accordance with section 59B (section 59A(5)(a))
- all the circumstances of the case, including:
    - the nature of the offence
    - the antecedents of the person (section 59A(5)(b))
- any alternative disposals available (section 59(5)(c))

Statutory criteria

99. The statutory criteria regarding the medical evidence necessary for a court to make a hospital direction are identical to those for a hospital based compulsion order and should be addressed in an identical way (see paragraphs 27 to 33). However three additional factors should also be considered in such cases:

- as with a compulsion order and restriction order, it would be expected that an interim compulsion order would be recommended first unless there are good reasons not to do this

- it would be expected that the nature of the offence and the background of the person should be such that if a compulsion order were being considered, a recommendation for a restriction order would also be likely

- the link between the specified mental disorder and the index offence and/or the risk of further serious harm would be expected to be weak in contrast to the compulsion order

100. In considering these matters it would be expected that the RMO and the MHO would consult closely before a recommendation for a hospital direction is made to the court.

MEDICAL EVIDENCE

101. There must be medical evidence from two medical practitioners (one of whom is approved (section 61(1)) satisfying the court that:

- the person suffers from mental disorder (section 59A(3)(a))
- medical treatment which would be likely to
  - prevent the mental disorder worsening; or
  - alleviate any of the symptoms, or effects, of the disorder

  is available for the person (section 59A(3)(b))
- if such treatment were not provided to the person there would be a significant risk
  - to the health, safety or welfare of the person; or
  - to the safety of any other person (section 59A(3)(c))
- the hospital proposed is suitable for the giving of medical treatment and it has a bed available for the person within 7 days of the direction being made (section 59A(4))
- the making of a hospital direction is necessary (section 59A(3)(d))
- in a case where detention at a state hospital is to be authorised:
  - the person requires to be detained in hospital under conditions of special security; and
  - that such conditions of special security can be provided only in a state hospital (section 59A(6))

102. Before imposing a hospital direction in terms of section 59A(2) it would be expected that the court would consider:

- has the risk this person poses been thoroughly assessed? If not, is adequate information available to address the following question so that an interim compulsion order is unnecessary?
- does the person's mental disorder play a substantial part in determining this risk?

103. It would be expected that (apart from in cases where the person has been convicted of murder), if the person has not previously undergone a period of assessment on an interim compulsion order (section 53), then there would need to be a good reason for not making such an order before a hospital direction is made.

104. In most cases it would be expected that the medical evidence would be in the form of written reports; oral evidence in the absence of a written report as the basis for making a hospital direction would be rare.

105. At least one of the two medical practitioners must be approved under section 22 of the 2003 Act. The medical evidence must address the matters set out above in paragraphs 101 to 102.

106. Both medical practitioners must agree that the person suffers from the same category of mental disorder (section 59A(9)(a)). There would be expected to be a statement in the reports that an appropriate bed will be available for the person in a specified hospital (usually also specifying the ward or unit where the person will be admitted).

107. In all but exceptional cases, or cases where the person has been convicted of murder, a recommendation for a hospital direction would be expected to follow a prolonged period of

multi-disciplinary in-patient assessment whilst the person is detained under an interim compulsion order (section 53). If following this period it appears to the reporting medical practitioners that a hospital direction should be made, then this recommendation may be made in the final reports with evidence as to why this conclusion has been reached, addressing the matters set out in section 59A(2)(a).

108. It would be expected that the key issue in a case where a hospital direction is under consideration is the extent of the link between the specified mental disorder and the index offence and/or the risk of further offending. The MHO would be expected to contribute to the consideration of these matters. If the person appears to pose a substantial risk, but the specified mental disorder is not a major factor determining this risk, then it would be expected that a hospital direction would be the appropriate disposal.

MENTAL HEALTH OFFICER'S REPORT FOR THE COURT UNDER SECTION 59B

109. Where the court is considering making a hospital direction it must direct the MHO to prepare a report in terms of section 59B.

110. Reference should be made to paragraphs 34 to 53 (MHO's report in relation to compulsion orders) and paragraphs 81 to 85 (MHO's report in relation to compulsion orders with restriction orders).

111. However, unlike compulsion orders there is no scope for statutory mental health powers in the community under a hospital direction; the direction allows for a convicted mentally disordered offender to be given a hospital disposal along with a prison sentence.

112. In considering whether a hospital direction may constitute an appropriate disposal, the MHO will wish to be satisfied that there is no other appropriate mental health disposal and that the person's circumstances and mental health needs are not more appropriately served by a compulsion order with a restriction order.

113. Alternatively the MHO will also wish to be satisfied that person's circumstances do merit detention and treatment in hospital at the point of disposal.

114. Given that the person has mental health needs the MHO would be expected to consider the implications of these needs and any potential aspects of vulnerability that should be highlighted in the report in the context of the person undertaking a custodial sentence.

MEASURES WHICH MAY BE AUTHORISED BY A HOSPITAL DIRECTION

115. A hospital direction allows the court to remove a person to the hospital specified in the direction by a constable, a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the managers of that hospital to remove persons to hospital for the purposes of section 59A, or a specified person within 7 days of the making of the order (section 59A(7)). It allows a person to be given compulsory treatment in hospital in accordance with Part 16 of the 2003 Act.

116. A hospital direction ceases to have effect upon the release of the person under Part 1 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (section 217 of the 2003 Act).

Change of hospital prior to admission and within 7 days of order being made

117. Under section 59C, if within 7 days of the hospital direction being made it is apparent that the hospital specified in the direction is unable to admit, or inappropriate for the person, then this should be notified to the court or the Scottish Ministers, and they may direct that the person be admitted to an alternative hospital.

118. It would be usually be the medical practitioner who had recommended the hospital direction, or the prospective RMO, who would inform the court or the Scottish Ministers that another hospital needs to be specified but it may be another doctor or someone else (e.g. hospital manager) depending on the circumstances.

119. This alternative should only be made because of emergency or other special circumstances. For example:

- a deterioration in the mental condition of the person such that the specified hospital would no longer be an appropriate placement
- a bed being unavailable in the specified hospital due to emergency circumstances

120. When such circumstances are alerted to the court or the Scottish Ministers, it would be expected that a medical practitioner should make a recommendation as to the alternative hospital after making arrangements with this hospital for the person to be admitted there.

Duty of a local authority to appoint an MHO

121. A local authority has a duty to designate an MHO to be responsible for the person’s case as soon as is practicable after a hospital direction has been made in accordance with section 229 of the 2003 Act. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless the MHO records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the MWC within 21 days of the direction being made. (For further information about SCRs please see section 231 of the 2003 Act or chapter 11 of the Code of Practice: Volume 1).

122. It would be expected that the medical records office of the hospital to which the person is admitted would ensure that the local authority is notified and sent a copy of the order. The notification would be sent to the Chief Social Work Officer for the relevant local

authority. Hospital managers would be required to ensure that this is done speedily and, if possible, within 2 working days. Best practice would suggest that the relevant local authority should designate an MHO responsible for the patient's case within 2 working days of receiving notification. It would be expected that procedures would be developed to ensure that there is no undue delay in this process.

INTERVENTION ORDERS AND GUARDIANSHIP ORDERS UNDER THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000 AS APPLIED TO MENTALLY DISORDERED OFFENDERS

Background

123. Previously under the 1995 Act, the measure that could be applied for was guardianship under the 1984 Act. This could be applied for in cases where a person had been found insane (either in bar of trial or at the time of the offence) under section 57(2)(c) of the 1995 Act or where a mentally disordered person had been convicted (section 58 of the 1995 Act).

124. Guardianship under the 1984 Act was replaced by measures set out in the Adults with Incapacity (Scotland) Act 2000, ("the 2000 Act"). The 2003 Act makes little change in this area, the major changes having been made to the 1995 Act by the 2000 Act. The court may use section 60B of the 1995 Act to make an intervention order or either of sections 57(2)(c) or 58(1A) of that Act to make a guardianship order.

Purpose

125. In general terms, the purpose of an intervention order (section 60B) in these circumstances is to allow for specific one off measures relating to matters such as personal welfare to be authorised for a mentally disordered person, who has been found insane or convicted of an offence, and who has incapacity in relation to taking the relevant action or decision.

126. In general terms, a guardianship order (section 57(2)(c) or 58(1A)) is a longer-term measure. It allows for a welfare guardian to be appointed for a mentally disordered person, who has been found insane or convicted of an offence, and who has incapacity in relation to making decisions relating to personal welfare. The guardian's role is to safeguard the person's interests in this regard.

Overview

127. The requirements for medical and MHO evidence are similar to those for these orders under civil proceedings.

128. Guardianship and intervention orders made through criminal proceedings may be made in relation to matters of personal welfare. Orders in relation to property and financial matters can be made through an application under the 2000 Act.

129. It would be expected that the process of comprehensive assessment and very full consultation that is required as part of the consideration of whether powers under the 2000 Act are appropriate, is likely to take significant time. Early consultation between the RMO and MHO would therefore be expected in order to avoid unnecessary delay to the court in making a disposal.

For information about these orders refer to the Adult with Incapacity (Scotland) Act 2000 and its Code of Practice.

PROBATION ORDER WITH REQUIREMENT OF TREATMENT FOR MENTAL CONDITION

Background

130. A probation order requiring treatment for mental condition is available under section 230. Section 135 of the 2003 Act makes two minor changes to this order: the 12 month time limit has been removed, so the potential maximum duration is now the full 3 years for which any probation order may apply; and the court must be satisfied on the evidence of the medical practitioner or psychologist under whom the treatment will be given that the relevant services are available and appropriate.

Purpose

131. In terms of section 230(1) the probation order requiring treatment for a mental condition is appropriate where a person with a mental condition is convicted of an offence (section 228(1)), but their condition does not warrant a compulsory treatment order under section 64 of the 2003 Act or a compulsion order, and the circumstances do not lead the court to conclude that imprisonment is necessary. Medical or psychological treatment for the mental condition is made a requirement of the probation order.

Overview

132. To make a probation order the court must be satisfied on the evidence of an AMP that the mental condition of the person does not warrant a CTO under section 64 of the 2003 Act or a compulsion order, but requires or may be susceptible to treatment directed by a registered medical practitioner or a chartered psychologist (section 230(1)).

133. The medical practitioner or psychologist who will be responsible for the treatment must also give evidence (section 230(3)(a)).

134. A probation order cannot be made unless the court has received a Social Enquiry Report ("SER") under section 228(1)(b) and is satisfied that a local authority can make suitable arrangements for the supervision of the person (section 228(2)).

135. The order allows treatment by a registered medical practitioner or a chartered psychologist, either as an out-patient or an in-patient, to be made a condition of probation (section 230(2)). It must have the agreement of the person, the supervising officer and the medical practitioner or psychologist (section 230(6)).

GENERAL: SECTIONS 230 TO 232

Criteria for making a probation order with requirement of treatment for mental condition

136. To make a probation order with a requirement of treatment for a mental condition the court must be satisfied:

- that the local authority can make suitable arrangements for the supervision of the person (section 228(2))
- on the evidence of an approved medical practitioner (section 230(1))
  - that the person has a mental condition; and
  - this mental condition requires and may be susceptible to treatment; but
  - a compulsory treatment order or a compulsion order is not warranted
- on the written or oral evidence of the registered medical practitioner or chartered psychologist by whom or under whose direction the treatment will be provided that the treatment is appropriate (section 230(3)(a))
- arrangements have been made for the treatment, including reception in hospital if treatment as a resident in-patient in hospital is to be specified (section 230(3)(b))

137. In addition such an order cannot be made unless the person and the supervising officer agree to this course of action (section 230(6)).

138. When making the order the court must have regard to:

- the circumstances, including the nature of the offence and the character of the person (section 228(1)(a))
- the SER (section 228(1)(b))

Treatment

139. A probation order does not provide any compulsory powers of detention or treatment. Section 230(2) sets out the alternative types of treatment which may be specified in the order:

- treatment as a resident patient in hospital (excluding a state hospital) where the patient has the status of a voluntary patient in all respects
- treatment as a non-resident patient at a specified institution or place
- treatment by or under the direction of a registered medical practitioner or chartered psychologist

140. Other aspects of the treatment need not be specified.

Medical and psychological evidence

141. In all cases an approved medical practitioner must give evidence addressing the issues in section 230(1), even in cases where the treatment is to be by or under the direction of a chartered psychologist. If that medical practitioner is also to be the registered medical

practitioner by or under whom treatment is given, then this evidence would also be expected to address the treatment to be given by reference to section 230(2) and the matters set out in section 230(3), and no other medical or psychological evidence is required. But where the treatment is to be by or under another medical practitioner or a chartered psychologist then this person must also give evidence addressing the matters set out in section 230(2) and (3).

142. Evidence would usually be given by way of written reports, but under some circumstances oral evidence may be required.

143. The approved medical practitioner addressing the matters in section 230(1) is required to assess the person to:

- diagnose a mental condition – it would be expected that the definition of a mental condition would be broader than the definition of mental disorder under section 328 of the 2003 Act, and would include both conditions that are included and excluded under that section.
- consider whether this mental condition is a mental disorder which warrants a compulsion order (section 57A)
- consider whether this mental condition requires or may be susceptible to treatment - this is broader than the treatability criteria for compulsion. This treatment may be by or under the direction of a registered medical practitioner or chartered psychologist, and may be as an in-patient, day-patient or out-patient.

144. If this medical practitioner is not the registered medical practitioner by or under whom the treatment will be given, then he/she would be expected to consult the relevant medical practitioner or psychologist, name him in his report and request that the court seeks evidence from him regarding the matters in section 230(2) and (3).

145. A recommendation for an order under section 230 should never be made without the prior agreement of the person who will be responsible for the treatment, the potential supervising officer and the offender.

146. To address the matters in section 230(2) the registered medical practitioner or chartered psychologist by or under whom the treatment will be given would be expected to set out in his/her report whether the treatment would be given to the person as an in-patient, a day-patient or an out-patient by reference to the relevant subsection, either sections 230(2)(a), (b) or (c).

147. The exact nature of the treatment in terms of medication, psychological treatment or input from particular staff or services, may be included, but is not required, and such details will not be specified in the order.

148. To address the matters in section 230(3) it would be expected that the registered medical practitioner or chartered psychologist by or under whom the treatment will be given would state that the treatment is appropriate for the person's mental condition and that arrangements have been made for the treatment to occur, whether in the community or in hospital.

149. Best practice would suggest that those preparing medical or psychological reports should not make a recommendation for an order under section 230 without consulting the

social worker preparing the SER, or a potential supervising officer, from the relevant criminal justice social work service.

150. This consultation would be necessary not only to consider the appropriateness and viability of such a recommendation but also to ensure proper consideration is given to the possible consequences for the person and implications for their future care and treatment planning, arising from such an order. For example, that proper consideration is given to the consequences of a breach of the order that may be required in respect of further offending, and the resulting possibility of a custodial sentence. Alternatively where the person defaults in respect of conditions of attendance or residence, the breaching process may be protracted and may not provide the level of compulsion required to support the required treatment programme. The availability of compulsion orders with community powers (section 57A) may provide an alternative disposal in cases otherwise punishable by imprisonment.

151. It would be expected that the duration of the requirement of treatment would be specified in the report by the registered medical practitioner or chartered psychologist by or under whom the treatment will be given. This may be any length of time between 6 months and 3 years.

Effects

152. The person would be expected to attend for the treatment specified in section 230(2). However the order does not authorise the conveyance of the person by force to a hospital or clinic nor does it authorise the detention of the person or require him/her to remain resident at a location. Part 16 of the 2003 Act concerning medical treatment does not apply to persons made subject to an order under section 230.

153. Any treatment for a mental condition which is directed by a registered medical practitioner or a chartered psychologist as a condition of probation must be authorised by an order under section 230. Section 230(9) states that:

"Except as provided by this section, a court shall not make a probation order requiring a probationer to submit to treatment for his mental condition."

Non-compliance with the conditions of the order by the probationer

154. If a person fails to comply with the treatment specified in the order by, for example, leaving hospital or failing to attend appointments, then it would be expected that this would be reported to the supervising officer by the registered medical practitioner or chartered psychologist by or under whom the treatment would be given.

155. The supervising officer would then need to decide whether the non-compliance warrants being reported to the court under section 232. Section 232(5) specifically allows the court to find that a person has not been non-compliant with an order under section 230 if a refusal to submit to surgical, electrical or other treatment is deemed to be reasonable having regard to all the circumstances.

156. If the order under section 230 specifies that the treatment should be as an in-patient in hospital and the person either fails to attend or leaves, then although the order does not

authorise the person's detention in hospital, consideration may be given to using compulsory measures under the 2003 Act (emergency detention (section 36), short-term detention (section 44) or a compulsory treatment order (section 64)) if there has been sufficient change in the mental condition of the person so that such a measure is warranted. This may also be the case where a probationer is non-compliant whilst being treated as a non-resident patient or as an out-patient. However it would be expected that such circumstances would be rare.

Variation of the conditions specified in the order

157. Under section 230(4) if the registered medical practitioner or chartered psychologist by or under whom the treatment will be given, is of the opinion that the probationer requires a different type of treatment or treatment at a different place or institution, then he/she may make such alternative arrangements for the treatment of the probationer. Examples of such situations are that the probationer no longer requires in-patient treatment, the probationer requires treatment by or under a different medical practitioner or psychologist, or the probationer requires treatment at a different clinic.

158. Such alternative arrangements may only be made if the probationer and the supervising officer agree to these; the alternative treatment will be given by or under a registered medical practitioner or a chartered psychologist who has agreed to accept the probationer as his patient; and, if the alternative involves treatment in hospital, then arrangements have been made for admission (section 230(6)).

159. When such alternative arrangements are made the supervising officer must notify the court, and the alternative treatment is deemed to be treatment to which the person should submit in pursuance of the order (section 230(7)).

CHAPTER 6: OVER-ARCHING ISSUES

Introduction

This chapter provides information and guidance on issues that are common to many of the mental health orders in the previous chapters.

It also describes the procedures associated with the urgent detention of a person who has been acquitted under section 60C

SITUATIONS WHERE THE CRIMINAL JUSTICE PROCESS ENDS UNEXPECTEDLY OR PREMATURELY

Introduction

1. Much of the information in Part 1 of this Code of Practice is contingent on the continuation of the criminal justice process through its various stages. However in some cases the criminal justice process may terminate, perhaps unexpectedly or prematurely, and therefore the current mental health order may end (e.g. an assessment order ends if a case is deserted *simpliciter*) or the proposed mental health order may not be made (e.g. in a case where a compulsion order has been recommended, if a person is acquitted, other than on account of insanity, then this recommendation may not be acted on). In some cases a court may decide not to act on a recommendation for a specific mental health disposal.

2. The reason for the termination of proceedings will be based on criminal justice grounds (such as lack of evidence or prosecution not being in the public interest). In some circumstances, through liaison between the prosecutor and/or court and mental health services it may be appropriate for this to happen in a planned way, with care and treatment being put in place either informally or through compulsion under civil procedure (sections 36, 44 or 65 of the 2003 Act). However there are circumstances where a termination in the criminal justice process is unexpected and does not allow the recommended disposal to be made, but with no contingency arrangements in place.

3. Examples of relevant situations are:

Pre-trial

- the police decide not to report an offence to the prosecutor
- the prosecutor decides not to initiate a prosecution
- after initiating a prosecution the prosecutor may decide to desert proceedings

Trial:

- the person may be acquitted (other than on account of insanity)

Post-conviction

- the court decides not to follow a mental health disposal recommendation.

4. There is specific statutory provision under section 60C of the 2003 Act to deal with such situations but this is only available where a person is acquitted and the court had received evidence from two medical practitioners that the person met the relevant criteria.

Expected or planned termination of criminal justice process

5. In circumstances where it is expected and/or agreed (between the police/prosecutor/court and mental health services) that the criminal justice process will end, then consideration would be expected to be given to the most appropriate care plan for the person. This may involve compulsory measures under civil procedure and/or informal measures. It is important in such circumstances that the necessary measures and services are put in place before the criminal justice process terminates.

Unexpected termination of criminal justice process

6. Such circumstances would be expected to be rare, as in most cases there should be time for communication between criminal justice agencies and mental health services to pre-empt such a situation. Where the situation is that a person has been unexpectedly acquitted, which is the most likely scenario where this issue will arise, then section 60C allows for a medical examination with a view to potential emergency or short-term detention under civil procedures (see sections 36 and 44 of the 2003 Act).

Measures to be put in place

7. The measures to be put in place would usually be similar to those that had been in place or proposed during the criminal justice process. However with the more stringent criteria for compulsory detention through civil procedure as compared to that through criminal procedure it may not be possible to put very closely similar measures in place. The measures to put in place will depend on the needs of the person and the risk they may pose to themselves or others. Each case will require to be considered on its facts.

URGENT DETENTION OF ACQUITTED PERSONS UNDER SECTION 60C

Background

8. Section 134 of the 2003 Act inserts section 60C into the 1995 Act, allowing for the removal to and detention in a place of safety of a person acquitted of an offence so that a medical examination can be carried out. The court must be satisfied on the evidence of two medical practitioners that the person meets the criteria set down in section 60C(3) (the forensic criteria for compulsion) and that it is not possible to arrange an immediate examination of the person by a medical practitioner.

9. It would be expected that an order under section 60C would be made where the court had received recommendations from two medical practitioners for a mental health disposal which cannot be acted on by the court as the person was not convicted.

Purpose and overview

10. The purpose of section 60C is to allow a person to be held in a place of safety for up to 6 hours (beginning with the time at which the order under section 60C was made) following an acquittal, provided there have been medical recommendations available to the court which were recommending a hospital disposal. This period of detention is to allow for an examination by a medical practitioner to ascertain whether emergency detention or short-term detention under the 2003 Act is warranted.

GENERAL: SECTION 60C

Criteria for urgent detention of acquitted person

11. For the detention of a person under section 60C:

- the person must have been acquitted of an offence (section 60C(1))
- there must be medical evidence from two medical practitioners (one of whom is approved) satisfying the court that:
  - the person has a mental disorder;
  - medical treatment which would be likely to prevent the mental disorder worsening; or alleviate any of the symptoms, or effects, of the disorder is available for the person; and
  - if such treatment were not provided there would be a significant risk to the health, safety or welfare of the person, or to the safety of any other person (section 60C(2)(a) and (3))
- the court must be satisfied that it is not practicable to secure the immediate examination of the person by a medical practitioner (section 60C(2)(b))

Which orders may have been recommended by the medical practitioner to warrant the use of section 60C?

12. The criteria for detention under section 60C are such that two medical recommendations for the following orders may allow a court to detain a person under this section if they are acquitted. These are:

- treatment order (section 52D)
- interim compulsion order (in some circumstances – see below) (section 53)
- compulsion order (section 57A)
- hospital direction (section 59A)

13. The criteria for an interim compulsion order are such that there only needs to be *reasonable grounds for believing* that:

- medical treatment would be likely to prevent the mental disorder worsening; or alleviate any of the symptoms, or effects, of the disorder is available for the person; and
- if such treatment were not provided there would be a significant risk to the health, safety or welfare of the person or to the safety of any other person

Effects of detention under section 60C

14. The order authorises the removal of the person to a place of safety by a constable or a person specified by the court; and his/her detention in a place of safety for a period of up to 6 hours beginning with the time that the order is made by the court (section 60C(4)).

