

# mental health

(care and treatment) (scotland) act 2003

code of practice

volume 3  
compulsory powers in relation  
to mentally disordered offenders

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compulsory powers in relation  
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introduction  
to volume 3



# introduction

## Coverage of this volume

- 01 This Volume of the Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 covers a range of issues relating to mentally disordered offenders.
- 02 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.
- 03 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.
- 04 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 The 1984 Act has been repealed by the Act, but there is a similar division between the provisions of the Act and the 1995 Act. 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 their variation, renewal and revocation.
- 05 Part 1 of this volume addresses the procedures relating to mentally disordered offenders under Part VI of the 1995 Act as amended by Part 8 of the Act.
- 06 Part 2 of this volume addresses the consequences of the mental health disposals inserted into Part VI of the 1995 Act by the Act, and the procedures for their variation, renewal and revocation.

# introduction

## Structure of this volume

*Part 1: Part VI of the Criminal Procedure (Scotland) Act as amended by the Mental Health (Care and Treatment) (Scotland) Act 2003*

07 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 mental health disposals such as absconding and suspension of detention. Unless detailed otherwise, all section numbers in Part 1 refer to the 1995 Act.

08 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 disposals 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: Parts 9 to 13 of the Mental Health (Care and Treatment) (Scotland) Act 2003*

09 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 where it makes a final disposal in the case of a mentally disordered offender. It therefore provides guidance on Parts 9, 10, 11, 12 and 13 of the Act. Unless detailed otherwise, all section numbers in Part 2 refer to the Act.

10 Part 2 consists of nine chapters. Chapter 1 covers 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. The chapter describes the review and renewal procedures for a Compulsion Order which 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 2 of the Code of Practice which describes these procedures for a CTO, this chapter simply points out where the two procedures are different.

# introduction

- 11 Chapter 2 covers the effect of the Compulsion Order when combined with a Restriction Order (“CORO”) and describes the processes which should be followed in the immediate aftermath of a CORO being imposed.
- 12 Chapter 3 examines the processes to be followed when carrying out a review of a CORO as set out in Part 10 of the Act. Chapter 4 outlines the procedures surrounding the conditional discharge and absolute discharge of a person who is subject to a CORO.
- 13 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.
- 14 Chapter 6 covers the effect of the Hospital Direction and the Transfer for Treatment Direction as set out in Part 11 of the Act. Chapter 7 describes the processes associated with their review and revocation. Chapter 8 outlines the procedures surrounding the discharge of a person who is subject to one of these directions and describes the different scenarios which may arise at the expiry of the person’s sentence in relation to his/her detention.
- 15 Chapter 9 details the processes associated with the transfer to another hospital within Scotland of a person who is subject to a CORO, a Hospital Direction or a Transfer for Treatment Direction as set down in Part 12 of the Act.
- 16 Chapter 10 provides a glossary of commonly used terms throughout this volume.
- 17 Chapter 11 provides a list of both statutory and non-statutory forms. Although there is no requirement to use the non-statutory forms, you are strongly recommended to do so as these draw attention to some procedural requirements under the Act. Failure to observe procedural requirements may invalidate the application or certificate or report etc. From September 2005, all forms will be available on the Scottish Executive website at: [www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw)

# introduction

## **Good practice versus best practice**

18 The phrase “best practice” has been used throughout this Code of Practice in preference to the phrase “good practice”. This is to provide consistency with the duty placed on the Mental Welfare Commission by way of section 5 of the Act to “promote best practice” in relation to the operation of Act. The use of the term “best practice” does not imply that any of the activities or duties described in that way are purely aspirational or less likely to be achieved than an activity or duty which might elsewhere be described as being indicative of “good practice”. Where the phrase “best practice” is used in this Code of Practice, it should be read as being synonymous with the phrase “good practice”.

## **Patient Confidentiality**

19 The principles in Section 1 of the 2003 Act require that any decision or course of action being considered (other than a decision about medical treatment) should as far as practical and reasonable take into account the needs and circumstances of the patient's carer and the importance of providing such information to any carer as might assist the carer to care for the patient. However, when a person is considering the information to be shared with the carer, it would be best practice to consider in every case the patient's right to confidentiality about their private medical details and treatment options, before information is supplied. It should also be noted that the Community Care and Health (Scotland) Act 2002 amends the Social Work (Scotland) Act 1968 to give carers a right to have their carer needs assessed by the local authority. It would be best practice to bring this assessment right to the notice of any carer providing a substantial amount of care where the carer appears to have unmet caring needs.