Place of safety

15. The most appropriate place of safety would be expected to be the hospital where the person was due to be admitted but 6 hours may be too short a time period for this, and therefore in many cases detention may be at the court holding cells or perhaps a police station.

The medical examination during detention under section 60C

16. The medical practitioner carrying out the medical examination under section 60C should follow the information in Volume 1 Chapters 3 and 4 of this Code of Practice about examinations in relation to emergency and/or short-term detention. Ideally the doctor assessing the person should be one of the doctors who had made a recommendation for disposal if the person had been convicted. However under certain circumstances this may not be practical within the available time-scale. Under such circumstances the medical practitioner carrying out the medical examination would be expected to consult one or both of the medical practitioners who had made the initial recommendations and the designated MHO who may have prepared an SCR in terms of section 231 of the 2003 Act.

17. In general, the hospital in which a person should be detained under the emergency or short-term detention order, should be the same as the one where they would have been admitted if convicted. Exceptions to this would be cases where the acquittal changes the

assessment of risk to the extent that it is considered that the person does not require the same degree of security.

18. Medical examinations in these circumstances must follow the information and guidance in the Code of Practice for the 2003 Act in relation to emergency and short-term detention procedures. It would be expected that the assessment of the person would require the involvement of an MHO from the local authority for the area where the patient is being held in a place of safety.

Treatment

19. Medical treatment under Part 16 of the 2003 Act cannot be given during the 6 hour period and as the person is not detained in hospital (but is detained in a place of safety, which may happen to be a hospital); similarly urgent treatment cannot be given under section 243 of the 2003 Act. If a person does require emergency treatment during detention under section 60C then this may be given under common law.

RISK ASSESSMENT

20. There are two statutory definitions of risk criteria that may need to be given consideration in any particular case:

- the criterion under civil detention procedures in terms of section 64(5) of the 2003 Act is one of the criteria which must be met before a CTO is applied for. This risk criterion is concerned with the risk to self and others.
- the criteria for a restriction order as set down in section 59(1). This criterion is concerned only with risk to others

21. *"….significant risk to the health, safety or welfare of the offender; or to the safety of any other person; and….."*
This would be expected to be interpreted in an identical way to civil procedures under sections 36(5)(b) or 44(4)(d) or 64(5)(c) of the 2003 Act. For information refer to Volume 1 of the Code of Practice to the 2003 Act.

22. *"……risk that as a result of his mental disorder he would commit offences if set at large,…."*
Where a restriction order is under consideration there would be expected to be detailed consideration of the background history (including history of violence and offending; history of mental disorder and psychiatric treatment; and history of alcohol or drug misuse; along with other relevant factors) and the current index offence and its circumstances.

23. Good practice would suggest that the conclusion of the risk assessment should consider the nature of the risk the person might pose in the future and the circumstances that might exacerbate or protect against that risk in the future. This should be placed within the context of the future management that may address this risk and the role of special restrictions in facilitating this future management.

TRANSPORTING PERSONS SUBJECT TO THESE PROVISIONS BETWEEN PRISON, COURT AND HOSPITAL

24. Prior to conviction, the prosecutor would be expected to arrange for the accused to be transported from prison or hospital to court, or from court to prison or hospital. After conviction, the court would be expected to arrange for the transport of the person to hospital. The transporting of the patient, whether before or after conviction, would usually be carried out by the Prisoner Escort and Court Custody Service.

25. Only after a person has been admitted to hospital following the imposition of a final disposal by the court would the hospital be expected to have responsibility for arranging any future transport of the patient.

ATTENDANCE AT COURT – BEST PRACTICE POINTS

26. It would be expected that the patient would usually attend the court hearing at which the court decides whether to make an assessment order (section 52D), a treatment order (section 52M) or to make or extend an interim compulsion order (sections 53 and 53B).

27. However, if the RMO considers that the person's mental condition is such that it may be detrimental to his/her health to appear in court, or they may pose a significant risk were they to appear in court there are provisions in the 1995 Act to enable the court to make one of these orders in the absence of the person. Therefore where the medical practitioner considers that the person should not attend court for the reasons previously mentioned he/she would be expected to inform the prosecutor or the court of this, giving the reasons.

28. For the court to make one of the orders listed in paragraph 26 in the absence of the person the court must be satisfied that it is impracticable or inappropriate that the person be brought before it. Under such circumstances the person's legal representative must be present and have an opportunity to be heard.

29. There is no provision in the 1995 Act for the patient to not attend the court where the court is making a final disposal. If the person's mental condition is such that it may be detrimental to his/her health to appear in court the medical practitioner would be expected to inform the clerk of the court so that another diet may be arranged.

SUSPENSION OF DETENTION

Overview

30. Suspension of detention was called 'leave of absence' under the 1984 Act. Part 13 of the 2003 Act sets out the statutory procedures for the suspension of the measure in the order specifying detention of a patient who is subject to an assessment order (section 52D), a treatment order (section 52M), an interim compulsion order (section 53), a compulsion order with a restriction order (sections 57A and 59), a hospital direction (section 59A) and a transfer for treatment direction (section 136 of the 2003 Act). Section 179 of the 2003 Act sets out the procedures for suspending the detention of a patient who is subject to a compulsion order without a restriction order.

31. Suspension of detention may be requested for a number of reasons, including:

- attendance at court
- rehabilitation including pre-transfer visits to another hospital
- quality of life
- compassionate visits
- scheduled treatment in hospital
- emergency treatment in hospital

32. It would be expected that any proposed suspension of detention would generally form part of an agreed care plan and so should be a matter of consultation between the RMO, the MHO and the rest of the multi-disciplinary team where relevant and appropriate, as part of the care planning process. The MHO would be expected to consult, and consider the implications for, the patient, the primary carer, the named person or care provider, and any significant care provider that may be supporting or supervising the patient during the period of suspension. The MHO would also take into account any relevant victim issues or community concerns related to the index offence. Any child protection matters should be considered and requirements in terms of registration in relation to the Sexual Offences Act 2003.

Assessment Order

The granting of the certificate (section 221(2))

Consent of the Scottish Ministers

33. Where a patient is subject to an assessment order the RMO may grant a certificate, suspending for a period, the measure in the order which authorises detention under section 221(2) after the RMO has obtained the consent of the Scottish Ministers in accordance with section 221(3).

34. It would be expected that the Scottish Ministers' consent would be sought by way of an application which would address the matters set down in sections 221(4) to (6) but there may also be other non-statutory issues that the Scottish Ministers would require to be covered. Best practice would suggest that, where the RMO is unfamiliar with the process and the administrative procedures involved he/she should contact the Health Department of the Scottish Executive for further information prior to making the application.

The certificate
35. After obtaining the approval of the Scottish Ministers in accordance with section 221(3) the patient's RMO may grant a certificate specifying a period during which the assessment order does not authorise detention in hospital (section 221(2)). In terms of section 221(4) the period specified may be expressed as

- the duration of an event; or a series of events, or
- the duration of an event; or a series of events, and any associated travel.

36. Conditions may be included in the certificate if the RMO considers it necessary in the interests of the patient, or for the protection of any other persons (section 221(5)). These conditions may include that the patient be kept in the charge of a person authorised in writing by the RMO in terms of section 221(6)(a) (such as a nurse or family member) or other conditions as may be specified by the RMO in terms of section 221(6)(b).

Revocation of the certificate (sections 222 and 223)

The circumstances in which a certificate may be revoked
37. A certificate granted under section 221(2) may be revoked by the RMO under section 222(2) or by the Scottish Ministers under section 223(2) if either is satisfied that it is necessary in the interests of the patient, or for the protection of any other person.

Notification
38. Where the RMO revokes the certificate he/she must, as soon as practicable after doing so, inform the patient, any person in whose charge the patient may have been for the purposes of section 221(6)(a) and the Scottish Ministers (section 222(3)).

39. Where the Scottish Ministers revoke the certificate they must, as soon as practicable after doing so, inform the patient, any person in whose charge the patient may have been for the purposes of section 221(6)(a) and the RMO (section 223(3)).

Treatment Order
Interim Compulsion Order

40. The procedures for the suspension of detention in relation to a treatment order (section 52M) and an interim compulsion order (section 53) are the same as those for a compulsion order with a restriction order (sections 57A and 59), a hospital direction (section 59A) and a transfer for treatment direction (section 136 of the 2003 Act). For further information on these procedures refer to Part 2, Chapter 5 of this Code of Practice.

ABSCONDING

41. *[Section 310 of the 2003 Act confers on the Scottish Ministers a power to make regulations addressing absconding by patients detained under the 1995 Act. For further information on the policy intentions which are being considered with respect to these regulations, refer to volume 2 of the Regulations Policy Proposals Consultation Document.]*

MEDICAL TREATMENT

42. Procedures related to the giving of medical treatment to patients subject to certain orders under the 1995 Act are set out under Part 16 of the 2003 Act. The following sets out the applicability of Part 16 to the various provisions for mentally disordered persons involved in criminal proceedings.

43. In general terms only orders that require two medical recommendations, one of which is by an approved medical practitioner, allow medical treatment under Part 16; but any order allowing detention in hospital permits emergency treatment under section 243 of the 2003 Act.

Assessment order (section 52D)
Medical treatment under Part 16 may be given if this is determined to be in the patient's best interests by an approved medical practitioner who is not the patient's RMO and this determination is recorded in writing (see section 242(5)(b) of the 2003 Act).

Treatment order (section 52M)
Medical treatment may be given in accordance with Part 16 if this is determined to be in the patient's best interests by the patient's RMO.

Committal to hospital under section 200
The giving of medical treatment under Part 16 is not authorised. Section 243 of the 2003 Act (urgent medical treatment) does apply. If non-urgent compulsory medical treatment is necessary then it would be best practice to follow the same procedure as outlined above for assessment orders.

Interim compulsion order(section 53)
Medical treatment may be given in accordance with Part 16 if this is determined to be in the patient's best interests by the patient's RMO.

Compulsion order (section 57A)
Medical treatment may be given in accordance with Part 16 if this is determined to be in the patient's best interests by the patient's RMO.

Restriction order (section 59)
Medical treatment may be given in accordance with Part 16 under the compulsion order attached to the restriction order if this is determined to be in the patient's best interests by the patient's RMO.

Hospital direction (section 59A)
Medical treatment may be given in accordance with Part 16 if this is determined to be in the patient's best interests by the patient's RMO.

Guardianship order (section 58(1A))
The Adults with Incapacity (Scotland) Act 2000 rather than the 2003 Act applies. Part 16 of the 2003 Act does not apply; compulsory medical treatment for mental disorder cannot be authorised under a guardianship order.

Intervention order(section 60B)
The Adults with Incapacity (Scotland) Act 2000 rather than the 2003 Act applies. Part 16 of the 2003 Act does not apply; compulsory medical treatment for mental disorder cannot be authorised under an intervention order.

Probation order with a requirement of treatment for mental condition (section 230)
Part 16 does not apply. Treatment can only be given with the patient's consent.

Supervision and treatment order (Section 57(2)(d) and Schedule 4)
Part 16 does not apply. Treatment can only be given with the patient's consent.

Urgent detention of acquitted person
Part 16 does not apply. Treatment can only be given with the patient's consent.

APPEALS

44. A person who is made subject to:

- a compulsion order (section 57A)
- an interim compulsion order (section 53)
- a guardianship order (section 58(1A)
- a restriction order (section 59)
- a hospital direction (section 59A)

has a right of appeal to the court under section 60 of the Act against its initial imposition in the same manner as an appeal against sentence.

45. There is no specific appeal procedure available against the making of an order, or the failure to make an order, under the following provisions:

Section 52D (assessment order)
Section 52M (treatment order)
Section 200 (committal to hospital)
Section 54(1) (temporary compulsion order)

46. In cases involving insanity, a person who is made subject to:

- a finding made under section 54(1) that he/she is insane so that his trial cannot proceed or continue, or the refusal of the court to make such a finding
- a finding under section 55(2) that he/she did the act or made the omission constituting the offence and that there are no grounds for acquitting him/her
- an insanity disposal in terms of section 57(2)

has a right of appeal under section 62. This right is without prejudice to the person's right of appeal under section 74 against any decision made at a first or preliminary diet. However in relation to insanity disposals in terms of section 57(2), the right of appeal here supersedes the general right of appeal under section 60 as detailed above.

MEDICAL EVIDENCE

47. Section 61 sets out the requirements as to the medical evidence on which courts should base their decisions as to the making of orders. For some orders these requirements are set out under the sections dealing with the making of the specific order (i.e. a supervision and treatment order (section 57(2)(d) and Schedule 4)) and a probation order with a requirement of treatment for mental condition(section 230)).

Do the medical practitioners need to be approved under section 22 of the 2003 Act?

48. At least one of the two medical practitioners giving evidence to be taken into account for finding or making the following must be approved:

- insanity in bar of trial (section 54(1))
- temporary compulsion order (section 54(1)(c))
- treatment order (section 52M)
- interim compulsion order (section 53)
- compulsion order (section 57A)
- guardianship order (section 58(1A)
- hospital direction (section 59A)
- an order under authorizing detention of an acquitted person for medical examination (section 60C)

49. For the making of the following order both medical practitioners giving evidence must be approved:

- a supervision and treatment order (section 57(2)(d), paragraph 2(1)(b) of Schedule 4)

50. For the making of the following orders medical evidence is only required from one medical practitioner who does not have to be approved:

- assessment order (section 52D)
- committal to hospital following conviction for inquiry into mental condition (section 200)

51. For the making of the following order medical evidence is required from one approved medical practitioner:

- probation order with a requirement of treatment for a mental condition (section 230)

Must there be evidence from the medical practitioner or psychologist who will be responsible for the assessment or treatment of the patient if the order is made?

52. This is good practice in all cases. However where the medical practitioner who will be responsible for the patient’s care or his/her representative (i.e. a medical practitioner working at the same hospital or for the same Health Board) does not give evidence, the medical practitioners making recommendations would be expected to consult him/her or his/her representative to:

- seek his/her agreement to accepting the patient under his care
- ascertain that arrangements have been made for the patient to be received under the relevant order

53. Section 61(1A) sets out that before making one of the following orders or directions one of the medical practitioners giving evidence must be employed by the hospital which is to be specified in the order or direction:

- temporary compulsion order (section 54(1)(c))
- treatment order (section 52M)
- interim compulsion order (section 53)
- compulsion order (section 57A)
- hospital direction (section 59A)

54. In most circumstances it would be expected that this would be the medical practitioner who would be appointed as the patient's RMO in terms of section 230 of the 2003 Act. In relation to a patient who is subject to a temporary compulsion order (where there is no statutory duty on the hospital managers to appoint an RMO) the medical practitioner would be expected to be the one under whose care the patient will be treated.

55. For the making of a probation order with a requirement for treatment for a mental condition under section 230, where the treatment is not going to be given by or under the supervision of that medical practitioner, then there must also be evidence from the registered medical practitioner or the chartered psychologist by or under whom the treatment will be given that the treatment is appropriate (section 230(3)(a)).

Oral or written evidence?

56. For the making of all the relevant orders the statute states that the evidence given by medical practitioners may be written or oral. In the majority of cases the evidence would be expected to be in the form of a written report. In certain cases oral evidence may be given where a written report has not been submitted. For example where a medical practitioner has carried out an urgent assessment of a person immediately prior to the court appearance. However in such circumstances written reports would also be submitted as soon as practicable.

57. Under some circumstances oral evidence may need to be given in addition to submitting a written report. For example:

- if the court wishes to make a restriction order it must hear oral evidence from the approved medical practitioner whose evidence has been taken into account in making the accompanying compulsion order (section 59(2))
- if the court requires clarification about any aspect of a report
- if there are differing opinions expressed by different medical practitioners
- under section 61(4)(c) the accused may require that a medical practitioner who has prepared a report is called to give oral evidence, and evidence to rebut the evidence in the report may be called by or on behalf of the accused

How should a second report be commissioned where this is necessary?

58. Under some circumstances (described above) a second report by a medical practitioner may be required so that the court can act on a recommendation. The medical practitioner preparing the first report may be in a position to identify a medical practitioner who would be able to prepare this second report. The prosecutor or court may then be contacted so that a formal written request can be made for this medical practitioner to prepare the second report.

Where two or more reports are required should there be consultation between the report writers?

59. Where more than one report is required or is being prepared in a particular case then it would be expected that the medical practitioners preparing the reports would consult each other regarding the appropriate disposal to recommend. This would prevent a situation arising where a court cannot act on the recommendations as there are not two appropriate medical recommendations.

Is it acceptable for the two reports to be prepared by doctors working in the same unit or hospital?

60. It would usually be preferable for the two reports to be prepared by medical practitioners working in different units. If the order being recommended is for detention at a state hospital or another hospital outwith the patient's area of residence, then it would be expected, if possible, that one report should be prepared by a medical practitioner from the admitting hospital and the other by a medical practitioner from the person's area of residence. However, this may not be practical in all cases, so in some cases reports may be prepared by medical practitioners from the same unit or hospital.

What should a medical practitioner do when assessing a person involved in criminal proceedings?

61. The request for the assessment, whether from the prosecutor, the court or on behalf of the accused, would be expected to allow enough time for arrangements to be made to interview the person, examine relevant documents and prepare a written report. Where there is not enough time for this process to be undertaken thoroughly then this may affect the quality of the report produced. Therefore urgent requests for reports which do not allow enough time for a thorough assessment would only be expected to be made where there are good reasons for this, and this would usually be discussed directly between the person commissioning the report and the medical practitioner.

62. The medical practitioner should arrange to interview the person, whether this is in hospital, prison or the community. The medical practitioner would be expected to explain to the person:

- who has requested the report
- the nature of the interview
- the purpose of the interview

- the limits of confidentiality

63. The medical practitioner should seek the person's consent to:

- carry out the interview
- to prepare the report
- to contact any other person for further information
- to access relevant documents or records

The medical practitioner should then prepare a written report as set out below. Even if the medical practitioner is to give oral evidence, a written report should be submitted.

What should the medical practitioner do if the person refuses to be examined and/or does not have capacity to consent to be examined?

64. If the person refuses to be examined the medical practitioner would be expected to attempt to ascertain whether the person has capacity to refuse. This may be assessed from the person's presentation when attempts are made to speak to him/her, from background information from hospital staff, prison staff or others who know the person well. In most circumstances the person will usually have capacity to refuse. In such circumstances the medical practitioner should inform the court that the person refused to be examined, and should not give any further information about the person.

65. If the person appears to be suffering from mental disorder such as to make him/her incapable of refusing to allow an assessment to be undertaken and reported, then the medical practitioner would be expected to carry out an assessment based on

- any contact that is possible with the person
- information from staff or others who know the person's background or recent circumstances
- information from relevant documents

66. When reporting such an assessment the medical practitioner should state in his report that the person refused to be examined but appeared to have incapacity in relation to this decision.

67. If the person does not refuse to be assessed, but nevertheless appears to be suffering from mental disorder such as to make him incapable of consenting to the assessment to be undertaken and reported, then the medical practitioner should undertake the necessary assessment and state in his report that the person was incapable of consenting to the assessment.

What may be covered in the report?

68. Reports would be expected to state the circumstances of the assessment, lay out the information on which the conclusions in the report are based, state the conclusions of the medical practitioner by way of an opinion and recommendation and would state the status of the medical practitioner.

69. The following sets out a comprehensive list of non-statutory matters that may be included in a psychiatric report on a person involved in criminal proceedings. Not all of the issues may be relevant in every case. For example:

- where there is little information available and the recommendation is for an assessment order (section 52D) or a committal to hospital under section 200 then the report may be relatively brief, focusing on the issues of relevance to the making of the order

- where the person has been convicted, consideration of insanity in bar of trial, insanity at the time of the offence and diminished responsibility (in murder cases) is irrelevant

- where a report is updating a previous report prepared in the same case relating to the same offence (or alleged offence), or is recommending the extension of an order (such as an interim compulsion order, an assessment order or a committal to hospital). then the report may be relatively brief, as long as it addresses whether the person fulfils the criteria for that order and why extension is necessary

Matters that would be expected to be addressed in a psychiatric report

70. *Preliminary information:*
- at whose request the assessment was undertaken, circumstances of assessment (place, time, any constraints on assessment such as inadequate time to complete assessment due to prison routine),
- sources of information used (interview with the person, interviews with others, documents examined)
- the person's capacity to take part or refuse to take part and understanding of the limits of confidentiality.
- if any important sources of information could not be used, there should be a statement as to why this was the case.

Background history:
- family history
- personal history
- medical history
- psychiatric history
- recent social circumstances
- personality
- forensic history

Circumstances of offence or alleged offence

Progress since offence or alleged offence

Current mental state

Opinion: would cover all or some of the following matters
- fitness to plead

- presence of mental disorder currently and whether the criteria for the relevant order are met
- presence of mental disorder at the time of the offence:
  - the relationship between any mental disorder and the offence (this is still relevant even if the person has been convicted as it may affect the choice of disposal)
  - whether the person was insane at the time of the offence
  - in murder cases, whether there are grounds for diminished responsibility
- assessment of risk
  - the risk of harm to self or others
  - the risk that the person might pose of re-offending
  - the relationship between this risk and any mental disorder present
  - does the person require to be managed in a secure setting, and if so should this be at a state hospital?
- what assessment or treatment does the person require?
  - does the person need further assessment?
  - where? Does the person need a period of in-patient assessment and at what level of security
  - why? What issues remain to be clarified?
- does the person require treatment for a mental disorder or condition?
  - what treatment do they need and where?
- state any matters that are currently uncertain and the reasons they remain uncertain

Recommendation:

- should the court consider using any particular order?
- if so what arrangements have been made for the person to be received in hospital or elsewhere under this order?
- whose care will the person be under?
- consider whether an alternative order may be appropriate if circumstances change so that the order recommended above cannot be acted on. For example:
  - if the person is or is not found to be insane
  - if the person is or is not convicted

Medical practitioner's qualifications etc:

- name
- current post
- current employer
- qualifications
- fully registered with the General Medical Council
- approved under section 22 of the 2003 Act and with which health board
- a statement that the report is given on soul and conscience
- a statement as to whether the medical practitioner is related to the person
- a statement as to whether the medical practitioner has any pecuniary interest in the person's admission to hospital or placement on any community based order
- the medical practitioner should sign the report

THE SOCIAL CIRCUMSTANCES REPORT

71. In accordance with section 231 of the 2003 Act the MHO designated in terms of section 229 of the same Act must provide the RMO and the MWC with a report on the social circumstances of a person who is made subject to the following orders:

- assessment order (section 52D)
- treatment order (section 52M)
- interim compulsion order (section 53)
- compulsion order (section 57A)
- hospital direction (section 59A)
- transfer for treatment direction (section 136 of the 2003 Act)

72. The MHO must prepare the Social Circumstances Report (SCR) and send a copy to the patient's RMO and the MWC within 21 days of the order, or as the case may be, direction being made. The exception to this would be if the MHO considers that the report would serve little or no purpose; this could be where the MHO has already recently prepared an SCR in relation to a previous order. For example where an SCR has been prepared in relation to an assessment order, it may be unnecessary to provide a further one if the person is subsequently made subject to a treatment order. Where the MHO has decided not to prepare a report he/she must record his/her reasons for reaching this decision and send a statement of those reasons to the RMO and the MWC in accordance with section 231(2) of the 2003 Act. For further information about SCRs in general refer to Volume 1, Chapter 11 of the Code of Practice.

73. With regard to mentally disordered offenders in particular, when preparing the SCR, some additional specific issues that the MHO would be expected to consider in relation to the following orders are:

Assessment Order (section 52D)
- identify if a treatment order may be required.

Treatment Orders (section 52M)
- what are the elements of any required on-going care and treatment plan?
- are appropriate services available?
- are compulsory powers required and appropriate?
- identify and detail the powers of compulsion required

Interim Compulsion Orders (section 53)
- do the circumstances of the case require consideration of a restriction order?
- do the circumstances of the case require consideration of a hospital direction?

Compulsion Orders (section 57A)
- the requirements of this SCR should mirror those for a CTO.

74. In circumstances where an MHO report has been prepared under section 57C (MHO Report and compulsion orders) or 59B (MHO Report and hospital directions), best practice would suggest that it the SCR would refer to the content and the recommendations of that

report, particularly with regard to the proposed plan of care and the intended use of the powers.

How does the Social Circumstances Report interact with the Social Enquiry Report?

75. The SCR is prepared by the designated MHO for the RMO in accordance with section 231 of the 2003 Act to inform the mental health assessment and at times, the consideration of possible mental health disposals in the case.

76. The Social Enquiry Report (SER) is prepared for the court to inform the sentencing (see paragraph 78 below). Where SCRs are being prepared pre-trial it can be rare for an SER to be requested.

77. Where an SCR is being prepared post-conviction and pre-sentence an SER may have also been requested by the court to assist in the eventual consideration of sentencing options. In general the author of the SER should always consult closely with the designated MHO for the case. Consideration would be expected to be given to the development of procedures to support appropriate information sharing in such cases, including mutual access to the respective reports subject to any necessary consent requirements.

SOCIAL ENQUIRY REPORT

78. The term "social enquiry report" does not exist in law but is used to describe reports which local authority social workers prepare and submit to the courts in carrying out their duties under section 27(1)(a) of the Social Work (Scotland) Act 1968. The 1995 Act:

- empowers the court to adjourn a case before sentence "for the purpose of enabling enquiries to be made or of determining the most suitable method of dealing with his case" (section 201(1)).
- requires the court to obtain "such information as it can about an offender's circumstances; and it shall also take into account any information before it concerning the offender's character and physical and mental condition" before imposing a first sentence of imprisonment on any offender aged 21 or over. A sentence may be imposed only if the court is of the opinion that no other method of dealing with the offender is appropriate. (section 204(2)).
- requires the court to obtain a report regarding the circumstances and character of the offender and arrangements for supervision before making a Probation Order (section 228(1)(b)).
- requires the court, where a person specified in section 27(1)(b)(i) to (vi) of the Social Work (Scotland) Act 1968 commits an offence, to obtain a report as to the circumstances of the offence; and the character of the offender, including his behaviour while under the supervision, or as the case may be subject to the order, so specified in relation to him. (section 203).

79. The purpose of the report is to provide the court with information and advice which will assist sentencing. The report provides information about the offender and his/her personal and social circumstances. On the basis of a risk and needs assessment the report

also advises the court on the suitability of an offender for a community based disposal, particularly those which local authorities supervise on behalf of the courts.

PART 2

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CHAPTER 1: COMPULSION ORDERS (PART 9)

Introduction

This chapter examines the procedures to be followed in the review, variation, extension and revocation of a CO, as laid out in Part 9 of the Act. These procedures are very similar to those for a CTO in relation to patients subject to civil proceedings under Part 7 of the Act. Rather than duplicating the information contained in Volume 1, Chapters 5 and 6 of the Code of Practice for the Act which describes these procedures for a CTO, this chapter simply points out where the two procedures are different. Therefore Volume 1, Chapter 5, should be followed taking into account these differences.

The chapter begins by setting out the differences in the procedures.

It then outlines the RMO's duty to prepare a care plan, followed by the processes associated with the formal reviews of a CO.

Finally the chapter includes a table which sets out the analogous procedures for a CO and a CTO and the corresponding sections of the Act and the Code of Practice for Part 7.

OVERVIEW

1. A CO may be imposed by a court under section 57A of the 1995 Act where a mentally disordered person is convicted of an offence which is punishable by imprisonment. The order may authorise compulsory measures either in hospital or in the community for a period of 6 or 12 months depending on if and when it is being renewed. For information and guidance on the procedures prior to the imposition of a CO refer to Part 1, Chapter 5 of this document.

DIFFERENCES BETWEEN A CO AND A CTO

2. The processes that should be followed in the operation of a CO once imposed are very similar to those for a CTO in relation to patients subject to civil proceedings under Part 7 of the 2003 Act. Therefore the sections of the Code of Practice for the 2003 Act that cover the operation of a CTO (Volume 1, Chapters 6, 7 and 8) should be followed, **taking into account the following differences in procedure.**

3. A CTO is granted by the Tribunal under section 64(4)(a) of the 2003 Act following the submission of an application, a mental health officer's report and a proposed care plan by the designated MHO, and mental health reports by two medical practitioners. A CO is made by a criminal court under section 57A(2) of the 1995 Act following recommendations by two medical practitioners (section 57A(2)(a) of the 1995 Act); and an MHO report (section 57C of the 1995 Act).

4. As soon as practicable after a CTO has been made, the patient's RMO is under a duty to prepare a care plan in accordance with section 76(1) of the 2003 Act. Following the

imposition of a CO the patient's RMO must prepare a care plan in accordance with section 137(2) of the 2003 Act. There is no statutory provision for a proposed care plan to have been submitted to the court by the designated MHO prior to the imposition of the CO although the order must specify the measures that the court authorises and these will cover the patient's health and social care requirements.

5. The care plan prepared after the CTO has been made sets out the forms of care and treatment for the mental disorder which it is proposed to give to the patient for the duration of the CTO and which are currently being given to the patient. The care plan for a CO contains the same core information as the care plan for a CTO.

6. *[The full contents of the care plan, along with information as to which elements of the care plan may not be amended by the RMO, may be prescribed in regulations by way of section 137(5) and (6) of the 2003 Act. For further information on the policy intentions which we are considering with respect to these regulations, see Volume 2 of the Regulations Policy Proposals Consultation Document.]*

7. A CTO can specify "recorded matters" (section 64(4)(a)(ii). These are particular types of medical treatment, community care services, relevant services or any other form of treatment, care or service which the Tribunal wishes to mark out as being essential to the care package for the patient. There is no provision in the 2003 Act for a CO to specify recorded matters. Best practice would suggest however that where any treatment, care or service(s) is regarded as being essential for the care package of a patient subject to a CO, this should be described as such in the patient's care plan.

8. The criteria considered in the imposition of, or renewing a CO, are identical to those for the granting of a CTO, except that for a CO the criterion set down in section 57(3)(d) of the 2003 Act does **not** apply. Quoting from section 57(3) of the 2003 Act, this criterion is:

> that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired; and

9. At the first mandatory review of a CTO, if the RMO concludes that the order should be extended for a further 6 months (where no variation to any of the measures or recorded matters specified in the order is required), he/she may make a determination under section 86(1) of the 2003 Act to extend it without any recourse to the Tribunal. At the first mandatory review of a CO, if the RMO concludes that the order should be extended for a further 6 months (regardless of whether a variation to any of the measures specified in the order is required), he/she must apply to the Tribunal in terms of section 148(3) as read with section 149 of the 2003 Act. This is because, unlike a CTO, the Tribunal did not review the patient's case at the time of the imposition of the order given that the order was imposed by a criminal court.

10. However, as for a CTO, all further extensions (where no variation is proposed) may be made without referral to the Tribunal under section 152(2) of the 2003 Act.

11. These differences are covered in detail in the rest of this chapter but otherwise the Code of Practice for the 2003 Act, Volume 1, Chapter 7 should be followed.

12. The table on pages 163 to 165 sets out the analogous sections of the 2003 Act and the corresponding sections of Volume 1 of the Code of Practice for the 2003 Act for a CO and CTO.

THE PART 9 CARE PLAN

Before a CO is imposed

13. Although the procedures prior to the imposition of a CO by a court do not include a statutory requirement for the preparation of a proposed care plan (as they do for a CTO under section 62 of the 2003 Act), it would be expected that a patient's future care plan would be considered by the RMO and the MHO and drawn up prior to a recommendation for a CO being made to the court. Indeed aspects of the future care plan, such as the consideration of, and recommendations for, compulsory measures to be applied, form part of the medical reports and the MHO report submitted to the court under sections 57A and 57C of the 1995 Act respectively. (See Part 1, Chapter 5 of this document).

RMO duties after a CO is imposed

14. The patient's RMO must, in accordance with section 137 of the 2003 Act, prepare a care plan setting out the forms of care and medical treatment for the mental disorder which it is proposed to give to the patient for the duration of the CO and which are currently being given to the patient.

15. Best practice would suggest that, in most cases, there would have been a multi-disciplinary assessment, involving the RMO, the MHO, a suitably qualified chartered psychologist where appropriate, (for example where the patient has learning disability or a personality disorder), and the rest of the multi-disciplinary team, prior to the recommendation for a CO being made to the court. It would be expected that the 'future' Part 9 care plan would therefore already have been considered in detail. The RMO should therefore be in a position to prepare the Part 9 Care Plan under section 137 of the 2003 Act soon after the CO has been imposed.

16. If this is not the case, it would be expected that there would be a multi-disciplinary review soon after the imposition of the CO, involving the RMO, the MHO and rest of the multi-disciplinary team so that the details of the care plan may be agreed and set out.

17. The procedures associated with the preparation of the care plan and the core information contained in it are identical to those for a CTO.

18. Procedures relating to the amendment of the Part 9 care plan by the RMO under section 137(4) of the 2003 Act are identical to those for a CTO under section 76(3).

REVIEWING THE CO

What are the criteria which must be considered when reviewing a CO?

19. The criteria against which a patient's mental health must be judged when any review of a CO is being carried out are identical to those for a CTO except for the absence of the criterion set down in section 57(3)(d) as detailed in paragraph 8 above. There is therefore no requirement to assess the ability of a patient to make decisions about the provision of his/her medical treatment before renewing a CO. (It should be noted that the patient's 'decision-making' ability with respect to medical treatments covered by Part 16 of the 2003 Act will be relevant when considering specific medical treatments but not for the renewal of the CO itself).

Renewal of a CO after the first 6 months

20. The procedures to be followed by the RMO and MHO at the first mandatory review of a CO (section 139 of the 2003 Act) are identical to those for a CTO (section 77 of the 2003 Act), as detailed in Volume 1, Chapter 5, paragraphs 1 to 23 of the Code of Practice to the 2003 Act. Where the procedures differ is where the RMO concludes that the CO should be renewed; rather than renewing it at his/her own initiative by issuing a determination (as the RMO would do for a CTO under section 86 of the 2003 Act), the RMO must make an application to the Tribunal seeking an extension of the CO under section 149 of the 2003 Act.

21. The RMO can make the application to the Tribunal (section 149) for an order extending the CO (section 167) only when he/she has complied with the following duties in accordance with section 148:

- he/she has notified the patient's MHO of the intention to make the application to the Tribunal to extend the CO (section 146(2)) and has had regard to the views of the MHO with regard to the proposed application (section 148(2)(b))
- he/she has had regard to the views of any other persons involved in providing treatment, care or other services to the patient with regard to the proposed application (sections 148(2)(a);
- he/she is satisfied that it continues to be necessary for the patient to be subject to a CO and that the order should not be varied (section 146(2)(a) and(b))

22. Best practice would suggest that the RMO should make this application as soon as practicable after the need to make the application arises.

23. An application made under section 149 of the 2003 Act must state the following points:

- the patient's name and address;
- the named person's name and address;
- whether the patient's MHO agrees or disagrees with the RMO's application to extend the order or has failed to comply with the duty to inform the RMO of his/her opinion.

24. [The application to the Tribunal for extension of a CO is to be accompanied by such other documents which may be prescribed by regulations. For further information on the

policy intentions we are considering with respect to these documents, please see Volume 2 of the Regulations Policy Proposals Consultation Document.]

25. If the RMO is seeking to vary the original compulsory measures in the CO in addition to extending the order he/she must apply to the Tribunal in accordance with section 158, not section 149 as stated in paragraph 21. This procedure mirrors that for the extension and variation of a CTO so the information contained in Volume 1, Chapter 7, paragraphs 48 to 54 applies.

The CO and CTO analogous procedures

26. Apart from the matters outlined above, procedures relating to the CO mirror those relating to the CTO. For information on these procedures refer to Volume 1 of the Code of Practice to the 2003 Act, Chapters 5, 6 and 7 bearing in mind the differences outlined in this chapter.

27. The table over page sets out the analogous sections and the corresponding information in Volume 1 of the Code of Practice for the 2003 Act.

Procedure	CO section no	CTO section no	Code of Practice Part 7			Comments
	2003 Act	2003 Act	Chap	Page	Para	
Part 9 care plan	137	76	5 6	79-80 90 91	53-61 11-14 19-20	The proposed care plan (s.62) and the care plan (s.76) for a CTO is relevant to the Part 9 care plan bearing in mind the differences noted on page 7 of this chapter
MHO's duties subsequent to a CO being imposed	138 231	59 231	6	73 90-91	32-36 15-18	
First review of CO	139	77	7	95	7-10	Different review criteria for a CO as noted on page 8 of this chapter
Further reviews of CO	140	78	7	95	7-10	As for first review
RMO's duty to revoke CO: mandatory reviews	141	79	7	96	14	
Revocation of CO: RMO's duty to keep under review	142	80	7	96	11-13	
MWC's power to revoke CO	143	81	7	97	17-19	
Revocation of CO: notification	144	82	7	97	15	
Mandatory reviews: further steps to be taken where CO not revoked	145	83	7	98	20-23	
First review: RMO's duty where extension proposed	146	84	7	99	25-29	No recorded matters in a CO
Proposed extension on first review: MHO's duties	147	85	7	99	25-29	
First review RMO's duty to apply for extension of CO	148	N/A	N/A	N/A	N/A	No equivalent for CTO as there is no automatic application to the Tribunal on first renewal
Application to Tribunal for extension of order following first review	149	N/A	N/A	N/A	N/A	
Further review: RMO's duty where extension proposed	150	84	7	99	25-29	No recorded matters in a CO
Proposed extension of order on further review: MHO's duties	151	85	7	99	25-29	
Further reviews: RMO's duty to extend CO	152	86	7	99	25-29	
Determination extending CO: notification	153	87	7	100	30-35	
RMO's duty where extension and variation proposed	154	88	7	103	41-47	
MHO's duties: extension	155	89	7	103	41-47	No recorded matters

and variation of CO						in a CO
RMO's duty to apply for extension and variation of CO	156	90	7	104	48-51	No recorded matters in a CO
Application for extension and variation of CO: notification	157	91	7	103	41-47	
Application to Tribunal for extension and variation of CO	158	92	7	104	48-51	No recorded matters in a CO
RMO's duties: variation of CO	159	93	7	107	57-60	No recorded matters in a CO
Application for variation of CO: notification	160	94	7	107	59-60	
Application to Tribunal by RMO	161	95	7	107	61-64	
Commission's power to make reference to Tribunal	162	98	7	111	79-81	
Application to Tribunal by patient etc. for revocation of determination extending CO	163	99	7	112	85-87	
Application to Tribunal by patient etc. for revocation or variation of CO	164	100	7	112	85-87	No recorded matters in a CO
Tribunal's duty to review determination under section 152	165	101	7	101	36-39	
Powers of Tribunal on review under section 165	166	102	7	101	36-39	No recorded matters in a CO
Powers of Tribunal on application under section 149, 158, 161, 163 or 164	167	103	7	105	52-53	No recorded matters in a CO
Interim extension etc. of order: application under section 149	168	105	7	105	54	No recorded matters in a CO
Interim variation of order following application, reference or review under Chapter	169	106	7	105	54	No recorded matters in a CO
Limit on power of Tribunal to make interim order	170	107	7	106	55	
Powers of Tribunal on reference under section 162	171	104	7	112	82-84	No recorded matters in a CO
Tribunal's order varying CO	172	108	7	109	68	No recorded matters in a CO
Applications to Tribunal: ancillary powers	173	109	7	-	-	
Effect of interim orders: calculation of time periods in Chapter	174	110	7	-	-	
Meaning of "modify"	175	111	7	-	-	No recorded matters in a CO
Medical treatment: failure	176	112	8	120	26-29	Rather than repeating

to attend						procedures from Part 7 in Part 9 these sections set out that the relevant procedures for CTOs apply in an identical way to COs
Non-compliance generally with CO	177	113-123	8	115-119	1-23	
Transfers	178	124-126				
Suspension of measures	179	127-129				
Interpretation of Part	180	N/A				

CHAPTER 2: THE COMPULSION ORDER AND RESTRICTION ORDER IN OPERATION (PART 10)

Introduction

This chapter begins by setting down the statutory criteria that is considered by a court under section 59(1) of the 1995 Act when a restriction order is imposed. It then outlines the effect of a restriction order on a compulsion order and describes how this differs from a hospital order and a restriction order under the 1984 Act.

The chapter then moves on to describe the processes which should be followed in the immediate aftermath of a compulsion order and restriction order ("CORO"), including the duty on the RMO to prepare a care plan. It also describes what would be expected of the designated MHO in relation to the provision of information to the patient in terms of sections 260 and 261.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 unless stated otherwise.

OVERVIEW

1. Part 10 of the Act governs the effect of a compulsion order when combined with a restriction order and sets out the procedures for review and conditional discharge of the patient. Section 59(1) of the 1995 Act sets down the circumstances in which a court may add a restriction order to a compulsion order.

Section 59(1) of the 1995 Act states:

Where a compulsion order authorising the detention of a person in a hospital by virtue of paragraph (a) of section 57A(8) of this Act, is made in respect of a person, and it appears to the court—

(a) having regard to the nature of the offence with which he is charged;
(b) the antecedents of the person; and
(c) the risk that as a result of his mental disorder he would commit offences if set at large,

that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the person shall be subject to the special restrictions set out in Part 10 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp13), without limit of time.

2. For guidance on the imposition of a restriction order refer to Part 1, Chapter 4 of this Code of Practice.

What effect does a restriction order have on a compulsion order?

3. Where a restriction order is added to a compulsion order:

- the patient must be detained in hospital on disposal; there is no option for initial compulsory measures to be imposed in the community
- the compulsion order is not time-limited and therefore does not need to be renewed
- neither the RMO nor the MWC has the power to revoke the orders
- suspension of the measure authorising detention and transfer to another hospital (irrespective of the levels of security) must be authorised by the Scottish Ministers
- only the Tribunal has the power to authorise the lifting of the compulsion order and restriction order and discharge (both conditional and absolute)
- patients may be conditionally discharged for an indefinite period, and are subject to recall to hospital by the Scottish Ministers during this period

How does this differ from the 'old' Hospital Order with a Restriction Order under the 1984 Act?

4. Although the Scottish Ministers keep their role of monitoring the progress of patients, authorising suspension of the measure of detention (section 224(3)), authorising transfer to another hospital (section 218(3)(b)) and varying the conditions imposed by the Tribunal on conditionally discharged patients (section 200(2)), they no longer have the power to authorise the revocation of a restriction order or a patient's discharge (both conditional and absolute).

5. Only the Tribunal has the power to instruct the revocation of a restriction order (section 193(5)) and the discharge of the patient (conditional discharge – section 193(7); absolute discharge – sections 193(3) and 193(4).

6. The Scottish Ministers are under a statutory duty in certain circumstances to refer the patient's case to the Tribunal (sections 185, 186 and 189). The Scottish Ministers can also make their own applications to the Tribunal under section 191.

7. The patient and the patient's named person may make applications directly to the Tribunal (section 192(2)).

8. The RMO must consult the designated MHO and have regard to his/her views in relation to the annual review (sections 182(3)(c) and 183), in advance of making any recommendation to the Scottish Ministers for a change to be made to the status of the patient.

9. As previously stated, the Scottish Ministers therefore retain their role in authorising the suspension of the measure of detention and the transfer of patients subject to restriction orders, but they lose their direct ability to authorise discharge. However, with the exception of applications by patients and named persons, all referrals to the Tribunal regarding patients subject to restriction orders must be made by the Scottish Ministers who therefore still have an important role. It should be noted that if the Scottish Ministers receive a recommendation from an RMO (sections 183(2) or 184), or a notification from the MWC (section 186(2)) they are under a duty to refer the case to the Tribunal in terms of sections 185(1) or 187(2); they have no discretion regarding this matter.

RESPONSIBILITIES SUBSEQUENT TO A COMPULSION ORDER AND A RESTRICTION ORDER BEING IMPOSED

10. Following the imposition of a compulsion order and a restriction order ("CORO"), the patient must be conveyed from the court to the specified hospital within 7 days of the making of the compulsion order in accordance with section 57B of the 1995 Act. This would usually be done by the Prisoner Escort and Court Custody Service. Although not a statutory provision under the Act best practice would suggest that as soon as practicable after admission the hospital managers should inform the Scottish Ministers of the patient being admitted.

11. As soon as practicable after the patient's admission to hospital the hospital managers have a duty under section 260(5)(a) to ensure that the patient and his/her named person are fully informed of, and understand the 'relevant matters' as set down in sections 260(5)(a) to (h) and also informed of the availability of independent advocacy services under section 259. For further information on these procedures refer to Volume 2, Chapter 4 (Independent Advocacy) of this Code of Practice.

12. An RMO and an MHO must be allocated to the patient under sections 230 and 229 respectively (on the occurrence of a relevant event as defined in section 232) and a multi-disciplinary assessment would be expected to be initiated. In the case of a patient who has been made subject to a CORO, an RMO and an MHO should already have been appointed given that the patient would have been assessed in hospital prior to the making of the CORO (by way of an assessment order (section 52D of the 1995 Act) and/or an interim compulsion order (section 53 of the 1995 Act)).

RMO RESPONSIBILITIES – THE CARE PLAN

13. As with cases where a compulsion order has been imposed without a restriction order the RMO must, in accordance with section 137, prepare a care plan setting out the medical care and treatment which is currently being given to the patient and the medical treatment which it is proposed will be given to the patient for the duration of the CORO (section 137(3)).