## **Timescales in the Act**

20 The Act uses a number of ways of counting the time period in relation to orders, etc. In all cases, the relevant section of the Act is specific about how these time periods should be counted.

21 Where the Act specifies a number of hours these should be counted in hours from the time of signing the certificate, etc. Examples of this are the period of 72 hours provided for at section 36(8) and in section 44(5)(a) where the Act says the ‘period beginning with the granting of the certificate’.

# introduction

- 22 Where the Act specifies a number of days or weeks beginning at a certain point these are counted from the beginning of the 1st day of the period. Examples of this are the period of 3 days provided for at section 44(5)(a) and the 7 day period in section 45(3)(b) where the Act states 'before the expiry of the 7 day period beginning with the day on which the MHO is consulted ...', and the period of 28 days provided for at section 44(5)(b) where the Act says 'a period of 28 days beginning with ... the beginning of the day on which ...'
- 23 The Act also provides at some points for time periods (generally months or years) ending at a specific time. For example section 165 states 'the period of 2 years ending with the day on which the order would have ceased to authorise these measures ...'. This period will be counted back from the beginning of the day on which the order ceases to have effect.
- 24 At some sections the Act specifically says "working" days. Section 47(8) of the Act defines a 'working day' as a day which is not:
- (a) a Saturday;
  - (b) a Sunday; or
  - (c) a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in Scotland.
- 25 At all other places where the Act mentions days, weeks or months these are calendar days, weeks, months as appropriate.

# introduction

## Note of abbreviations

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

<b>AMP</b>	Approved medical practitioner
<b>CO</b>	Compulsion order
<b>CORO</b>	Compulsion order and a Restriction Order
<b>CTO</b>	Compulsory treatment order
<b>EDL</b>	Earliest date of liberation
<b>EOF</b>	Examination of facts
<b>HD</b>	Hospital direction
<b>LPT</b>	Life Prisoner Tribunal
<b>MHO</b>	Mental health officer
<b>MWC</b>	Mental Welfare Commission
<b>PCS</b>	Police casualty surgeon
<b>PQD</b>	Parole qualifying date
<b>RMO</b>	Responsible medical officer
<b>SCR</b>	Social Circumstances Report
<b>SER</b>	Social Enquiry Report
<b>STO</b>	Supervision and treatment order
<b>Tribunal</b>	The Mental Health Tribunal for Scotland
<b>TTD</b>	Transfer for treatment direction

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

<b>“the 1984 Act”</b>	Mental Health (Scotland) Act 1984
<b>“the 1993 Act”</b>	Prisoners and Criminal Proceedings (Scotland) Act 1993
<b>“the 1995 Act”</b>	Criminal Procedure (Scotland) Act 1995
<b>“the 2000 Act”</b>	Adults with Incapacity (Scotland) Act 2000
<b>“the Act”</b> <b>“the 2003 Act”</b>	Mental Health (Care and Treatment) (Scotland) Act 2003

# introduction

## The Code of Practice

- 28 **The Act and the 1995 Act should be read in conjunction with all subordinate legislation made under the Act. The Code of Practice refers to the regulations, orders and directions made under the Act at appropriate points.**
  
- 29 **Readers should be aware in particular of two orders made under the Act – The Mental Health (Care and Treatment) Scotland Act 2003 Modification Order 2004 (SSI No. 533) and The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005 – which have amended the Act.**
  
- 30 **The Code of Practice points out where important changes have been made but practitioners may be advised to check the relevant orders themselves and to seek their own legal advice as required, when referring to the relevant provisions of the Act.**
  
- 31 **At the time of drafting this version of the Code of Practice and some of the regulations and orders referred to have not yet been approved by the Scottish Parliament. It was felt that nonetheless it was helpful to the reader to include references prospectively. Practitioners are advised to check the mental health pages on the Scottish Executive website for current information and links to the latest versions of subordinate legislation on HMSO.**

part 1

part vi

of the criminal procedure  
(scotland) act 1995  
as amended by the  
mental health  
(care and treatment)  
(scotland) act 2003





# chapter 1

## overview

# chapter one

## Introduction

This chapter begins with a discussion of the principles and other matters which underpin the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) and which are laid out at section 1 to 3 of that Act. It then describes two important terms commonly used throughout the 2003 Act and the provisions which it inserts into Part VI of the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”): namely, “mental disorder” and “medical treatment”.

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.