14. For further information on the care plan refer to paragraphs 5 to 6 and 13 to 18 of Part 1, Chapter 1 of this document.

15. Although not a statutory provision under the Act, it is current practice for the Scottish Ministers to request a report from the RMO three months after the admission of a patient subject to a CORO; and thereafter an annual report is requested. The care plan would be expected to form part of the RMO's report to the Scottish Ministers in every case. Best practice would suggest that, where the RMO is unfamiliar with the process and the administrative procedures involved he/she should contact the Health Department of the Scottish Executive for further information.

16. It would be expected that the RMO would send a copy of the care plan to the patient, the patient's named person/nearest relative/primary carer, the MHO, the Scottish Ministers, and the rest of the multi-disciplinary team where relevant and appropriate. The RMO would

record on the care plan who has received a copy and when the next mandatory review of the CORO is due.

17. Although not a statutory duty under the Act best practice would suggest that the RMO would, in consultation with the MHO, update the care plan at least once a year, if not more often, and send a copy to the parties mentioned in paragraph 21 at the time of the mandatory annual review of the CORO under section 182. It would be expected that a copy would be also submitted to the Scottish Ministers with any RMO report.

MHO RESPONSIBILITIES

18. As with cases where a compulsion order has been imposed without a restriction order it would be expected that the MHO (designated in terms of section 229) would work in close collaboration with the RMO and the rest of the multi-disciplinary team who are responsible for overseeing the care of the patient. The duties of the MHO after a CORO has been imposed are very similar to those of an MHO after a CTO has been granted by the Tribunal under section 64. One exception is in relation to the SCR prepared by the MHO in terms of section 231; best practice would suggest that the MHO would send a copy of the SCR to the Scottish Ministers. For information on the duties of the MHO refer to Volume 1 of this Code of Practice, Chapter 6, paragraphs 15 to 18.

CHAPTER 3
REVIEWING A COMPULSION ORDER AND A RESTRICTION ORDER
(PART 10, CHAPTER 2)

Introduction

This chapter begins by examining the formal processes to be followed where a CORO is being reviewed, as laid out in Chapter 2 of Part 10 of the Act. It explores the duty placed on the RMO to carry out a formal review of the CORO and report to the Scottish Ministers, followed by good practice points for the designated MHO in relation to the review. The possible outcomes of the review are:

- the CORO could remain unchanged;
- the restriction order could be revoked and the patient remain subject to the compulsion order, the measures in which could be varied
- the patient could be conditionally discharged with the Tribunal imposing such conditions as it thinks fit;
- the compulsion order could be revoked and the patient absolutely discharged;

The chapter goes on to describe the duty placed on the RMO and the Scottish Ministers to keep under review the continuing need for the CORO in terms of sections 184 and 188 respectively.

The remainder of the chapter covers the applications that may be made to the Tribunal by the patient and named person, and the referrals to the Tribunal that may be initiated by the MWC.

OVERVIEW OF THE REVIEW PROCESS

What are the criteria which should be used when reviewing a CORO?

1. The criteria against which a patient's mental health must be judged when any review of a CORO is taking place are referred to in section 182(3)(b) and (4) of the Act. The criteria are that:

- the person has a mental disorder ("mental disorder criterion")
- medical treatment which would be likely to prevent the mental disorder worsening, or alleviate any of the symptoms, or effects, of the disorder is available for the patient ("treatability criterion")
- if the patient were not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person ("civil risk criterion")
- as a result of the person'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 ("serious risk to others criterion")

- it continues to be necessary for the person to be subject to the compulsion order ("compulsion order necessity criterion")
- it continues to be necessary for the person to be subject to the restriction order ("restriction order necessity criterion")

2. When assessing whether the patient still meets the criteria for the CORO it must be borne in mind by the reviewer that it is his/her responsibility to demonstrate that the criteria are met. In other words, the presumption is always in favour of revoking the CORO unless the above criteria are met. The onus is therefore not on the patient to demonstrate that he/she does not meet the criteria.

3. Where it is the RMO (rather then the Scottish Ministers) who is assessing the patient against these criteria, it would be expected that he/she would be fully supported by all members of the multi-disciplinary team who are involved in providing care, support and treatment to the patient.

MANDATORY REVIEW BY THE RMO (sections 182 to 184)

Overview

4. During the 2 month period prior to the one year anniversary of the CORO being imposed, the RMO must examine the patient (or arrange for another approved medical practitioner to do so) (section 182(3)(a)), consider the review criteria set down in section 182(3)(b) and (4), consult the MHO (section 182(3)(c) and then prepare and submit a report to the Scottish Ministers in accordance with section 183.

5. Best practice would suggest that in most cases this review should be multi-disciplinary and multi-agency involving all those involved in the patient's care currently and perhaps those that might be involved in the patient's future care. The process of carrying out a mandatory review should be characterised from beginning to end by as great a sense of multi-agency and multi-disciplinary co-operation and consultation as is practicable. In that connection, it would be good practice for a full case conference to be held when a mandatory review is being carried out. It would also be good practice to use the opportunity presented by the mandatory review to review not only whether the patient still meets the criteria for compulsory powers but also the efficiency of the various reporting procedures which have been in operation since the previous mandatory review.

6. Aside from the statutory review criteria set down in section 182(3)(b) and (4) that must be considered by the RMO best practice would also suggest that there would also be other issues which, although not a statutory provision under the Act, would require to be considered and reported on to the Scottish Ministers (see 'Responsible medical officer's report to the Scottish Ministers (section 183(2)), paragraphs 11 to 17).

7. Most of these issues would be expected to be relevant to the statutory review criteria and would give a broader understanding of the progress of the patient, his/her treatment needs and the assessment and management of risk.

Medical examination

8. The statutory criteria that must be addressed in the medical examination are set out in section 182(3)(b) and (4). The RMO is under a duty to consult the MHO in accordance with section 183(3)(c) as part of the review. In addressing these criteria it would be expected that the RMO would:

- interview the patient
- discuss the patient with all members of the multi-disciplinary team where relevant and appropriate
- consider the progress of the patient over the last year
- consider the nature and circumstances of the index offence, previous offending and any other relevant incidents of concern
- consider any other relevant background information
- consider any issues requested by the Scottish Ministers

Recommendations which may result from the review of a CORO

9. In considering the statutory criteria under section 182(3)(b) and (4) the RMO's conclusions may result in his/her being under a duty to recommend to the Scottish Ministers that changes should be made to the compulsion order or the restriction order (thereby requiring referral of the patient's case by the Scottish Ministers to the Tribunal under section 185(1)). With reference to the statutory criteria as described in paragraph 1 of this chapter, it would be expected that the following recommendations would be made by the RMO:

- if the mental disorder criterion is not met the compulsion order (and therefore the restriction order) should be revoked – *absolute discharge.* (section 183(4))

- if the mental disorder criterion is met, but the treatability criterion or the civil risk criterion or the compulsion order necessity criterion is not met, and the serious risk to others criterion is not met the compulsion order (and therefore the restriction order should be revoked – *absolute discharge*. (section 183(5))

- if the mental disorder criterion, the treatability criterion, the civil risk criterion and the compulsion order necessity criterion are met, but the serious risk to others criterion and the restriction order necessity criterion are both not met then *the restriction order should be revoked*, but the compulsion order continues. (section 183(6))

- if the mental disorder criterion, the treatability criterion, the civil risk criterion, the compulsion order necessary criterion and the restriction order necessary criterion are met, but the serious risk to others criterion is not met *the patient should be conditionally discharged*. (section 183(7))

10. Where the RMO is recommending that the restriction order should be revoked (section 183(6)), he she should also consider whether the measures in the compulsion order require to be varied (section 183(8))

***RESPONSIBLE MEDICAL OFFICER'S REPORT TO THE SCOTTISH MINISTERS* (section 183(2))**

11. As soon as practicable after carrying out the review the RMO must submit a report to the Scottish Ministers in accordance with section 183(2). Sections 183(3) to 183(8) specify the recommendations that the RMO must make depending on his/her conclusions regarding the application of the statutory criteria as set down in section 182(3)(b) and (4). If the outcome of the review is that the compulsion order or the restriction order should be revoked, the RMO is under a duty to recommend this course of action in his/her report to the Scottish Ministers under section 183(4), (5) or (6).

12. The format and content of the RMO's report (aside from the information detailed in section 183(3)) is not set down in the Act. Non-statutory guidance on the report may be obtained from the Health Department of the Scottish Executive. Best practice would suggest that the report to the Scottish Ministers should detail the patient's progress in hospital since the last annual report and include the following information:

- nursing and other care
- medication
- psychological assessment and treatment
- changes in mental state since the last annual report
- MHO opinion
- social work assessment
- child protection issues
- issues in relation to sex offending registration
- patient's relations with staff and other patients
- patient's participation in activities while in hospital
- freedoms available e.g. leave in grounds, suspension of detention etc and how they are used
- patient's relations with family and friends
- plans for patient's future care
- victim and public safety issues

13. Where any of the information on the patient's background, family background, criminal record, medical history, psychiatric history or any other information previously provided to the Scottish Ministers has been important in informing the current understanding of the patient, and new information has come to light in the course of the year or where old information has been proved inaccurate, this would be expected to be set out in the report. The report should also address whether there has been a change of understanding by the multi-disciplinary team of information previously known about the patient.

14. Where detailed consideration of the risk posed by the patient and the management of this risk is of particular importance, the RMO would be expected to consider and report on:

- the level of security which the patient requires
- the factors relating to the index offence and other previous dangerous behaviour
- the potential risk factors in the future
- the patient's attitude to his/her index offence, other dangerous behaviour and any previous victims
- issues related to previous and potential future victims

- issues related to alcohol or substance misuse
- the outward evidence of change and how the patient has responded in stressful situations
- any physical, verbal or sexual aggression by the patient
- short and longer-term treatment plans
- the patient's attitude to supervision and the quality of his/her relationship with the care team.

15. Where the patient has a **mental illness** the report would be expected to address the following:
    - the relationship between dangerous behaviour and his/her mental illness
    - which symptoms of mental illness remain
    - whether the patient's condition is currently stable and whether this has been tested in various circumstances
    - issues relating to medication including effectiveness and compliance
    - the patient's insight into his/her illness and the need for treatment
    - early signs indicating relapse in the patient's illness and signs which indicate there may be an immediate risk

16. Where the patient has **learning disability** the report would be expected to address the following:
    - whether the patient has benefited from treatment or training
    - whether his/her behaviour is now more acceptable
    - whether the patient now learns from experience and takes into account the consequences of his/her actions

17. Where the patient has a **personality disorder** the report would be expected to address the following:
    - which characteristics are useful and which cause problems
    - which personality issues are considered to relate to the index offence/other dangerous behaviour
    - treatment approaches and effectiveness
    - how generalised the patient's learning has become and shows itself and how much is context specific
    - areas of functioning that continue to be a problem, how this showed in the past and present, and how it may be managed in the future

Consultation between the RMO and the MHO

18. Section 182(3)(c) requires that the RMO must consult the MHO as part of the patient's annual review. To aid this communication the designated MHO would be expected to make him/herself known to the RMO as soon as practicable after the imposition of the CORO and ensure that the RMO has his/her contact details.

19. Best practice would suggest that there should be a procedure in place to support the RMO notifying the MHO well in advance of the annual review being carried out so that the MHO has sufficient time to come to an informed opinion.

20. It would be expected that the designated MHO would maintain a sufficiently close involvement with the patient, any carer(s), and all members of the multi-disciplinary team, to ensure that the MHO has a good understanding of the patient's progress and knowledge of any events which may have a bearing on recommendations at the time of a review. The multi-disciplinary team would be expected to keep the MHO informed of any key developments in the care and/or treatment of the patient.

BEST PRACTICE POINTS FOR THE MHO

21. When forming his/her opinion in relation to the annual review of a patient subject to a CORO (section 182(3)(c)) the MHO would be expected to:

- interview the patient
- consult the named person and/or primary carer
- consult the RMO
- consult all members of the multi-disciplinary team where relevant and appropriate
- review medical and social work records
- with the patient's agreement, consult any other relevant person who is significantly involved in the patient's care and treatment.

22. When interviewing the patient and consulting the named person and/or the primary carer as outlined in paragraph 21, the MHO should ensure that each party has a clear understanding of the purpose of the review and the procedure that will be followed. The MHO should also ensure that each of the parties are aware of the possible consequences of the review in relation to recommendations that may be made to the Tribunal. The MHO should ensure that the patient is aware of the availability of advocacy services and support the patient in making arrangements to have access to these services if required. For further information refer to Volume 2, Chapter 4 (Independent Advocacy) of this Code of Practice.

23. Although not set down in the Act best practice would suggest that when forming an opinion in relation to the review of a CORO, some of the issues that the MHO should consider may include:

- does the person continue to suffer from a mental disorder? What is the psychiatric opinion and evidence in relation to this matter?
- does the person require medical treatment in a hospital? Could the treatment be provided safely and effectively in the community?
- as a result of the mental disorder does the person present a risk of serious harm to others?
- which compulsory measures are necessary to safeguard the person's care and treatment requirements, and ensure the safety of others?

24. When considering the issues listed in paragraph 23 the MHO should take into account his/her own direct knowledge of the patient (for example the patient's presentation, capacity and capabilities), the patient's understanding of the mental disorder or diagnosis and the patient's attitude towards any ongoing treatment that may be required.

25. In relation to the assessment and management of risk, matters that the MHO would be expected to give careful consideration to may include:

- the original circumstances that led to the person being made subject to the CORO
- the needs which were identified in the original care plan, and the extent to which these have been met
- progress that has been achieved during the period of care and treatment.
- any potential risks which still require management with powers of compulsion.
- the person's history of drug or alcohol misuse, and any implications this may have in relation to the person's behaviour.

- victim issues, including the person's attitude towards his/her offending; evidence of victim empathy; possible risks from previous victims or associates;
- the person's historical and current attitude towards complying with services and treatment

26. When forming his/her opinion the MHO should bear in mind the different outcomes that may result from the annual review of the CORO and give full consideration to their implications, these being: no change to the CORO; the revocation of the restriction order (with or without a variation to the compulsion order); conditional discharge or absolute discharge

The revocation of the restriction order

27. When forming his/her opinion on whether the restriction order should be revoked it would be expected that the MHO would consider the criteria applied by the RMO under section 183(6). With reference to the statutory criteria as described in paragraph 1 of this chapter, it would be expected that in reaching this conclusion the MHO would be satisfied that the mental disorder criterion, the treatability criterion, the civil risk criterion and the compulsion order necessity criterion are met, but the serious risk to others criterion and the restriction order necessity criterion are both not met.

28. Best practice would suggest that before a recommendation is made to the Scottish Ministers for the restriction order to be revoked there would be agreement on this point between the RMO, the MHO and all members of the multi-disciplinary team where relevant and appropriate.

29. It would be expected that the MHO would also be satisfied that the person's ongoing care and treatment can only be safely and adequately managed by compulsory measures, whether in hospital or in the community. In forming this opinion the MHO would give careful consideration to his/her own knowledge of the patient and to that of the RMO, the multi-disciplinary team and the patient's carer (if appropriate).

30. If the Tribunal subsequently revoke the restriction order under section 193(5) the patient's future care and treatment would be managed under the same arrangements that apply to any patient on a compulsion order under Part 9 of the Act.

Conditional discharge

31. Before conditional discharge is considered as a possibility for a patient subject to a CORO it would be expected that the patient would already have undergone periods during which his/her detention in hospital had been suspended under section 224. This practice allows the patient to have a graduated experience of rehabilitation to the community, and it provides an informed basis for all members of the multi-disciplinary team to formulate the requirements of the future care plan and proposed conditional discharge.

32. When forming his/her opinion on whether the patient should be conditionally discharged it would be expected that the MHO would consider the criteria applied by the RMO under section 183(7)(a) and (b). With reference to the statutory criteria as described in

paragraph 1 of this chapter, it would be expected that in reaching this conclusion the MHO would be satisfied that the mental disorder criterion, the treatability criterion, the civil risk criterion, the compulsion order necessity criterion and the restriction order necessity are met, but the serious risk to others criterion is not met.

33. The MHO would be expected to be satisfied that the patient's care and treatment requirements, and the protection of others, can be safely and effectively provided for and managed in the community. It would be expected that a comprehensive care plan informed by a full community care assessment detailing need and risk management requirements would be prepared and the services that would be necessary to support the care plan would be identified and their provision agreed. These may include accommodation; levels of support and supervision; programme of structured activity; and any other relevant requirements that will form part of the proposed conditional discharge.

34. In the interests of good practice the RMO, the MHO, and the rest of the multi-disciplinary team, should bear in mind that planning and commissioning appropriate community services can require significant time, particularly in complex cases. Therefore in cases where conditional discharge is a possibility, it would be expected that the patient would be kept informed about realistic timescales and possible outcomes of the annual review.

35. Given that an MHO and an RMO will have been allocated to the patient's case from the time of the imposition of the restriction order, or earlier, under sections 229 and 230 respectively, it would be expected that joint assessment and care planning for a proposed conditional discharge would be able to be commenced well in advance of a recommendation for conditional discharge being made to the Scottish Ministers by the patient's RMO under section 183(7). Best practice would suggest that planning for a conditional discharge should conform with any local health and social work procedures that are in place which apply to planning for the discharge of a patient from hospital.

Absolute discharge

36. When forming his/her opinion on whether the patient should be absolutely discharged it would be expected that the MHO would consider the criteria applied by the RMO under section 183(4) and (5). With reference to the statutory criteria as described in paragraph 1 of this chapter, it would be expected that in reaching this conclusion the MHO would be satisfied that:

- the mental disorder criterion is not met; or
- the mental disorder criterion is met, but the treatability criterion or the civil risk criterion or the compulsion order necessity criterion is not met, and the serious risk to others criterion is not met

37. Best practice would suggest that the MHO may also wish to consider the following:

- the patient's current needs for care, treatment and support
- the extent to which these needs will continue to be adequately met by a suitable care plan
- the patient's own opinion about his/her need for any required ongoing care and treatment
- the implications for the provision of future care and treatment, if the powers of

compulsion or conditional discharge are removed

- the risks, if any, which may arise if the patient were to disengage from services in future.
- the risks, if any, which may result from any future deterioration in the patient's health or behaviour
- the contingency plans, if any, that require to be put in place to respond to the patient's possible future disengagement from services or deterioration in health and the patient's awareness of these plans
- is the person properly provided with information about how to seek assistance or access to services in future?
- the views of the named person, primary carer, or others who may have a significant involvement with the patient
- the views of any current service providers, particularly where it is expected that such services will continue to support the patient in future.

38. A recommendation for the absolute discharge of a patient subject to a CORO would usually be expected to follow a successful period of the patient being conditionally discharged under section 193(7).

OTHER REVIEWS OF A CORO

RMO's duty to keep a CORO under review (section 184)

39. Section 184 places a duty on the RMO to keep a CORO under ongoing review, by considering 'from time to time' the matters set down in section 184(2) (see paragraph 1 of this chapter). This review is outwith the annual review under section 182 and report to the Scottish Ministers under section 183(2).

40. The RMO should carry out the "from time to time" review as regularly as is practicable. By definition, it is difficult to place a precise timetable on when such reviews should take place. However, a "from time to time" review should not necessarily be seen as a formal review separate from the day-to-day monitoring of the CORO. Existing multi-disciplinary or multi-agency forums, such as ward rounds, planned out-patient visits to a day hospital or NHS resource centre could all, for example, be seen as appropriate settings for a "from time to time" review. The fact that such a review has taken place could be noted alongside any other matters routinely noted at such meetings.

41. Even though the Act does not place a formal duty on the RMO to consult with, for example, the patient's MHO and those providing care and treatment to the patient during this 'from time to time' review process, it is considered that it would nonetheless be best practice for the RMO to remain in close consultation with these parties as regularly as is practicable in order to be in full possession of all the relevant assessment information, including the social circumstances dimension for which the MHO has responsibility. This is important to allow an assessment of the extent to which the care plan's objectives are being met. It would be poor practice for the RMO to only consult these parties when statutorily required to do so during the operation of the CORO – i.e. at the time of a mandatory review. The views of the MHO and the other various members of the multi-disciplinary care team should be sought regularly and often as these parties may have crucial information relating to the advisability of any course of action which the RMO is considering taking. The involvement of such parties should not be restricted to simple notification after the event. It is also important that this consultation process be seen as a dynamic two-way process. Other members of the multi-disciplinary team should feel free to contact the RMO with relevant information wherever they deem it appropriate.

42. While the Act places the responsibility for a "from time to time" review on the RMO and the Scottish Ministers (see paragraph 44), it would be expected that the continuing need for a CORO and the compulsory measures it authorises would also be monitored on a daily basis by all the parties providing care and treatment to the patient. These parties should be engaging with the RMO and the MHO as well as with the other members of the multi-disciplinary team providing care, treatment and support to the patient to ensure that the order is monitored and reviewed effectively.

43. If after the review described in paragraph 39, the RMO is of the opinion that there should be a change to the status of the patient, he/she must in terms of 184 submit a report to the Scottish Ministers complying with the requirements set down in section 183(3) and including the recommendation as soon as practicable after carrying out the review.

Scottish Ministers' duty to keep a CORO under review (section 188)

44. Section 188 places a duty on the Scottish Ministers to keep a CORO under ongoing review, by considering 'from time to time' the matters set out in paragraph 1 of this chapter. If following the review the Scottish Ministers are of the opinion that a change in the status of the patient is indicated then they are under a duty to make an application to the Tribunal under section 191 for an order under section 193. (In relation to the case of a patient who is subject to a CORO a referral to the Tribunal is called an 'application' in the Act when it is made on someone's own initiative such as the Scottish Ministers, the patient or the named person, and it is called a 'reference' when made by the Scottish Ministers following a recommendation from the RMO (section 185) or notification from the MWC (section 186) or because it has been 2 years since the last Tribunal review of the patient's case (section 189)).

THE TRIBUNAL

What are the circumstances which may prompt a 'reference' or an 'application' being made to the Tribunal?

45. Where the RMO has submitted a report to the SM which includes a recommendation for a change to the status of a patient subject to a CORO (sections 183(2) or 184), the SM must in accordance with section 185 refer the patient's case to the Tribunal. This reference must include the name and address of the patient and of the patient's named person, and the recommendation of the RMO (section 185(3)). Where they are making such a reference the SM must in accordance with section 185(2) notify the patient, the patient's named person, any guardian, any welfare attorney, the RMO, the MHO and the MWC.

46. The MWC may notify the Scottish Ministers in writing under section 186 that they require the patient's case to be referred to the Tribunal for review. The MWC must, in accordance with section 186(3), include in the notification to the Scottish Ministers its reasons for requiring the reference to be made. Although not set down in the Act best practice would suggest that when considering whether to require the Scottish Ministers to refer the patient's case to the Tribunal the MWC should apply the same statutory criteria as that applied by the RMO at an annual review under section 182(3)(b). The reference to the Tribunal by the Scottish Ministers under such circumstances (section 187) proceeds in an identical way to that under section 185 (following a recommendation by the RMO) except that rather than the recommendation of the RMO being included in the reference by the Scottish Ministers, the MWC's reasons for requiring the reference to be made must be stated (section 187(4)).

47. Under section 192 the patient and his/her named person may make an application direct to the Tribunal for an order under section 193 of the Act:

- conditionally discharging the patient;
- revoking the restriction order to which the patient is subject;
- revoking the restriction order and varying the compulsion order by modifying the measures specified in it; or
- revoking the compulsion order to which the patient is subject

48. In accordance with section 192(4) the patient and the patient's named person can each apply once in the period beginning with the day 6 months after the compulsion order was made and ending on the anniversary of the order; and once in any subsequent twelve month period. Neither of them can apply within a three month period following the Tribunal having conducted any review of the compulsion order and restriction order to which the patient is subject and this includes where the Tribunal has carried out such a review and decided to make no order. The named person must notify the patient if they make an application (section 192(6)).

49. Best practice would suggest that the RMO and the MHO should bear in mind that the patient and/or the named person may require particular assistance to make an application, the support of advocacy services, or information about appropriate legal services. The RMO and the MHO should be satisfied that where required the patient and the named person have

access to appropriate information about services that are available for the purpose of making the application.

50. Under section 189, where none of the following references or applications have been made to the Tribunal during the two year period following the imposition of the CORO, or during any subsequent two year period ending with the anniversary of the imposition of the CORO, the Scottish Ministers must refer the patient's case to the Tribunal for review:

- a reference by the Scottish Ministers under section 185(1) following a recommendation from the patient's RMO
- a reference by the Scottish Ministers under section 187(2) following notice from the MWC
- an application under section 192 by the patient or the patient's named person

51. In terms of section 189(3) a previous reference to the Tribunal under section 189 must be disregarded if it was made in the first year of the two year period under consideration. In practice it would be expected that the Tribunal would review the patient's case a minimum of every two years. Section 189(5) sets down the information that should be included in the reference, namely the name and address of the patient, the name and address of the patient's named person and the reason for making the reference. Where making such a reference to the Tribunal the Scottish Ministers must, in accordance with section 189(4), inform the patient, the patient's named person, any guardian, any welfare attorney, the RMO, the MHO and the MWC.

Powers of the Tribunal upon receipt of a reference or application

52. Section 193 sets out the powers of the Tribunal following a reference or application being made under sections 185(1), 187(2), 189(2), 191 or 192(2). The Tribunal may make:

- no order - the compulsion order and restriction order remain in place (section 193(2))

- an order revoking the compulsion order (and therefore the restriction order – see section 197. i.e. absolute discharge (sections 193(3) or 193(4))

- an order revoking the restriction order but keeping the compulsion order in place – see section 198 as read with section 193(5)). The compulsion order may remain unchanged or it may be varied under section 193(6). If the compulsion order is varied the Tribunal shall specify the modifications made in accordance with section 194. In terms of section 1198, the compulsion order continues as set out under Part 9.

- an order that the patient be conditionally discharged (section 193(7)). This may be deferred by the Tribunal under section 195 until the necessary arrangements have been made. The Tribunal may attach any conditions it sees fit to the discharge in accordance with section 193(7).

53. In terms of section 193(8) and (9), before making a decision the Tribunal must hold a hearing, and allow the following persons to make representations (orally or in writing) or lead/produce evidence:

- patient
- named person
- primary carer
- guardian
- welfare attorney
- curator *ad litem* appointed by the Tribunal in respect of the patient
- Scottish Ministers
- RMO
- MHO
- any other person appearing to have an interest (This might include, for example, the patient's solicitor or a psychologist or other party who is providing care and treatment to the patient).

End of restriction order with continuation of compulsion order

54. Where a patient is subject to a CORO, the assessment of the risk posed by the patient and the measures required to manage any risks may be such that it is no longer felt to be appropriate for the patient to be subject to a restriction order, although he/she continues to meet the criteria for a compulsion order. In these circumstances where the restriction order is revoked in terms of sections 193(5) the compulsion order will continue under the provisions set down in Part 9 as if the patient had been placed on the compulsion order on the date of the Tribunal (section 198(2)). The renewal and review procedures as set down in Part 9 would also apply and continue with the timescales for the reviews being based on the day on which the Tribunal revoked the restriction order (section 198).

55. Where the Tribunal revokes a restriction order, section 193(6) allows it to also vary the measures specified in the compulsion order at that time, for example from specifying detention in hospital to authorising compulsory measures in the community. However it would be expected that this route to community supervision of the patient would be unusual – conditional discharge should be the usual route, provided that the statutory criteria are met.

Appeal against a decision of the Tribunal

56. The procedures for appeals to be made against a decision of the Tribunal are set down in Part 22 of the Act. In accordance with section 196 an order made by the Tribunal to revoke a compulsion order, revoke a restriction order, conditionally discharge a patient or vary a compulsion order does not come into effect until whichever occurs first of the following:

- the expiry of the appeal period, if no appeal has been made under section 322 during that period; or

- if an appeal under section 322 has been lodged with the Court of Session within the appeal period:

    - the Scottish Ministers have notified the Court of Session and the hospital managers that they do not intend to ask the Court of Session to

order that the patient should continue to be detained under restrictions pending the outcome of the appeal (section 323);

- the Court of Session have refused to make such an order; and

- the recall of such an order or the expiry of its effect

57. *[Section 324(7) confers on the Scottish Ministers a power to make regulations specifying the length of the appeal period for an appeal under sections 320(2), 321(1) or 322(2).]*

CHAPTER 4: DISCHARGE OF A PATIENT SUBJECT TO A CORO

Introduction

This chapter outlines the processes surrounding the conditional discharge and absolute discharge of a patient subject to a CORO. It describes the statutory provisions which relate to conditional discharge as set down in Chapter 3 of Part 10 of the Act as well as best practice points allied to these provisions.

The chapter goes on to examine the statutory processes involved in the absolute discharge of a patient subject to a CORO and also best practice points allied to these provisions.

CONDITIONAL DISCHARGE

Overview

1. Section 193(7) allows the Tribunal to order the conditional discharge of a patient who is subject to a CORO and impose such conditions as it sees fit. Conditional discharge allows a period of formal supervision of the patient in the community by closely monitoring his/her mental health and behaviour for any indicators of increased risk to others so that steps can be taken to assist him/her and protect the public. It also allows a period of assessment of the patient in the community before a final decision is taken on whether to remove the safeguards and control imposed by the restriction order by means of an absolute discharge.

2. Although it is the Tribunal alone that has the power under the Act to order the conditional discharge of a patient, it would be expected that the process of planning for conditional discharge would involve liaison between the Scottish Ministers and the patient's multi-disciplinary team. Consideration of plans for conditional discharge should be made well in advance involving appropriate local health and social work services. In so doing, a supervising RMO and MHO should be identified for the period when the patient is in the community, and consideration given to the following matters:

- where the patient will reside
- who will be the individuals involved in providing care, treatment and services
- which places will the patient be required to attend (e.g. clinic, hospital, day-hospital, day-centre, work placement, college)
- treatment to be given (e.g. medication, psychological therapies).

3. In some cases the police may be involved in planning conditional discharge; certain mentally disordered offenders may be required to register with the police following discharge (e.g. those patients requiring to register under the Sexual Offences Act 2003.

4. It would be expected that in most cases, prior to conditional discharge, the patient will have undergone periods where his/her detention was suspended in accordance with section 224, during which time he/she was able to spend time in the community and engage with the treatment, care and services which would make up his/her conditional discharge care package.

The power to grant conditional discharge

5. Conditional discharge may be ordered by the Tribunal under section 193(7) and such conditions as seem fit to the Tribunal may be imposed. Best practice would suggest that the minimum conditions that would usually be imposed would include:

- residence at a stated address
- supervision by a social worker
- psychiatric supervision

6. Extra conditions which may be added on a case by case basis may include:

- attendance at specific places (e.g. clinics, hospitals, day-hospitals, day-centres, work placements)
- allowing access to specified people (e.g. psychiatrist, MHO, social worker, community psychiatric nurse)
- taking medication (treatment cannot be physically forced on a patient while in the community, but failure to take medication could be seen as a breach of the conditions of discharge; this may result in the patient being taken to a clinical setting to be given compulsory medical treatment in accordance with the Act)
- compliance with other treatments (e.g. attending for psychological treatment)
- restrictions on use of alcohol and illicit substances including compliance with regular drug/alcohol screening
- prohibition from going to certain areas or places (e.g. to prevent contact with victims)

It should be noted that this is not an exhaustive list of conditions that may be added.

Variation of conditions by the Scottish Ministers

7. Section 200 allows the Scottish Ministers to vary the conditions imposed by the Tribunal in terms of section 193(7) on the conditional discharge of the patient if they are satisfied that it is necessary. For example this might be as a result of a psychological course of treatment coming to an end or the victim moving away to another area. As soon as practicable after varying the conditions the Scottish Ministers must notify the patient, the named person, the RMO and the MHO of the variations (section 200(3)).

Appeal against variation

8. Within 28 days of being notified by the Scottish Ministers of the proposed variation the patient, or his/her named person, may appeal against the variation of the conditions imposed on conditional discharge to the Tribunal in terms of section 201. In terms of section 201(3), section 193 of the Act (which sets out the procedures and powers available to the Tribunal) is deemed to apply in relation to such an appeal as if the patient or named person had applied under section 192 for conditional discharge.

Recall from conditional discharge

9. A conditionally discharged patient may be recalled to and detained in hospital if the Scottish Ministers are satisfied that this is necessary and they issue a warrant to this effect (section 202). If there are concerns that a patient's mental state has deteriorated, or there is an increased risk to others, or the patient has breached any of the conditions imposed then the Scottish Ministers would be expected to be notified of this, usually by the patient's RMO. Good practice would suggest that where the MHO becomes aware of such concerns he/she should immediately notify the RMO.

10. It would be expected that before notifying the Scottish Ministers, the RMO would always consult the designated MHO to consider what action may be required, and to inform any recommendation to the Scottish Ministers. In notifying the Scottish Ministers the RMO would be expected to give an opinion as to whether the patient should be recalled to hospital, but the decision to issue a warrant under section 202 is for the SM to make.

11. There may be circumstances where admission to hospital (voluntarily or under civil procedures) is necessary but recall is not appropriate or not considered necessary. Where admission is being arranged on a voluntary basis good practice would suggest that great care should be taken to ensure that the patient is properly and fully aware of his/her rights. (For example the patient may decide to discharge him/herself or refuse treatment). However it would be expected that in most cases where a prolonged admission to hospital is necessary, the patient would be recalled under section 202.

12. In most cases the hospital specified will be the one from which the patient had been discharged (i.e. the one specified in the compulsion order). However, under certain circumstances (for example, if no bed is available or a patient requires a degree of security higher or lower than that available at that hospital), it would be expected that the patient would be recalled to an alternative hospital, and this alternative must be specified in the warrant. Where a patient is recalled he/she is subject to detention under the compulsion order as had been the case prior to his/her conditional discharge in terms of section 203.

Appeal against recall from conditional discharge

13. Within 28 days of the patient returning to hospital, the patient or his/her named person may appeal against the recall from conditional discharge to the Tribunal in terms of section 204. In terms of section 204(3), section 193 of the Act (which sets out the procedures and powers available to the Tribunal) is deemed to apply in relation to such an appeal as if the patient or named person had applied under section 192 for conditional discharge.

Review of patients while on conditional discharge

14. If conditional discharge is granted in terms of section 193(7) the CORO to which the patient is subject is still in effect given that it has not been revoked by virtue of section 193(3) or (4) as read with section 197.

15. Therefore the provisions set down in Part 10 of the Act concerning reviews and reports by RMOs, reviews by the Scottish Ministers, notification from the MWC to the

Scottish Ministers, references and applications to the Tribunal by the Scottish Ministers, automatic referral to the Tribunal if there has not been a review within a specified period and applications to the Tribunal by patients or named persons, all apply to patients on conditional discharge as they do to patients detained in hospital under a CORO. It should be noted that the Scottish Ministers may require that a patient's case is reviewed and a report submitted to them more frequently during the initial period of conditional discharge.

16. Although not a statutory provision under the Act, it is the current practice of the Scottish Ministers to request a monthly report from the RMO during the first year of conditional discharge and then every three months thereafter. Best practice would suggest that where the RMO is unfamiliar with the process and these administrative procedures he/she should contact the Health Department of the Scottish Executive for guidance.

Patients granted conditional discharge unexpectedly

17. In most cases it would be expected that conditional discharge would be part of the patient's planned rehabilitation. However there may be cases where the Tribunal conditionally discharges a patient under section 193(7) against the recommendation of the RMO and/or the Scottish Ministers. Where no arrangements have been put in place in the community for the patient the conditional discharge of the patient may be deferred by the Tribunal in accordance with section 195 to allow for appropriate services to be put in place.

18. During this period it would be expected that an appropriate package of care incorporating the conditions specified by the Tribunal would be set up as soon as practicable. It would be expected that there would be clear procedures for Health Boards and local authority services together to support immediate care and treatment planning and the provision of necessary services.

19. The parties as set down in section 322(3) have the right to appeal to the Court of Session against an order made by the Tribunal under section 193. In relation to conditional discharge in particular, where the Scottish Ministers appeal against a decision of the Tribunal to order a patient's conditional discharge the Scottish Ministers may also, in accordance with section 323, ask the Court of Session to order that the patient continue to be detained and that the CORO continue to have effect pending the outcome of the appeal.

Further offending

20. If a patient has committed an offence during a period of conditional discharge and a prosecution is pending, and if he/she is on bail or in custody and is no danger to him/herself or others as a result of his/her mental disorder, the Scottish Minister may choose to decide to let the law take its course. In that event, the court would be expected to decide whether a new mental health order is necessary (such as an assessment order), whether a different disposal is called for, or whether the most appropriate course would be for the patient to be recalled to hospital. In this last event the court may, for example, convict the patient but impose no penalty or only a nominal penalty in the knowledge that the Scottish Ministers intend to recall the patient immediately to hospital.

21. If a conditionally discharged patient is convicted of a further offence and the court imposes a non-custodial sentence, and recall to hospital is not considered appropriate, it would be expected that the terms of the previous conditional discharge would continue and the supervisors would resume their roles. However in such circumstances good practice would suggest that the RMO, the MHO and the rest of the multi-disciplinary team should review the patient's care plan to ensure that it fully takes the further offending into account and update the risk management plan accordingly.

22. If a conditionally discharged patient is convicted of a further offence and the court imposes a sentence of imprisonment, the Scottish Ministers may choose to reserve judgement on the patient's status under the Act until the patient nears the end of his/her prison sentence when an application to the Tribunal under section 191 may be initiated seeking the revocation of the compulsion order (absolute discharge), so ending liability to detention under the Act. Alternatively conditional discharge may continue on release from prison (with the accompanying conditions of residence, social work supervision and psychiatric supervision etc) or the patient may be recalled to hospital under section 202 on release from prison.

ABSOLUTE DISCHARGE

Overview

23. A patient subject to a CORO is absolutely discharged when the Tribunal revokes the compulsion order to which he/she is subject in terms of sections 193(3) or (4). In such circumstances, in terms of section 197, any restriction order to which the patient was subject shall cease to have effect at the same time as the compulsion order was revoked. It would be expected that in most cases this would follow a period of conditional discharge in the community during which the patient has been settled and is no longer considered to require formal supervision. Non-compulsory treatment and contact with services would be expected to continue in most cases.

24. Best practice would suggest that there should be close consultation between the RMO, the MHO and the rest of the multi-disciplinary team before a recommendation is made to the SM for the absolute discharge of a patient. Suitable aftercare arrangements for the patient would be expected to be agreed and put in place in advance of the recommendation being made even though these would not be subject to compulsion.

25. Where the RMO is not making such a recommendation, but it is anticipated that the Tribunal may absolutely discharge a patient, it would be expected that contingency aftercare arrangements should be made in advance. Where such arrangements have not been made, then efforts should be made to rectify this as soon as possible. Where the Tribunal orders absolute discharge under sections 193(3) or 193(4) there is no provision in the Act for it to be deferred until arrangements have been made; the patient must be discharged once any appeal period has expired or once any appeal has been determined (section 196(2)).

CHAPTER 5: THE IMPOSITION OF A TRANSFER FOR TREATMENT DIRECTION (PART 8, CHAPTER 3)

Introduction

Section 136 of the Act allows the Scottish Ministers to transfer a sentenced prisoner to hospital for care and treatment of his/her mental disorder under a Transfer for Treatment Direction (TTD). This procedure was previously set down in section 71 of the 1984 Act and a restriction direction under section 72 of the 1984 Act could also be imposed in addition to the order. However under the Act all such patients are restricted patients for the duration of the TTD; there is therefore no option or requirement for a restriction order to be added to the direction.

This chapter sets out the formal procedures involved in the making of a TTD.

OVERVIEW

What are the criteria which must be considered prior to TTD being made?

1. A TTD may be made by the Scottish Ministers in accordance with section 136(2) following consideration of written reports from two medical practitioners, one of whom must be approved under section 22. The criteria for making a TTD are identical to those for a hospital based CTO except that, as with other procedures for mentally disordered offenders, the 'impaired decision making ability' criterion under section 57(3)(d) of the Act does not apply. So the criteria to be considered and which are set down in section 136(4) are:

- that the prisoner has mental disorder;
- that medical treatment which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder is available for the prisoner;
- that if the prisoner were not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the prisoner, or to the safety of any other person; and
- that the making of the TTD is necessary

2. There must be a suitable hospital available to admit the prisoner within 7 days of the imposition of the direction (section 136(3)(b) and (c)). A state hospital may be specified if having considered the medical reports the Scottish Ministers are satisfied that the prisoner requires to be detained under conditions of special security and that such conditions can be provided only in a state hospital (section 136(5)).

MEDICAL RECOMMENDATIONS

3. If there are concerns about the mental health of a prisoner, best practice would suggest that prison staff should refer the prisoner to health care staff within the prison. If following

assessment by the health care staff there are concerns that a prisoner may require treatment in hospital then an assessment by an approved doctor would be expected to be arranged.

4. Two medical reports are required in terms of section 136(2), one of which must be provided by an AMP. Usually one report would be by a prison medical officer and the other by the assessing medical practitioner who would be required to be an AMP. Good practice would suggest that one of the reports should be by a doctor from the hospital or unit where it is proposed that the prisoner should be admitted, although in urgent cases time may not allow for this. Best practice would also suggest that the two doctors should examine the prisoner within 5 days of each other. The reports should then be submitted to the Scottish Ministers by the prison governor or his/her representative.

5. In most cases the medical practitioners would be expected to interview the prisoner separately, although with the prisoner's consent they may interview him/her together. As much information as possible should be taken into account when assessing a prisoner, although the information available and the time to gather this will depend on the circumstances of the case. Relevant sources of information may include various records (e.g. health, prison, social work) and liaison with others (e.g. prison staff, relatives, social work services, mental health services). The criteria set out in section 136(4) (as detailed in paragraph 1) must be considered and the doctors must in accordance with section 132(7) agree about the presence of the same type of at least one of the three categories of mental disorder (as defined in section 328(1)).

6. The hospital to which it is proposed to admit the prisoner must be suitable for the purpose of giving medical treatment to him/her; it should be specified in the reports and a bed must be available within 7 days of the TTD being imposed (section 136(3)). The level of security of the unit to which the prisoner is to be transferred would be expected to be the least restrictive setting taking into account the risk the prisoner poses and his/her clinical needs. Section 136(5) allows for the prisoner to be admitted to a state hospital where it appears to the Scottish Ministers that the prisoner requires to be detained in hospital under conditions of special security that can only be provided by a state hospital. Whether a prisoner should be admitted to a state hospital would depend on the risk he/she poses to others and whether this could be managed safely in a less secure setting.

7. It should be noted that although there is no legal bar to the transfer of a prisoner to hospital for voluntary treatment (as happens when a prisoner requires treatment for physical illness), this would not be expected to happen where hospital treatment is required for mental disorder. In such cases (provided that the statutory criteria set down in section 136(3) are met) prisoners would be expected to be transferred under a TTD; the fact that a prisoner consents to treatment in hospital does not mean that a TTD cannot be imposed.

8. The assessing medical practitioners would be expected to bear in mind that the prisoner is serving a sentence of imprisonment, and therefore treatment in the community as an alternative to hospital is not an option; in these cases the options are either voluntary treatment in prison or compulsory treatment in hospital.

BEST PRACTICE – MHO OPINION

9. Although not a statutory provision under the Act best practice would suggest that an MHO opinion should be sought as part of the assessment of the prisoner prior to reports being submitted to the Scottish Ministers recommending a TTD. In forming his/her opinion the MHO should consider:

- the views of the prisoner about the proposed transfer
- the views of any primary carer, or significant other person who has current and direct knowledge of the prisoner
- the medical practitioners' concerns relating to the prisoner's mental health
- the diagnosis and proposed treatment
- if there any alternative ways in which the required care and treatment could be provided other than by imposing powers of compulsion.
- the risks if the prisoner were not made subject to compulsory powers

10. In considering these matters the MHO should take into account all information that is available about the prisoner's personal circumstances and history, including the information contained in the prison social work records. Consideration should be given to whether the prisoner has a history of serious mental health difficulties that may have required treatment in the past and if so, the manner in which this was provided, whether on a voluntary basis or under compulsory powers. What risks, if any, were known previously as being associated with a deterioration in the prisoner's mental health? For example, is there knowledge of current or historical drug misuse and if so has this been associated in the past with the onset of serious mental illness? The MHO should also identify if the prisoner is subject to any statutory notification requirements in terms of the Sexual Offences Act 2003.

MEASURES AUTHORISED BY A TTD

11. Section 136(6) sets out the measures that may be authorised in a TTD. These are:

- within 7 days of the making of the direction the person may be removed to the specified hospital by a constable; a person employed in, or contracted to provide services in or to, the specified hospital who is authorised by the managers of that hospital to remove persons to hospital for the purposes of this section; or a specified person;
- the detention of the prisoner in the specified hospital; and
- the giving of medical treatment to the prisoner under Part 16 of the Act.

12. The removal of the prisoner to hospital would be expected to be arranged by the Scottish Prison Service and it would usually be carried out by the Prisoner Escort and Court Custody Service. (Where the prisoner is being returned to prison after being detained in hospital under a TTD, it would be expected that the hospital managers would arrange for the transport of the patient).

13. The direction may also include such directions as the Scottish Ministers think fit for the removal of the prisoner to, and detention of the prisoner in, a place of safety pending the prisoner's admission to the specified hospital (section 136(8)(b)).

14. Information on the procedures after a prisoner has been admitted to hospital under a TTD are covered in the next chapter.

CHAPTER 6
THE HOSPITAL DIRECTION AND THE TRANSFER FOR TREATMENT DIRECTION IN OPERATION

Introduction

There are two ways in which a sentenced prisoner may receive compulsory care and treatment for his/her mental disorder in hospital. These are:

- At sentencing the court may, in addition to imposing a custodial sentence, impose a hospital direction in terms of section 59A of the 1995 Act which allows the prisoner to be detained initially in hospital for medical treatment in accordance with Part 16 of the Act
- The Scottish Ministers may make a transfer for treatment direction in terms of section 136 of the Act which allows for the transfer of a sentenced prisoner to hospital for medical treatment in accordance with Part 16 of the Act.

For information and guidance on the imposition of a hospital direction refer to Part 1, Chapter 5 of this document. For information and guidance on the imposition of a transfer for treatment direction refer to the previous chapter in this document.

In this chapter both procedures are referred to as ‘directions’. Unless stated otherwise the term “Tribunal” in this chapter refers to the Mental Health Tribunal for Scotland.

This chapter outlines the processes which should be followed in the immediate aftermath of a direction being made. It does not cover the procedures associated with formal reviews of a direction. These are examined in chapter 7.

The procedures for the transfer of the patient to another hospital, and for the suspension of the measure of detention, in terms of Parts 12 and 13 of the Act respectively in relation to a patient subject to a direction, mirror those for are patient who is subject to a compulsion order and a restriction order. For information on these matters refer to chapters 9 and 10.

OVERVIEW

1. A significant number of prisoners have mental disorders. In some cases it may be appropriate for the prisoner to receive voluntary treatment in prison. However in other cases treatment in hospital may be necessary. The Act provides a specific definition of “hospital” in section 329. Health care centres and hospitals in prisons are not hospitals in which patients may be detained for treatment under the Act. If a prisoner requires compulsory treatment for mental disorder in hospital he/she must be transferred to hospital using the appropriate legislation as outlined in the introduction above. **It would be expected that under no circumstances would compulsory treatment for mental disorder by way of a compulsory treatment order (section 64) or a compulsion order (section 57A of the 1995 Act) authorising compulsory measures in the community be appropriate whilst a person is serving a sentence in prison.**

Remand prisoners

2. A prisoner who has not yet been sentenced (either pre-trial or post-conviction) may be transferred to hospital under an assessment order or treatment order (sections 52D and 52M of the 1995 Act; see Part 1, Chapters 2 and 4 of this Code of Practice. Previously section 70 of the 1984 Act provided for the transfer of unsentenced prisoners to hospital for treatment. This has now been inserted by the Act after section 52 of the 1995 Act so there is no specific separate procedure for the transfer of such prisoners.

Sentenced prisoners

3. Section 136 makes provision for a "Transfer for Treatment Direction" (TTD) which allows for the transfer of sentenced prisoners with mental disorder to hospital.

4. The Hospital Direction (HD) was inserted into the 1995 Act by amendments made in the Crime and Punishment (Scotland) Act 1997. New provisions relating to HDs are inserted into the 1995 Act by paragraph 8(6) of Schedule 4 to the Act. An HD may be imposed by a court under section 59A of the 1995 Act where a person with mental disorder has been convicted on indictment of an offence punishable by imprisonment. It allows the court to impose a prison sentence and direct that the person be detained initially in hospital for medical treatment of his/her mental disorder in accordance with Part 16 of the Act (section 59A(7)). For further information about the imposition of this direction refer to the previous chapter.

5. Where a patient is subject to either direction mentioned in paragraphs 3 or 4 a prison sentence runs concurrently with his/her period of detention in hospital. When the patient no longer requires treatment in hospital in terms of the Act then the Scottish Ministers may revoke the direction in accordance with sections 210(2), 212(3) or (4) or 215(5)) and direct the return of the patient to prison, institution or other place in which the patient might have been detained had the patient not been detained in hospital by virtue of the direction (section 216).

6. In terms of section 217 the direction ceases to have effect upon the expiry of the prison sentence if it has not been revoked prior to this. Under such circumstances the patient must be discharged or may remain in hospital as an informal patient or be detained under civil procedures (by way of a CTO in terms of section 64 taking into account the application provisions contained in section 71 of and Schedule 3 to the Act). In some cases, for example where a life sentence has been passed, the patient may be released on life licence in accordance with section 2(4) of the Prisoners and Criminal Proceedings (Scotland) Act 1993 following a hearing by the Parole Board for Scotland ("the Parole Board") sitting as a Life Prisoner Tribunal (LPT) at which point the direction also ends.

7. While patients are subject to these directions they are restricted patients and so decisions about suspension of detention, transfer to another hospital or the revocation of the direction must be authorised by the SM. It should be noted that only the Scottish Ministers may revoke a direction as mentioned in paragraph 5 above although the Tribunal may, under certain circumstances, direct the SM to do so in accordance with section 215(5). Where a direction is revoked the patient must be returned to prison or other institution and the direction ceases to have effect (section 216).

RESPONSIBILITIES SUBSEQUENT TO A DIRECTION BEING IMPOSED

8. The effect of being admitted to hospital under an HD or a TTD is covered by Part 11 of the Act. Both sets of patients are subject to an almost identical regime which is itself very similar to that for patients who are admitted to hospital under a compulsion order and a restriction order (CORO).

9. Following the imposition of an HD or a TTD the patient must be conveyed from the court or prison to the specified hospital in accordance with section 59C(7) of the 1995 Act or section 136(6) of the Act respectively. Where a TTD has been imposed by the Scottish Ministers, it would be expected that the arrangement of the transport of the patient to hospital would be the responsibility of the Scottish Prison Service. Where a HD has been imposed by a court, it would be expected that the transport of the patient to the hospital would be the responsibility of the court.

13. As soon as practicable after the patient's admission to hospital the hospital managers have a duty under section 260(5)(a) to ensure that the patient and his/her named person are fully informed of, and understand the 'relevant matters' as set down in sections 260(5)(a) to (h) and also informed of the availability of independent advocacy services under section 259. For further information on these procedures refer to Volume 2, Chapter 4 of this Code of Practice.

14. An RMO and an MHO must be allocated to the patient under sections 230 and 229 respectively (on the occurrence of a relevant event as defined in section 232) and a multi-disciplinary assessment would be expected to be initiated. In the case of a patient who has been made subject to an HD, an RMO and an MHO should already have been appointed given that the patient would have been assessed in hospital prior to the making of the direction (by way of an assessment order (section 52D of the 1995 Act) and/or an interim compulsion order (section 53 of the 1995 Act)).

RMO RESPONSIBILITIES – THE CARE PLAN

15. Although not a statutory duty under the Act, the RMO would be expected to prepare a care plan setting out the care and medical treatment which is currently being given to the patient and the medical treatment which it is proposed will be given to the patient for the duration of the direction. This would be done as soon as practicable after admission (e.g. following next case review after the making of the direction) in consultation with the MHO, a suitably qualified psychologist where appropriate and the rest of multi-disciplinary team.

16. For further information on the care plan refer to Chapter 1.

17. Although not a statutory duty under the Act the RMO should send a copy of the care plan to the patient, the patient's named person / nearest relative / primary carer, the MHO, the SM and any other member of the multi-disciplinary team where relevant and appropriate. The RMO should record on the care plan who has received a copy and when the next mandatory review of the direction is due.

18. The RMO would be expected to update the care plan at least once a year if not more often and send a copy to the patient, the patient's named person/nearest relative/primary carer, the MHO, the Scottish Ministers, and the rest of the multi-disciplinary team where relevant and appropriate. The RMO would record on the care plan who has received a copy and when the next mandatory review of the direction is due.

19. It would be expected that a copy would also be submitted to the Scottish Ministers with any RMO report.

MHO RESPONSIBILITIES

20. When a direction is imposed the relevant local authority must allocate a designated MHO for the patient in accordance with section 229. This MHO would be expected to work in close collaboration with the RMO and the rest of the multi-disciplinary team who are responsible for overseeing the care of the patient. The duties of the MHO after a direction has been imposed are very similar to those of an MHO after a CTO has been granted by the Tribunal under section 64. One exception is in relation to the SCR prepared by the MHO in terms of section 231; best practice would suggest that the MHO would send a copy of the SCR to the Scottish Ministers. For information on the duties of the MHO refer to Volume 1, Chapter 6 of this Code of Practice.

21. As soon as practicable after the direction is imposed the MHO must take such steps as are reasonably practicable to ascertain the name and address of the patient's named person. (section 205).

22. Where a patient has been admitted under a TTD, the MHO would be expected to review the circumstances that led up to the transfer; interview the patient, the named person and any primary carer; ascertain the views of these parties about the need for the transfer, and their opinions about the expected benefit for the patient. The MHO should also obtain the views of prison social work staff who may have knowledge of the patient's circumstances leading up to the transfer. Depending on the status of the patient while in prison, it is possible that a through care criminal justice social worker may have been allocated from the patient's relevant local authority as being responsible for the prisoner's case. Best practice would suggest that if this is the case the designated MHO should liaise closely with this worker in the preparation of the SCR, and take steps to ensure that he/she is fully involved in the initial process of multi-disciplinary assessment, following the patient's transfer to hospital. Local criminal justice social work services may hold significant information about the patient's personal and social circumstances, previous pattern's of offending, mental health concerns; drug and alcohol misuse, and other relevant information.

23. Once a direction has been imposed and the person has been admitted to hospital, the role of the MHO is similar to that as described in chapters 3 and 4 in relation to patients who are subject to a CORO. However a significant difference is where the patient is still detained in hospital at the expiry of the sentence (at which time the direction simultaneously ceases to have effect); if the patient meets the criteria for a compulsory treatment order (CTO) the designated MHO may make an application to the Tribunal in accordance with Schedule 3. (See "Continued detention at the expiry of sentence in paragraphs 6 to 9 of chapter 8.

Best practice points for information that should be noted upon the admission of a patient under a direction

24. Short-term prisoners
In accordance with section 1(1) of the Prisoners and Criminal Proceedings (Scotland) Act 1993 ("the 1993 Act"), where a prisoner has been sentenced to a determinate sentence of less than four years, the prisoner must be released as soon as he/she has served one half of the sentence at which time the direction which he is subject to falls. This date is known as the prisoner's earliest date of liberation ("EDL"). Therefore on admission of a short-term prisoner the RMO and the MHO should take careful note of the prisoner's EDL because the direction will cease to have effect on this date.

25. Long-term prisoners
In accordance with section 1(2) of the 1993 Act where a prisoner has been sentenced to a determinate sentence of four years or more, he/she becomes eligible for parole after serving one-half of the sentence (this is known as the prisoner's parole qualifying date ("PQD")) and must be released on license after serving two-thirds of the sentence which is the prisoner's EDL. The prisoner may therefore be released on licence by the Parole Board at any point between the PQD and the EDL, at which time the direction falls. Where the prisoner is released he/she is placed on licence and conditions may be imposed which if breached may result in the prisoner being recalled to custody. Therefore on admission of a long-term prisoner the RMO and the MHO should take careful note of the prisoner's PQD and EDL because the prisoner may be released by the Parole Board at any point between those two dates at which time the direction will cease to have effect.

26. Life prisoners
In accordance with section 2(2) of the 1993 Act, when sentencing a person to life imprisonment the sentencing judge must specify a proportion of the sentence as being the 'punishment part' which is the period that the court considers the person should serve to satisfy the requirements of retribution and deterrence. In accordance with section 2(6) of the 1993 Act, after a life prisoner has served the punishment part, he/she may require the SM to refer his/her case to the Parole Board for review. It is the responsibility of the Parole Board sitting as the LPT to consider in terms of section 2(5)(b) of the 1993 Act, the level of risk the prisoner might present to the public if released. The right of a life prisoner to have his/her case referred to the LPT is not affected by his/her being subject to a direction.

27. A patient subject to a direction who is serving a life sentence may be discharged in one of two ways:

- by being returned to prison, institution or other place under section 216(2) because the direction has been revoked by the Scottish Ministers under section 210(2), 212(3) or (4) or 215(5)
- by being released directly from hospital on life licence under section 2(4) of the 1993 Act. In accordance with section 217 of the Act the direction ceases to have effect on the date of release.

28. The LPT has the power, in considering the case of a life prisoner, to instruct the Scottish Ministers to release the prisoner on life licence under section 2(4) of the 1993 Act where it is satisfied that it is no longer necessary for the protection of the public that the

prisoner should be confined (section 2(5)(b) of the 1993 Act). Where instructed to do so by the LPT the Scottish Ministers are under a duty to release the prisoner.

29. Therefore on admission of a life prisoner under a direction, the RMO and the MHO should take careful note of the date when the prisoner will have served the punishment part of his/her sentence because at that time he/she will have his/her case reviewed by the LPT which may result in the prisoner's release and at which point the direction will cease to have effect. If the prisoner is released he/she is placed on licence indefinitely in accordance with section 11(2) of the 1993 Act, and conditions may be imposed under section 12 of that Act, which if breached may result in the prisoner being recalled to custody in terms of section 17 of the same Act.

30. If the prisoner requires compulsory treatment for his/her mental disorder in terms of the Act while on life licence then an application may be made to the Scottish Ministers for a transfer for treatment direction under section 136 of the Act. However if the potential for recall and the need for compulsory medical treatment of the prisoner's mental disorder are issues at the time of his/her being released on life licence then it would be expected that an application would be made to the Tribunal by the designated MHO for a CTO authorising compulsory powers in the community under the Act. Where a prisoner who is released on life licence is subject to a CTO which authorises compulsory powers in the community, he/she may be recalled directly to hospital in accordance with sections 112 and 113.

CHAPTER 7: REVIEWING A DIRECTION (PART 11 OF THE ACT)

Introduction

This chapter begins by examining the formal processes to be followed where a hospital direction or a transfer for treatment direction is being reviewed, as laid out in Part 11 of the Act. It explores the duty placed on the RMO to carry out a formal review and report to the Scottish Ministers. The possible outcomes of the review are:

- the direction remains in place
- the direction is revoked by the Scottish Ministers under section 210(2) and the patient is admitted to prison, institution or other place in which he/she might have been detained had the direction not been imposed
- the Scottish Ministers refer the patient's case to the Tribunal in accordance with section 210(3).

After holding a hearing the Tribunal may:

- direct the Scottish Ministers to revoke the direction in terms of sections 215(3), (4) or (5) and the patient is admitted to prison, institution or other place in which he/she might have been detained had the direction not been imposed
- make no direction to the SM and the direction remains in place

The chapter goes on to describe the duty placed on the RMO and the Scottish Ministers to keep under review the continuing need for the direction in terms of sections 208 and 212 respectively.

The remainder of the chapter covers the applications which may be made to the Tribunal by the patient and named person, and the referrals to the Tribunal that may be initiated by the MW C.

In this chapter a hospital direction and a transfer for treatment direction are both referred to as "directions". Unless stated otherwise the term "Tribunal" in this chapter refers to the Mental Health Tribunal for Scotland.

OVERVIEW OF THE REVIEW PROCESS

1. The effect of being admitted to hospital under an HD or a TTD is covered by Part 11 of the Act. Both sets of patients are subject to an almost identical regime which is itself very similar to that for patients who are admitted to hospital under a compulsion order and a restriction order (CORO).

What are the criteria which should be used when reviewing a direction?

2. The criteria against which a patient's mental health must be judged when any review of a direction is taking place are referred to in section 206(3)(b) and (4) of the Act. The criteria are that:

- the person has a mental disorder (“mental disorder criterion”)
- medical treatment which would be likely to prevent the mental disorder worsening, or alleviate any of the symptoms, or effects, of the disorder is available for the patient (“treatability criterion”)
- if the patient were not provided with such medical treatment would there be a significant risk to the health, safety or welfare of the patient or to the safety of any other person (“civil risk criterion”)
- as a result of the person’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 (“serious risk to others criterion”)
- it continues to be necessary for the person to be subject to the direction (“direction necessity criterion”)

3. When assessing whether the patient still meets the criteria for the direction it must be borne in mind by the reviewer that it is his/her responsibility to demonstrate that the criteria are met. In other words, the presumption is always in favour of revoking the direction unless the above criteria are met. The onus is therefore not on the patient to demonstrate that he/she does not meet the criteria.

4. Where the RMO is assessing the patient against these criteria, it would be expected that he/she would be fully supported by all members of the multi-disciplinary team who are involved in providing care, support and treatment to the patient.

MANDATORY REVIEW BY THE RMO (SECTION 206)

5. During the 2 month period prior to the one year anniversary of the direction being imposed, the RMO must examine the patient (or arrange for another approved medical practitioner to do so) (section 206(3)(a)), consider the review criteria set down in section 206(3)(b), consult the MHO (section 206(3)(c) and then prepare and submit a report to the Scottish Ministers in accordance with section 207(2).

6. Best practice would suggest that in most cases this review should be multi-disciplinary and multi-agency involving all those involved in the patient's care currently and perhaps those that might be involved in the patient's future care. The process of carrying out a mandatory review should be characterised from beginning to end by as great a sense of multi-agency and multi-disciplinary co-operation and consultation as is practicable. In that connection, it would be good practice for a full case conference to be held when a mandatory review is being carried out. It would also be good practice to use the opportunity presented by the mandatory review to review not only whether the patient still meets the criteria for compulsory powers but also the efficiency of the various reporting procedures which have been in operation since the previous mandatory review.

7. Aside from the statutory review criteria set down in section 206(3)(b) and (4) that must be considered by the RMO best practice would also suggest that there would also be other issues which, although not a statutory provision under the Act, would require to be considered and reported on to the Scottish Ministers (see 'Responsible medical officer's report to the Scottish Ministers (section 207(2), paragraphs 11 to 19).

8. Most of these issues would be expected to be relevant to the statutory review criteria and would give a broader understanding of the progress of the patient, his/her treatment needs and the assessment and management of risk.

Medical examination

9. The statutory criteria that must be addressed in the medical examination are set out in section 206(3)(b) and (4). The RMO is under a duty to consult the MHO in accordance with section 206(3)(c) as part of the review. In addressing these criteria it would be expected that the RMO would:

- interview the patient
- discuss the patient with all members of the multi-disciplinary team where relevant and appropriate
- consider the progress of the patient over the last year
- consider the nature and circumstances of the index offence, previous offending and any other relevant incidents of concern
- consider any other relevant background information
- consider any issues requested by the Scottish Ministers

10. The RMO must consider the criteria in paragraph 2 at the annual review of a direction under section 206 and when reviewing a direction 'from time to time' under section 208. In considering the statutory criteria, the RMO's conclusions may result in his/her being under a duty to recommend to the Scottish Ministers (in accordance with section 207(4) or

(5)), that the direction should be revoked. With reference to the statutory criteria as described in paragraph 2, it would be expected that the following conclusions would be drawn:

- if the mental disorder criterion is not met *the direction should be revoked* (section 207(4))
- if the mental disorder criterion is met, but the treatability criterion or the civil risk criterion or the direction necessity criterion is not met, and the serious risk to others criterion is not met then *the direction should be revoked*. (section 207(5))

***RESPONSIBLE MEDICAL OFFICER'S REPORT TO THE SCOTTISH MINISTERS* (sections 207(2))**

11. When carrying out a review of a direction under section 206 the RMO must consider the statutory criteria as set down in section 206(3)(b) and (4) (and described in paragraph 2) and consult the designated MHO and any other person that the RMO considers appropriate.

12. As soon as practicable after carrying out the review the RMO must submit a report containing his/her findings to the SM in accordance with sections 207(2) or 208(3). Section 207(4) and (5) specifies the recommendations that the RMO must make depending on his/her conclusions regarding the application of the statutory criteria (see paragraph 2). If the outcome of the review is that the direction should be revoked the RMO is under a duty to recommend this course of action in his/her report to the Scottish Ministers.

13. The format and content of the RMO's report is not set down in the Act. However non-statutory guidance may be obtained from the Scottish Executive Health Department. Best practice would therefore suggest that, where the RMO is unfamiliar with the process and the administrative procedures involved he/she should contact the Health Department of the Scottish Executive for further information prior to preparing and submitting the report.

14. It would be expected that the report would detail the patient's progress in hospital since the last annual report and may include the following information:

- nursing and other care
- medication
- psychological assessment and treatment
- changes in mental state since the last annual report
- MHO opinion
- social work assessment
- child protection issues
- issues in relation to sex offending registration
- patient's relations with staff and other patients
- patient's participation in activities while in hospital
- freedoms available e.g. leave in grounds, suspension of detention etc and how they are used
- patient's relations with family and friends
- plans for patient's future care
- victim and public safety issues

15. Where any of the information on the patient's background, family background, criminal record, medical history, psychiatric history or any other information previously provided to the Scottish Ministers has been important in informing the current understanding of the patient, and new information has come to light in the course of the year or where old information has been proved inaccurate, this would be expected to be set out in the report. The report should also address whether there has been a change of understanding by the multi-disciplinary team of information previously known about the patient.

16. Where detailed consideration of the risk posed by the patient and the management of this risk is of particular importance, the RMO would be expected to consider and report on:

- the level of security which the patient requires
- the factors relating to the index offence and other previous dangerous behaviour
- the potential risk factors in the future
- the patient's attitude to his/her index offence, other dangerous behaviour and any previous victims
- issues related to previous and potential future victims
- issues related to alcohol or substance misuse
- the outward evidence of change and how the patient has responded in stressful situations
- any physical, verbal or sexual aggression by the patient
- short and longer-term treatment plans
- the patient's attitude to supervision and the quality of his/her relationship with the care team.

17. Where the patient has a **mental illness** the report would be expected to address the following:
- the relationship between dangerous behaviour and his/her mental illness
- which symptoms of mental illness remain
- whether the patient's condition is currently stable and whether this has been tested in various circumstances
- issues relating to medication including effectiveness and compliance
- the patient's insight into his/her illness and the need for treatment
- early signs indicating relapse in the patient's illness and signs which indicate there may be an immediate risk

18. Where the patient has **learning disability** the report would be expected to address the following:
- whether the patient has benefited from treatment or training
- whether his/her behaviour is now more acceptable
- whether the patient now learns from experience and takes into account the consequences of his/her actions

19. Where the patient has a **personality disorder** the report would be expected to address the following:
- which characteristics are useful and which cause problems
- which personality issues are considered to relate to the index offence/other dangerous behaviour
- treatment approaches and effectiveness
- how generalised the patient's learning has become and shows itself and how much is context specific
- areas of functioning that continue to be a problem, how this showed in the past and present, and how it may be managed in the future

Consultation between the RMO and the MHO

20. Section 206(3)(c) requires that the RMO must consult the MHO as part of the patient's annual review. To aid this communication the designated MHO would be expected

to make him/herself known to the RMO as soon as practicable after the imposition of the direction and ensure that the RMO has his/her contact details.

21. Best practice would suggest that there should be a procedure in place to support the RMO notifying the MHO well in advance of the annual review being carried out so that the MHO has sufficient time to come to an informed opinion.

22. It would be expected that the designated MHO would maintain a sufficiently close involvement with the patient, any carer(s), and all members of the multi-disciplinary team, to ensure that the MHO has a good understanding of the patient's progress and knowledge of any events which may have a bearing on recommendations at the time of a review. The multi-disciplinary team would be expected to keep the MHO informed of any key developments in the care and/or treatment of the patient.

BEST PRACTICE POINTS FOR THE MHO

23. When forming his/her opinion in relation to the annual review of a patient subject to a direction (section 206(3)(c)) it would be expected that the MHO would consider the criteria applied by the RMO under section 206(3). The MHO would also be expected to:

- interview the patient
- consult the named person and/or primary carer
- consult the RMO
- consult all members of the multi-disciplinary team where relevant and appropriate
- review medical and social work records
- with the patient's agreement, consult any other relevant person who is significantly involved in the patient's care and treatment.

24. The MHO should take into account his/her own direct knowledge of the patient (for example the patient's presentation, capacity and capabilities), the patient's understanding of the mental disorder or diagnosis and the patient's attitude towards any ongoing treatment that may be required.

25. When interviewing the patient and consulting the named person and/or the primary carer as outlined in paragraph 21, the MHO should ensure that each party has a clear understanding of the purpose of the review and the procedure that will be followed. The MHO should also ensure that each of the parties are aware of the possible consequences of the review in relation to the revocation of the direction and referral to the Tribunal. The MHO should ensure that the patient is aware of the availability of advocacy services and support the patient in making arrangements to have access to these services if required. For further information refer to Volume 2, Chapter 4 of this Code of Practice.

OTHER REVIEWS OF A DIRECTION

RMO's duty to keep a direction under review (section 208)

26. Section 208 places a duty on the RMO to keep a direction under ongoing review, by considering 'from time to time' the matters set down in section 208(2). This review is outwith the annual review under section 206 and report to the Scottish Ministers under section 207(2).

27. The RMO should carry out the "from time to time" review as regularly as is practicable. By definition, it is difficult to place a precise timetable on when such reviews should take place. However, a "from time to time" review should not necessarily be seen as a formal review separate from the day-to-day monitoring of the direction. Existing multi-disciplinary or multi-agency forums, such as ward rounds, planned out-patient visits to a day hospital or NHS resource centre could all, for example, be seen as appropriate settings for a "from time to time" review. The fact that such a review has taken place could be noted alongside any other matters routinely noted at such meetings.

28. Even though the Act does not place a formal duty on the RMO to consult with, for example, the patient's MHO and those providing care and treatment to the patient during this 'from time to time' review process, it is considered that it would nonetheless be best practice for the RMO to remain in close consultation with these parties as regularly as is practicable in order to be in full possession of all the relevant assessment information, including the social circumstances dimension for which the MHO has responsibility. This is important to allow an assessment of the extent to which the care plan's objectives are being met. It would be poor practice for the RMO to only consult these parties when statutorily required to do so during the operation of the direction – i.e. at the time of a mandatory review. The views of the MHO and the other various members of the multi-disciplinary care team should be sought regularly and often as these parties may have crucial information relating to the advisability of any course of action which the RMO is considering taking. The involvement of such parties should not be restricted to simple notification after the event. It is also important that this consultation process be seen as a dynamic two-way process. Other members of the multi-disciplinary team should feel free to contact the RMO with relevant information wherever they deem it appropriate.

29. While the Act places the responsibility for a "from time to time" review on the RMO and the Scottish Ministers (see paragraphs 31 to 32), it would be expected that the continuing need for a direction and the compulsory measures it authorises would also be monitored on a daily basis by all the parties providing care and treatment to the patient. These parties should be engaging with the RMO and the MHO as well as with the other members of the multi-disciplinary team providing care, treatment and support to the patient to ensure that the order is monitored and reviewed effectively.

30. If after the review described in paragraph 27, the RMO is of the opinion that the direction should be revoked, he/she must in terms of 208(3)or (4) submit a report to the Scottish Ministers complying with the requirements set down in section 207(3) and including the recommendation as soon as practicable after carrying out the review.

Scottish Ministers' duty to keep a direction under review (section 212)

31. Section 212 places a duty on the Scottish Ministers to keep a direction under ongoing review, by considering 'from time to time' the matters set out in section 212(2).

32. If following the review the Scottish Ministers are satisfied in terms of sections 210(2), or 212(3) or (4), that the direction should be revoked they may revoke it without recourse to the Tribunal. If the Scottish Ministers do not revoke the direction after receiving a report from the RMO under 207(2) that includes a recommendation, or a report under section 208(3) or (4), they are under a duty to refer the patient's case to the Tribunal in accordance with section 210(3).

POWER OF THE SCOTTISH MINISTERS TO REVOKE A DIRECTION

33. Where the Scottish Ministers have received a report from the RMO which contains a recommendation that the direction should be revoked they must either revoke the direction in accordance with section 210(2) or refer the patient's case to the Tribunal under section 210(3).

34. When considering whether the direction should be revoked, the Scottish Ministers must consider the matters set down in paragraphs (a) to (c) of section 212(2). These are essentially the same criteria as those considered by the RMO in the review of the direction.

35. Where a reference is made to the Tribunal in terms of section 210(3), after hearing the patient's case in accordance with section 215(6) the Tribunal may direct the Scottish Ministers to revoke the direction under section 215(3) or (4).

CIRCUMSTANCES WHICH MAY PROMPT A "REFERENCE" OR AN "APPLICATION" TO THE TRIBUNAL

Reference initiated by the RMO

36. Where the RMO has submitted a report to the Scottish Ministers which includes a recommendation for the direction to be revoked (sections 207(2) or 208(3) or (4)), if the Scottish Ministers do not revoke the direction, they are under a duty to refer the patient's case to the Tribunal in accordance with section 210(3). This reference must include the name and address of the patient and of the patient's named person and the reason for making the reference (section 210(5)). Where they are making such a reference the Scottish Ministers must, in accordance with section 210(4), notify the patient, the patient's named person, any guardian, any welfare attorney, the RMO, the MHO and the MWC.

MHO – best practice points for where a reference has been initiated by the RMO

37. On receiving such a notification the MHO would be expected to take account of the nature of the changes being proposed and form a clear opinion in relation to them. This will require the MHO to have a well informed current knowledge of the patient's circumstances, the views of the multi-disciplinary team and the basis of the RMO's opinion and recommendation. The MHO would be expected to discuss any proposed change in conditions with, and know the views of, the patient, the primary carer, the named person, and any guardian or welfare attorney.

38. Best practice would suggest that there should already have been close consultation and collaboration between the RMO and MHO prior to the RMO finalising his/her opinion and preparing the report to the Scottish Ministers.

39. Where, following the receipt of a report from the RMO recommending that that direction is revoked, the Scottish Ministers do not revoke the direction, the MHO would be expected to be clear as to the basis of the differing opinions, and consider carefully the potential implications for the patient's health, welfare, safety, or safety of others, associated with the revocation and the non revocation of the direction.

40. Many of the matters for consideration by the MHO in these circumstances, are similar to the considerations described in chapter 3 in relation to a review of a CORO. However a significant difference in relation to a direction is that the alternative to care and treatment in hospital under compulsory powers is a return to prison, and treatment only on a voluntary basis if appropriate. Best practice would suggest that the MHO should therefore consider carefully the implications of this alternative for the patient, and be satisfied that arrangements for his/her return to prison will not immediately present a serious risk of detriment or deterioration to the patient's mental health. Equally it may be that the patient is keen to return to prison and may perceive this as an important step and one that best enhances his/her sentence progression and eventual rehabilitation within the criminal justice system.

Reference initiated by the MWC

41. The MWC may notify the Scottish Ministers in writing under section 209(2) that it requires the patient's case to be referred to the Tribunal in a similar manner to a reference being made under section 186 in respect of a patient subject to a CORO. For further information refer to Chapter 3, paragraph 43.

Automatic reference made by the Scottish Ministers after two years

42. Under section 213, where none of the following references or applications have been made to the Tribunal during the two year period following the imposition of the direction, or during any subsequent two year period ending with the anniversary of the imposition of the direction, the Scottish Ministers must refer the patient's case to the Tribunal for review:

- a reference by the Scottish Ministers under sections 210(3) or 211(2)
- an application under section 214(2) by the patient or the patient's named person

43. In terms of section 213(3) a previous reference to the Tribunal under section 213 must be disregarded if it was made in the first year of the two year period under consideration. In practice it would be expected that the Tribunal would review the patient's case a minimum of every two years. Section 213(5) sets down the information that should be included in the reference, namely the name and address of the patient, the name and address of the patient's named person and the reason for making the reference. Where making such a reference to the Tribunal the Scottish Ministers must, in accordance with section 213(4), inform the patient, the patient's named person, any guardian, any welfare attorney, the RMO, the MHO and the MWC.

Application by patient or named person

44. The patient and the patient's named person may make an application to the Tribunal in terms of section 214(2) requesting that the Tribunal revoke the direction.

45. Where the patient is subject to an HD this application cannot be made within 6 months of the making of the direction (section 214(4)).

46. Where the patient is subject to a TTD, he/she may make an application to the Tribunal during the first 12 weeks of the direction being made. Should he/she not do so an application cannot be made until 6 months have passed since the making of the transfer for treatment direction (section 214(5)).

47. In accordance with section 214(6) only one application may be made in the 12 month period beginning with the imposition of a direction, and then in every 12 month period thereafter. Where an application is made by the named person then he/she must inform the patient in terms of section 214(7).

48. Best practice would suggest that the RMO and the MHO should bear in mind that the patient and/or the named person may require particular assistance to make an application, the

support of advocacy services, or information about appropriate legal services. The RMO and the MHO should be satisfied that where required the patient and the named person have access to appropriate information about services that are available for the purpose of making the application.

Powers of the Tribunal

49. Section 215 sets out the powers of the Tribunal following a reference or an application being made under sections 210(3), 211(2), 213(2) or 214(2). The Tribunal may make:

- no direction to the SM to revoke the direction (section 215(2))
- a direction to the SM to revoke the direction (section 215(3) or (4))

50. The Scottish Ministers are under a duty under section 215(5) to revoke the direction where directed to do so by the Tribunal; it is not a matter for the Scottish Ministers' discretion.

51. In terms of section 215(6), before making its decision the Tribunal must hold a hearing, and allow the following persons to make representations (orally or in writing) or lead/produce evidence:

- Patient
- Named person
- Primary carer
- Guardian
- Welfare attorney
- *Curator ad litem* appointed by the Tribunal
- the Scottish Ministers
- RMO
- MHO
- Any other person appearing to have an interest (This could include, for example, the patient's solicitor or a psychologist or other party who is providing care and treatment to the patient).

CHAPTER 8
DISCHARGE OF A PATIENT SUBJECT TO A DIRECTION

Introduction

Throughout the duration of a direction the Scottish Ministers may revoke it without any recourse to the Tribunal under sections 210(2) or 212(3) or (4) of the Act, either following their own review of the patient's case, or following a report which includes a recommendation from the patient's RMO. In certain circumstances the Scottish Ministers are under a duty to revoke the direction when directed to do so by the Tribunal in terms of sections 215(3) or (4).

This chapter describes the different scenarios that may arise at the expiry of the patient's sentence in relation to his/her detention under the Act.

Revocation of a direction before the expiry of sentence

1. Where the direction is revoked before the expiry of the patient's sentence the Scottish Ministers must, in accordance with section 216(2), direct that the person is admitted to prison or another institution or place in which he/she would have been liable to be detained if he/she had not been admitted to hospital under the direction. This would be expected to be instigated by the Scottish Ministers issuing a warrant.

2. It would be expected that the hospital managers arrange for the transportation of the person to prison.

3. The direction ceases to have effect upon the person's admission to the prison, institution or place to which the patient is admitted under section 216(3).

Direction ceasing to have effect at the expiry of sentence

4. If a patient remains detained in hospital under a direction at the point when he/she is released under Part 1 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 or otherwise, the direction ceases to have effect on that date (section 217).

5. If at that time the patient meets the criteria for a CTO as set down in section 64(4), the patient's designated MHO would be expected to make an application to the Tribunal for this order to come into force at the end of the direction in accordance with section 71 of and Schedule 3 to the Act. (See 'Continued detention at the expiry of sentence' in paragraph 6).

Continued detention at the expiry of sentence (section 71 and Schedule 3 to the Act)

6. For those patients who are considered to still require compulsory medical treatment for mental disorder under the Act at the time when he/she would have been released from prison, section 71 of, and Schedule 3 to, the Act sets out the procedure for an application for a CTO to be made to the Tribunal. The Tribunal may make the CTO within the 28 day

period before the expiry of the direction and the order takes effect on the day that the direction ceases. As with any CTO, the authorised medical treatment may be in hospital or in the community, and the duration of the CTO is 6 months before it will require to be renewed.

7. Given the timescale involved, best practice would suggest that at least 2 months before the direction is due to fall the RMO, in consultation with the MHO and the rest of the multi-disciplinary team, should review the patient's case and make a decision as to whether an application should be made to the Tribunal for a CTO. Where an application is considered necessary it must be made by the patient's designated MHO. For further information on the application process refer to Volume 1, Chapter 5 of this Code of Practice, taking into account Schedule 3.

8. As a general rule it would be expected that emergency detention (section 36) or short-term detention certificates (section 44) would <u>not</u> be used at the end of a direction to detain a person in hospital. However in some circumstances they may be necessary, for example:

- where a patient has agreed to remain as an informal patient but then, perhaps due to a deterioration in his/her mental state or otherwise, he/she refuses to stay in hospital
- where a decision has been made to allow a patient to be discharged, but prior to discharge there is a deterioration in his/her mental state
- where a prisoner has been transferred to hospital within days of the direction lapsing and there is insufficient time to take the necessary steps required to apply for a CTO

9. Under such circumstances Part 5 and Part 6 of the Act, and the Code of Practice relating to these parts must be followed. However it is expected that the circumstances where these procedures may require to be followed should be rare.

Compulsory powers imposed in the community on a patient who is released on licence

10. Where the RMO considers that compulsory treatment of the patient's mental disorder should be imposed in the community while the patient is on licence, an application may be made to the Tribunal by the designated MHO for a CTO (see section 71 of, and Schedule 3 to, the Act). The application requires a mental health officer's report and a proposed care plan by the designated MHO, and mental health reports by two medical practitioners. Volume 1 Chapter 5 of this Code ("Applying for a compulsory treatment order") should be referred to for information, bearing in mind the application provisions set down in section 71 of, and Schedule 3 to, the Act.

11. The Tribunal may make a CTO in these circumstances <u>provided that the direction has less than 28 days to run</u>. The measures specified in the CTO do not come into effect until the expiry of the direction. Care should therefore be taken in the timing of the application to the Tribunal in relation to any Parole Board hearing where the patient's release on licence is being considered.

CHAPTER 9: SUSPENSION OF THE MEASURE OF DETENTION (PART 13)

Introduction

Sections 224 to 226 of the Act set out the procedures for temporarily suspending the measure in a CORO which authorises detention in hospital. Suspension of the measure of detention is achieved by the patient's RMO granting a certificate in terms of section 224(2) after obtaining the consent of the Scottish Ministers (section 224(3)).

These procedures also apply to:

- a treatment order (section 52M of the 1995 Act)
- an interim compulsion order (section [153]? of the 1995 Act)
- a hospital direction (section 59A of the 1995 Act)
- a transfer for treatment direction (section 136 of the 2003 Act)

For the purposes of this chapter a CORO and the orders listed above are referred to as 'a relevant order'.

This chapter describes the formal processes associated with the temporary suspension of the measure in a relevant order which authorises detention in hospital.

OVERVIEW

1. Prior to the Act coming into force suspension of detention was generally referred to as 'leave of absence' or 'being out on pass'. Suspension of detention may be requested for a number of reasons, including:

- rehabilitation including pre-transfer visits to another hospital
- quality of life
- compassionate visits
- scheduled treatment in hospital
- emergency treatment in hospital
- attendance at court

2. In general terms, during the period where his/her detention is suspended, the patient is allowed to leave the hospital to travel to, take part in and return from the specified activity, and he/she must comply with any conditions that are set out in the certificate issued by the RMO granting the period of suspension.

3. It would be expected that any proposed suspension of detention would generally form part of an agreed care plan and so should be a matter of consultation between the RMO, the MHO and the rest of the multi-disciplinary team where relevant and appropriate, as part of the care planning process. The MHO would be expected to consult, and consider the implications for, the patient, the primary carer, the named person or care provider, and any

significant care provider that may be supporting or supervising the patient during the period of suspension. The MHO would also take into account any relevant victim issues or community concerns related to the index offence. Any child protection matters should be considered and requirements in terms of registration in relation to the Sexual Offences Act 2003.

GRANTING THE CERTIFICATE (SECTION 224(2))

Consent of the Scottish Ministers

4. The RMO may grant a certificate suspending the measure authorising detention for a period not exceeding three months under section 224(2) after the RMO has obtained the consent of the Scottish Ministers in accordance with section 224(3).

5. It would be expected that the Scottish Ministers' consent would be sought by way of an application which would address the matters set down in sections 224(4) to (8) but there may also be other non-statutory issues that the Scottish Ministers would require to be covered. Best practice would suggest that, where the RMO is unfamiliar with the process and the administrative procedures involved he/she should contact the Health Department of the Scottish Executive for further information prior to making the application.

The certificate

6. After obtaining the approval of the Scottish Ministers in accordance with section 224(3) the patient's RMO may grant a certificate specifying a period not exceeding three months during which the relevant order does not authorise detention in hospital (section 224(2)). In terms of section 224(5) the period specified may be expressed as

- the duration of an event; or a series of events, or
- the duration of an event; or a series of events, and any associated travel.

7. The total duration of the period specified in the certificate must not exceed 3 months and the total amount of leave during any 12 month period (ending with the expiry of the certificate currently being granted) must, in terms of section 224(4), not exceed 9 months.

8. Conditions may be included in the certificate if the RMO considers it necessary in the interests of the patient, or for the protection of any other persons (section 224(6)). These conditions may include that the patient be kept in the charge of a person authorised in writing by the RMO in terms of section 224(7)(a) (such as a nurse or family member) or other conditions as may be specified by the RMO in terms of section 224(7)(b).

Notification

9. Under section 224(8), where the period specified in a certificate under section 224(2) exceeds 28 days, or when taken together with the period specified in any other certificate granted under section 224(2), would exceed 28 days, the RMO must notify the patient, the patient's named person, the patient's general medical practitioner and the MHO before granting the certificate. It would be expected that this would allow for the arrangement of any necessary services for the patient. Where the certificate specifies a period of more than 28 days the RMO must also notify the MWC within 14 days of the granting of the certificate in accordance with section 224(10).

REVOCATION OF THE CERTIFICATE (SECTIONS 225 AND 226)

The circumstances in which a certificate may be revoked

10. A certificate granted under section 224(2) may be revoked by the RMO under section 225(2) or by the Scottish Ministers under section 226(2) if either is satisfied that it is necessary in the interests of the patient, or for the protection of any other person.

Notification

11. Where the RMO revokes the certificate he/she must, as soon as practicable after doing so, inform the patient, the patient's named person, the patient's general medical practitioner (if the leave was for more than 28 days), any person in whose charge the patient may have been, the MHO and the Scottish Ministers (section 225(3)).

12. Where the Scottish Ministers revoke the certificate they must, as soon as practicable after doing so, inform the patient, the patient's named person, the patient's general medical practitioner (if the leave was for more than 28 days), any person in whose charge the patient may have been, the RMO and the MHO (section 226(3)).

13. If the certificate had granted a period of suspension of more than 28 days the RMO and the Scottish Ministers are under a duty in terms of sections 225(4) and 226(4) respectively to notify the MWC within 14 days of the certificate being revoked.

CHAPTER 10: TRANSFERS (PART 12)

Introduction

Part 12 of the Act sets out the procedures for the transfer between hospitals of a patient who is subject to a CORO. These procedures also apply to:

- a hospital direction (section 59A of the 1995 Act)
- a transfer for treatment direction (section 136 of the 2003 Act)

For the purposes of this chapter a CORO and the orders listed above are referred to as 'a relevant order'.

This chapter describes the formal processes associated with the transfer of a patient who is subject to a relevant order.

OVERVIEW

1. Section 218 sets out procedures for the transfer of a patient who is detained in hospital under a relevant order. A patient subject to a relevant order may require to be transferred to another hospital under the following circumstances:

- as part of rehabilitation through lower levels of security and nearer to the community where the patient will ultimately return to
- where it is considered that the patient requires a higher level of security than that which he/she is currently subject to
- where the treatment for mental disorder that the patient requires cannot be adequately provided in the current hospital
- where the patient requires treatment for physical illness in a general medical hospital

Best practice points

2. A transfer to another hospital should be planned well in advance, and such planning should involve staff from the current services (Health Board and local authority) including the RMO, the MHO and a suitably qualified psychologist where appropriate; staff from the receiving services (Health Board and local authority) including the proposed RMO, MHO and suitably qualified psychologist where appropriate; the patient; the patient's named person and carers; the patient's advocate, and the Scottish Ministers.

3. Where the proposed transfer involves the patient moving outwith his/her area of origin (i.e to a different Health Board or local authority area other than that which holds current responsibility for funding and care management arrangements for the patient) the 'receiving'

Health Board and local authority should be consulted as early as possible in the proceedings so as to secure any funding or care management commitment that may be required to support the proposed transfer. However under certain circumstances (e.g. if it is necessary for the urgent medical treatment of the patient's physical illness) a rapid transfer may be necessary without such planning having occurred. In these circumstances the RMO would be expected to ensure that the MHO, the primary carer and the named person are notified as soon as possible.

NON-URGENT TRANSFERS

Overview

4. Under sections 218(2) and 218(3) the managers of the hospital in which the patient is detained ("the current hospital") may transfer a patient subject to a relevant order to another hospital ("the receiving hospital") with the consent of the managers of the receiving hospital and the Scottish Ministers. At least 7 days' notice must be given to the patient (unless the patient consents to the transfer) and the named person in accordance with section 218(4).

5. If the proposed transfer does not occur within 3 months of the notice being given, section 218(9) provides that the transfer may only proceed if the managers of the receiving hospital and the Scottish Ministers still consent to it, and at least 7 days' notice has been given to the patient (unless the patient consents to the transfer) and the named person of the proposed date of transfer.

6. Best practice would suggest that care should be taken in the assessment of what constitutes the patient giving consent in circumstances where the patient is still subject to powers of compulsion (as described in paragraph 4). For example where it is judged that the patient is giving voluntary consent, consideration should be given to the involvement of an advocate and/or the named person in the decision. A clear record should be made on the medical records and this may include any direct record the patient might him/herself wish to provide.

7. Section 218(12) places a duty on the managers of the current hospital to notify the MWC of the matters set down in section 218(13) within 7 days of the transfer taking place. These matters are:

(a) the date on which the patient was transferred;
(b) the hospital to which the patient was transferred;
(c) that—
  (i) notice was given under section 218(4); or
  (ii) if no such notice was given, the reasons why it was necessary that the patient be transferred urgently;
(d) whether notice was given under section 218(6) or (10)(b)

Transfer to another hospital as part of rehabilitation – best practice points

8. A patient subject to a relevant order may be transferred to another hospital as part of his/her rehabilitation. This may include a transfer to another hospital:

- which provides a lower level of security (e.g. a transfer from a state hospital to a local hospital's medium or low security ward, or transfer from a secure ward within one hospital to an open ward in another hospital)

- which is closer to the community where the patient will eventually be discharged to (e.g. a transfer from a secure ward in one part of Scotland to a secure ward in another part of Scotland)

- which provides treatment which may not be available for the patient in the current hospital (e.g. a transfer of a patient with learning disability from a ward in a hospital for patients with mental illness to a ward in another hospital specialising in the treatment of patients with learning disability)

9. It would be expected that such transfers would be planned well in advance (see paragraphs 2 and 3 of this chapter). Where the RMO, in consultation with the MHO and the rest of the multi-disciplinary team in the current hospital (and the patient and the primary carer), is of the opinion that such a transfer may be appropriate in the near future, a referral should be made to the appropriate local health and social work services. These local services should then arrange for a multi-disciplinary assessment involving the proposed RMO, MHO, nursing staff, and any other appropriate members of the team (e.g. a suitably qualified psychologist). Following these comprehensive assessments, if agreement to the transfer is reached in principle, the care planning process should be put in place to support further transfer planning.

10. Careful consideration should be given to any possible funding and care management issues that may need to be agreed or put in place prior to formally agreeing and commencing a transfer. For example it may be anticipated that the patient's future community care needs will be complex and that provisional planning for such services should be commenced as part of the proposed transfer to local services. Such forward planning can help reduce undesirable delayed discharges at a later stage, and potential difficulties in implementing rehabilitation planning in future. If agreement to the transfer is reached *in principle*, then plans should be put in place regarding the appropriate timing of the transfer actually taking place (in accordance with section 218) in liaison with the Scottish Ministers.

11. Usually the patient would visit the receiving hospital initially under suspension of detention provisions set down in section 224 which would require the consent of the Scottish Ministers (see chapter 5). Depending on the individual circumstances of the patient this may involve just a few visits, or may involve a number of visits over a more prolonged period. If following these visits the transfer seems feasible and appropriate, then a formal request should be made to the Scottish Ministers for consent to the transfer by the RMO (who will be acting on behalf of the managers of the current hospital) stating the approximate date of the proposed transfer, that there is an appropriate bed available and that an RMO in the receiving hospital has been identified and has consented to the transfer (he/she will be acting on behalf of the managers of the receiving hospital).

12. The request for the transfer to the Scottish Ministers may include details relating to the following matters:

- the patient's treatment and progress while in hospital including his/her response to any period where detention has been suspended
- evidence of patient's current condition and behaviour
- the patient's insight into his/her mental disorder and the need to accept treatment
- the opinion of the designated MHO

- the views of the primary carer and the named person
- confirmation that the proposed RMO has assessed the patient and is prepared to accept the patient into his/her care
- details of pre-transfer visits, if necessary, and the patient's reactions and behaviour on these
- details of the initial treatment and care plans for the patient in the receiving hospital following transfer, including any anticipated needs and planning for community care services in the foreseeable future (this would usually be drawn up by the receiving RMO in consultation with the rest of the multi-disciplinary team where relevant)
- information in relation to the victim or the victim's family if transfer is to the area in which the index offence took place.

Transfer to a more secure hospital – best practice points

13. The level of security of the unit to which a patient is transferred should be the least restrictive setting taking into account the risk the patient poses and his/her clinical needs. The question of whether a patient should be transferred to a more secure hospital depends on the risk he/she poses to others and whether this could be managed safely in a less secure setting. However under certain circumstances (e.g. a deterioration in a patient's mental state, a patient displaying aggressive behaviour, a patient escaping or absconding, the emergence of new information which changes the assessment of the risk the patient poses) consideration may require to be given to transferring the patient to another hospital so that he/she may be cared for in a more secure environment. Usually this would not arise as an urgent issue, but it may and if so should be dealt with as set out in paragraphs 14 to 16 below.

14. Although not a statutory provision under the Act best practice would suggest that the RMO should consult the designated MHO about any proposed transfer. In forming his/her opinion the MHO should consider if he/she is satisfied that the proposed transfer is necessary to provide the care and treatment that the patient requires, including the protection of others and the public.

15. Where practicable the MHO should interview the patient and, with the patient's consent, consult the primary carer and named person, or any other relevant party who is directly and significantly involved in the patient's care and treatment. In consultation with the RMO consideration should also be given to the assessment of the patient's capacity, particularly if the circumstances of the proposed transfer are associated with a significant or acute deterioration in the patient's mental heath.

16. The current RMO should refer the patient to the potential receiving hospital, for assessment by a psychiatrist (and usually other members of the clinical team including any proposed new designated MHO and a suitably qualified psychologist if appropriate). If the assessing psychiatrist accepts that the patient should be transferred, then a formal request for transfer should be made to the Scottish Ministers as outlined in paragraph 11. In most cases the RMO will have liaised with the Scottish Ministers regarding the potential transfer before

making this request. The RMO (who will be acting on behalf of the managers of the current hospital) should state the approximate date of the proposed transfer, that there is an appropriate bed available and that an RMO in the next hospital has been identified and has consented to the transfer (he/she will be acting on behalf of the managers of the receiving hospital).

Transfer to a general medical hospital for treatment of physical illness

17. In most cases treatment in a general medical hospital for physical illness would expect to be undertaken via the suspension of detention provisions set down in section 224 (see chapter 9). In such circumstances the MHO should be closely involved as it is likely that there may be increased concerns for the patient and any carers at that time. The MHO should be fully involved in assessing the need for increased support for carers which should also include advice and practical assistance.

18. If it seems likely that the patient will require a prolonged period of treatment for physical illness (lasting longer than 3 months – this is the maximum time that section 224(2) allows for one continuous period where the patient's detention has been suspended) then the Scottish Ministers' consent must be sought for a transfer to this hospital in terms of section 218(3). Best practice would suggest that this should be done well in advance of the end of the three month period allowed under the suspension of detention provisions set down in section 224.

19. An appropriate RMO at the receiving hospital, who would be expected to be a consultant psychiatrist, would be identified, and the consent of the managers of the receiving hospital must be given in terms of section 218(3).

URGENT TRANSFERS

Overview

20. An urgent transfer differs from a non-urgent transfer in that notification need not be given to the patient and named person at least 7 days before the transfer (section 218(5)), but such notification must be given as soon as practicable, either before or after the transfer has occurred (section 218(6)). As with non-urgent transfer, no notification to the patient is required if the patient consents to the transfer (section 218(7)) (see paragraph 6 relating to the assessment and the recording of consent). The requirements as to the consent of the SM and the managers of the receiving hospital still apply (section 218(3)). Similarly the duty placed on the current hospital by section 218(12) to notify the MWC also applies (see paragraph 7).

Transfer to a general medical hospital for treatment of physical illness

21. It would be expected that medical emergencies would not be dealt with using these provisions, but would be more appropriately dealt with under provisions for 'suspension of detention' as set down in sections 224 to 226 (see chapter 9).

Transfer to a more secure hospital – best practice points

22. It would be expected that 'suspension of detention' arrangements under sections 224 to 226 would not be used to transfer a patient to a more secure hospital. If an urgent situation arises where a patient requires to be transferred to a more secure hospital, or a more secure ward in another hospital, then:

- an urgent referral should be made to the proposed receiving hospital
- the Scottish Ministers should be notified and urgent consent should be sought for transfer if the receiving hospital accepts the referral.

23. Sometimes there will be time for an assessment by a psychiatrist (and perhaps other staff such as a suitably qualified psychologist) from the potential receiving hospital, but in emergency circumstances this may not be feasible.

24. Although not a statutory provision under the Act the RMO should notify the MHO as soon as possible in cases of urgent transfer. The MHO can ensure that any such transfer is urgently notified to the receiving local authority and if necessary, arrange the transfer of designated MHO duties. The MHO should liaise closely with the primary carer, the named person or any other significant party directly and significantly concerned with the patient.

25. This procedure should be used where the urgency of the situation means that giving the 7 days notice necessary for non-urgent transfers as set down in section 218(7) would involve undesirable delay bearing in mind the mental health needs of the patient and the risk he/she poses. However the urgent procedure should not be used to simply transfer a patient quickly, but where the circumstances do not warrant the use of non-urgent procedure with the required 7 days notice to the patient and named person.

APPEAL AGAINST TRANSFER

26. Sections 219 and 220 set down the procedures for a patient who is subject to a relevant order, and the patient's named person, to appeal to the Tribunal against the patient being transferred to another hospital.

27. Best practice would suggest that the RMO and the MHO should ensure that the patient and the named person are fully and properly advised of their rights of appeal against transfer, and are supported in pursing these rights where they require. This should be done as far in advance of any proposed transfer as possible, the exception being where the transfer has been urgently necessary to immediately safeguard the health and safety of the patient or others.

Appeal against transfer to a hospital other than a state hospital

28. Sections 219(2) and (3) set down the timescales for appeals by the patient and the named person against a transfer to a hospital other than a state hospital. Where the patient was notified of the transfer before it took place the patient and the patient's named person may appeal to the Tribunal during the period beginning with the day on which notice was given and ending 28 days after the transfer. Where the patient was notified on or after the transfer, he/she and his/her named person may appeal to the Tribunal during the period beginning with the day on which the patient was transferred and ending 28 days after the day on which notice was given. Where no notice was given to the patient, the patient alone may appeal to the Tribunal within the period of 28 days beginning with the day on which the patient was transferred.

29. If an appeal has been made to the Tribunal before the proposed transfer has taken place, the transfer may not go ahead until the appeal has been concluded unless the Tribunal orders that it should in accordance with section 219(4)(b).

Appeal against transfer to a state hospital

30. Sections 220(2) and 220(3) set down the timescales for appeals by the patient and the named person against a transfer to a state hospital. Where the patient was notified of the proposed transfer before it took place the patient and the patient's named person may appeal to the Tribunal during the period beginning with the day on which notice was given and ending 12 weeks after the transfer. Where the patient was notified on or after the transfer, he/she and his/her named person may appeal to the Tribunal during the period beginning with the day on which the patient was transferred and ending 12 weeks after the day on which notice was given. Where no notice was given to the patient, the patient alone can appeal to the Tribunal during the period of 12 weeks beginning with the day on which the transfer took place.

31. Where an appeal has been made to the Tribunal before the transfer has taken place, the transfer may not go ahead until the appeal has been concluded unless the Tribunal orders that it should in accordance with section 220(4)(b). An example of this might be where the patient's mental state and behaviour is such that the RMO and the SM consider that, for the safety of the patient and for the protection of others, the patient should be transferred to the state hospital before the appeal has been concluded.

32. If the Tribunal is not be satisfied that the patient requires to be detained in hospital under conditions of special security and that those conditions can be provided only in a state hospital then it may make an order that the proposed transfer not take place or, as the case may be, that the patient be returned to the hospital from which the patient was transferred. (section 220(5) and (6)).

CHAPTER 11: GLOSSARY OF COMMONLY USED TERMS

An **approved medical practitioner** is a medical practitioner who has been approved under section 22 of the Act by a Health Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder. An approved medical practitioner will often be a consultant psychiatrist.

An **Assessment Order** is a pre-disposal order made by the court under section 52D of the 1995 Act that authorises hospital detention for up to 28 days so that the patient's mental condition may be assessed.

For the purposes of the 1995 Act a "**chartered psychologist**" is someone who is entered on the British Psychological Society Register of Chartered Psychologists (section 307). It is expected that they will also be able to demonstrate the additional competencies necessary to carry out any specific duties under the Act.

In general, chartered psychologists with a clinical training ('Clinical Psychologists') have particular competencies in relation to assessing psychological attributes such as capacity and providing psychological treatment, while chartered psychologists with a forensic training ("Forensic Psychologists") have particular competencies in risk assessment and addressing offending behaviour. "Clinical Forensic Psychologists' have accredited expertise in both areas.

It is not envisaged that chartered psychologists will always personally implement all psychological interventions and often their skills may be more appropriately employed in assessment, formulation, treatment planning and support of other staff carrying out psychological interventions.

A **Compulsion Order** is a mental health disposal made by the court under section 57A of the 1995 Act that authorises compulsory measures (either hospital or community based) for a period of 6 months, if not otherwise renewed.

A **Compulsory Treatment Order** is an order granted by the Mental Health Tribunal under section 64(4) of the 2003 Act in relation to patients who are subject to civil detention procedures. It authorises compulsory measures (for example, detention in a hospital) for a period of six months, if not otherwise renewed.

Criminal justice social work services provide services to the courts. In relation to mentally disordered offenders, the role of criminal justice social work services is primarily concerned with providing information and advice for sentencers and with helping to access appropriate assessment, health and social care services. This should complement the work of other local authorities and health services in providing services for mentally disordered offenders.

An **Examination of Facts** is a court procedure under section 55 of the 1995 Act in cases of insanity. The court examines the evidence to determine beyond reasonable doubt whether the accused did the act or made the omission with which he/she is charged, and whether on the balance of probabilities there are any grounds for acquitting him/her.

'Forensic compulsion criteria': for a court to make a mentally disordered offender subject to a mental health disposal, generally speaking it must be satisfied that all of the following criteria are met:

- the person has a mental disorder
- medical treatment is available which would be likely to prevent that disorder worsening or be likely to alleviate the symptoms or effects of the disorder
- there would be a significant risk to the health, safety or welfare of the person or to the safety of any other person if treatment were not provided
- the making of the disposal is necessary

For the criteria relevant to each order, the relevant section will require to be considered.

Mentally disordered people who come into contact with the criminal justice service should receive care and support from health and social work services. **Health Boards** have a duty to ensure that health provision is provided by appropriate agencies.

A **Hospital Direction** is a mental health disposal imposed by the court under section 59A which is made in addition to a sentence of imprisonment. It allows the person to be detained in hospital initially for treatment of his/her mental disorder and then transferred to prison to complete his/her sentence once detention is no longer required.

An **Interim Compulsion Order** is a pre-disposal order made by the court under section 53 authorising hospital detention for 12 weeks (but can be renewed regularly for up to one year) so that the court can gather further evidence on whether the forensic compulsion criteria apply.

An **Intervention Order** in relation to criminal justice proceedings is made by the court under section 60B. In general terms, the purpose of the order in these circumstances is to allow for specific one off measures relating to matters such as personal welfare to be authorised for a mentally disordered person, who has been found insane or convicted of an offence, and who has incapacity in relation to taking the relevant action or decision.

A **Guardianship Order** in relation to criminal justice proceedings is made by the court under section 58(1A). It allows for a 'welfare guardian' to be appointed for a mentally disordered person who has been found insane or convicted of an offence, and who has incapacity in relation to making the relevant decisions with regard to personal welfare. This order is intended for continuous management where the person needs long-term involvement from someone else to make decisions for him/her.

The **Life Prisoner Tribunal** consists of three members of The Parole Board for Scotland, appointed by the Chairman of the Board. The Chairman of the Tribunal must be qualified to hold judicial office. All life prisoners must have their case for release on licence considered by a Tribunal of the Board. In considering the case of a life prisoner the Tribunal has the power to direct the release of the prisoner if it is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined.

Local authorities contribute to services for mentally disordered offenders through their responsibility for planning and providing community care services in partnership with the NHS; through their duty under the 2003 Act to provide MHO services; and their responsibility for providing criminal justice social work services in the criminal justice

system. The local authority also has specific duties under sections 25, 26 and 27 of the 2003 Act to provide care and support services, and to promote well-being and social development.

Medical treatment is treatment for mental disorder as defined by section 329 of the 2003 Act. This includes nursing, care, psychological intervention, habilitation (including education, and training in work, social and independent living skills) and rehabilitation. The term "medical treatment" includes pharmacological interventions as well as other physical interventions (such as ECT) in addition to psychological and social interventions made with respect to mental disorder. Any references to "medical treatment" in the 1995 Act and the 2003 Act should be read in light of the definition given at section 329 of the 2003 Act.

A **Mental Health Officer**, (MHO), must be designated for the patient by the relevant local authority as soon as reasonably practicable after the person is made subject to a 'relevant event' in terms of section 232 of the 2003 Act. The designated MHO is required to prepare a Social Circumstances Report in accordance with section 231 of the 2003 Act in all cases except where he/she considers that it would serve little or no purpose.

The MHO is expected to work closely with the RMO, to contribute to the assessment and formulation of recommendations in the case. The MHO also provides an MHO report to the court as directed under section 57C or 59C when the court is considering making a compulsion order or a hospital direction respectively. There must be a designated MHO for the patient throughout the period that he/she is subject to compulsory powers.

A **Mental Health Officer's report** is a report prepared by the MHO upon the instructions of the court under section 57C or 59C, the purpose of which is to assist the court in considering whether a compulsion order or a hospital direction respectively is an appropriate and feasible disposal for the offender.

The **Mental Welfare Commission** is an independent organisation set up by Parliament with responsibility for protecting the welfare of people with mental disorder (including learning disabilities and dementia) in Scotland. It has a duty to anyone with a mental disorder whether they are in hospital, in local authority, voluntary run or private accommodation, or in their own homes. It enquires into cases of alleged ill-treatment or deficiency of care and treatment, and visits patients in hospital or in the community.

A **multi-disciplinary team** is the team providing care, treatment and support to the patient while they are in receipt of mental health services. The membership and nature of the team will necessarily vary according to the needs and circumstances of the patient. It would, however, be expected that the team would be made up of, where appropriate and relevant, medical practitioner(s), an MHO and other social workers, nursing staff/CPNs, psychologists, occupational therapists etc. The team may also include community care service providers or voluntary organisations providing care and treatment. These components of the multi-disciplinary team would work together to co-ordinate and agree on all aspects of the patient's care and treatment. Multi-disciplinary working of a high quality will necessarily entail a genuine respect for the opinions of all members of the team; regular communication between all members of the team; and clearly defined information sharing processes.

Parole is a scheme which enables long term and life prisoners to be released on licence in the community under the supervision of a social worker

The Parole Board for Scotland is a Non-departmental Public Body the members of which are appointed by the Scottish Ministers and who direct the Scottish Ministers on matters relating to the release of prisoners on licence.

A **place of safety** for a mentally disordered offender is defined by section 307 as a police station, prison or remand centre, or any hospital the board of management of which are willing to temporarily receive the person.

A **Police Casualty Surgeon** may recognise mental disorder in police detainees and bring this to the attention of the police. In some circumstances they may also have a role in bringing this to the attention of the court and in initiating a psychiatric assessment.

The **Prisoner Escort and Court Custody Service** has the responsibility of escorting prisoners, including patients detained under the Act and the 1995 Act, between hospital, prison and the courts.

Remanded and convicted prisoners are in the care of the **Prison Medical Service** which is responsible for the provision of primary health care in prisons. This is achieved through directly employed or contracted health professionals. The service has a duty to recognise mental disorder and to initiate psychiatric assessment of mentally disordered prisoners.

In relation to mentally disordered offenders the **Prosecutor** has a statutory duty, where it appears to him/her that a person may be suffering from mental disorder, to bring before the court such evidence as may be available of the mental condition of the person.

Psychological treatments are prominent in all areas of mental disorder. They are used in the treatment of mental illness and are often the primary treatments in learning disability and personality disorder. Treatments for offending behaviour are also principally psychological in nature. In relation to treatment it is therefore important to consult an appropriately qualified chartered psychologist. It is considered particularly necessary if:

- the primary diagnosis is one of learning disability or personality disorder
- there is a need to assess any patient's psychological needs at an in-depth level;
- there is a need to assess capacity at a complex level;
- a complex psychological intervention is necessary as part of the treatment plan;
- the treatment involves a manipulation of the therapeutic environment using psychological techniques such as differential reinforcement of other behaviour.

In relation to criminal justice proceedings a **Responsible Medical Officer** must be appointed by the hospital managers under section 230 of the 2003 Act as soon as practicable after the occurrence of an appropriate act in relation to a patient (defined as including an assessment order, treatment order, temporary compulsion order, interim compulsion order, remand to hospital for inquiry into mental condition, compulsion order and variation of a compulsion order, hospital direction, a transfer for treatment direction. For a complete list refer to section 230(4) of the 2003 Act for a complete list.

In some cases a person may already have a RMO who will continue in this role. The RMO's role incorporates functions relevant to patients under civil detention procedures but also includes duties to liaise with and report to the prosecutor or the court in cases where a final disposal has not been made.

A **Restricted patient** is a patient who has been made subject to a compulsion order and a restriction order by the court in terms of section 57A and 59 respectively.

A **Restriction Order** is an order made by the court under section 59 at the time of disposal and which is added to a Compulsion Order. It means that the measures specified in the Compulsion Order are without limit of time and that the Scottish Ministers' consent is required before the patient can be granted leave or transferred to a different hospital.

The 2003 Act gives the **Scottish Ministers** particular duties and powers in relation to mentally disordered offenders. The consent of the Scottish Ministers is required at the following points in the care of mentally disordered offenders:

- the temporary suspension of detention for patients who are subject to an assessment order, a treatment order, an interim compulsion order, a compulsion order and a restriction order, a hospital direction or a transfer for treatment direction (Part 13 of the 2003 Act)
- transfer to other hospitals of patients who are subject to a restriction order, a hospital direction or a transfer for treatment direction (Part 12 of the 2003 Act)
- transfer between hospital and prison (section 136 of the 2003 Act)

A **Social Circumstances Report** is a report on the social circumstances of the patient produced under section 231 of the 2003 Act. It is prepared by the patient's designated MHO within 21 days of any of the following orders being made by the court: an assessment order, a treatment order, an interim compulsion order, a compulsion order (with and without a restriction order), a hospital direction or a transfer for treatment direction. An MHO does not need to complete an SCR where he/she is satisfied that it would serve little or no practical purpose.

A **Social Enquiry Report** is a post-conviction report prepared at the court's request by a criminal justice social worker, the purpose of which is to provide the court with information which will assist sentencing. The report provides information about the offender and his/her personal and social circumstances.

The **state hospital** is a high security hospital that provides conditions of special security and which is administered for Scottish Ministers as a Special Health Board. It serves Scotland and Northern Ireland and accommodates patients admitted under the 1995 Act or the 2003 Act. Patients from Northern Ireland are initially detained under the relevant Northern Irish legislation and are then detained under the equivalent Scottish legislation when they are transferred to the State Hospital.

A **Supervision and Treatment Order** is a disposal made by the court under section 57(2)(d) in cases of insanity. It allows the offender to reside and receive treatment in the community with the supervision and support of health and social services.

A **Transfer for Treatment Direction** is an order that is made by the Scottish Ministers under section 136 of the 2003 Act which allows the transfer of a convicted prisoner to hospital for treatment of a mental disorder.

A **Treatment Order is** a pre-disposal order made by the court under section 52M of the 1995 Act authorising hospital detention for treatment of a person's mental disorder. Section 52R(2) of the 1995 Act sets down the circumstances in which the order ceases to have effect.