## Principles of the 2003 Act

### Taking account of the principles

- 01 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 compulsory measures to be authorised 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.
- 02 Although persons subject to these procedures have been charged with or convicted of offences the principles detailed in Part 1 of the 2003 Act which apply to patients subject to civil proceedings should also be applied when medical practitioners and mental health officers are making recommendations for orders or directions.
- 03 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 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

# chapter one

offending, a mental health disposal should not be recommended unless there would be some prospect of benefit to the offender and reduction in risk as a consequence of treatment.

- 04 Section 1 of the 2003 Act sets out the principles according to which people performing functions under that Act must discharge those functions. These principles also apply in the case of persons whose route into the mental health system is by way of the criminal justice process.
- 05 The principles apply to any professional such as a medical practitioner or a mental health officer who is carrying out a function or exercising a duty in relation to a person who is subject to the 2003 Act and the provisions which it inserts into the 1995 Act. Examples of persons discharging a function under the 2003 Act would be a medical practitioner making a recommendation to the court for an assessment order to be imposed with respect to a person, or a mental health officer (“MHO”) preparing a report for the court where a compulsion order is under consideration. Other examples would include where a patient’s responsible medical officer applies to the Mental Health Tribunal (“The Tribunal”) for the renewal or variation of a compulsion order. The Tribunal is also bound by the principles when making decisions about a person who is subject to the provisions of the 2003 Act as are the Scottish Ministers with respect to restricted patients.
- 06 The following persons are not bound by the principles: the patient; the patient’s named person; the patient’s primary carer; a person providing independent advocacy services; the patient’s legal representative; a curator *ad litem* appointed by the Tribunal; and any guardian or welfare attorney of the patient. However, these principles may serve to guide such persons in their dealings with the patient, their carer and others.
- 07 The principles require that any person, other than those who are exempt, in considering a decision or course of action takes into account the following matters:
  - the present and past wishes and feelings of the patient, where they are relevant to the exercise of the function and in so far as they can be ascertained by any means of communication appropriate to the patient. Where the decision relates to medical treatment and the patient has an advance statement then this should be given due consideration. (*For further information on advance statements see Chapter 6 of Volume 1, of this Code of Practice*);

# chapter one

- the views of the patient's named person, carer, and any guardian or welfare attorney so far as it is practical and reasonable to do so. (*For further information about the role of the named person see Chapter 6 of Volume 1 of this Code of Practice*);
  - the importance of the patient participating as fully as possible in any decisions being made and the importance of providing information to help that participation (in the form that is most likely to be understood by the patient). Where the patient needs help to communicate (for instance, translation services or signing) then these should be considered. Any unmet need should be recorded;
  - the range of options available in the patient's case;
  - the importance of providing the maximum benefit to the patient;
  - the need to ensure that the patient is not treated any less favourably than the way in which a person who is not a patient would be treated in a comparable situation, unless that treatment can be shown to be justified by the circumstances;
  - the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background, and membership of any ethnic group.
- 08 Except where a decision is being made about medical treatment, the principles also require that the needs and circumstances of the patient's carer and the importance of providing such information to any carer as might assist him/her to care for the patient, so far as it is reasonable and practical to do so must also be taken into account. What is practical and reasonable will depend on the circumstances. While in an emergency the time available to consult and provide information may be limited, in other circumstances the person making the decision or taking a course of action should be able to take the time to do so.
- 09 When a person is considering the information to be shared with the carer, it would be best practice to consider in every case the patient's right to confidentiality about his/her private medical details and treatment options, before information is supplied. It should also be noted that the Community Care and Health (Scotland) Act 2002 amends the Social Work (Scotland) Act 1968 to give carers a right to have their own carer needs assessed by the local authority. It would be best practice to bring this assessment right to the notice of any carer providing a substantial amount of care where he/she appears to have unmet caring needs.

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- 10 Where the person is discharging a function in relation to anyone who is, or who has been, subject to
  - an emergency detention certificate under the 2003 Act;
  - a short-term detention certificate under the 2003 Act;
  - a compulsory treatment order under the 2003 Act; or
  - a compulsion order under the 1995 Act,that person must also have regard to the importance of the provision of appropriate services to the patient, including continuing care where he/she is no longer subject to the certificate or order.
- 11 The principles further require that, after taking into account the matters set out above and any other relevant circumstances the person discharging the function must then carry it out in the way that appears to that person to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances.
- 12 For the purposes of these principles, making a decision not to act is still considered as taking a decision and any such consideration is bound by the principles of the 2003 Act.

## **Welfare of the Child**

- 13 Section 2 of the 2003 Act makes specific provisions to safeguard the welfare of any child in respect of whom a person is discharging a function under that Act which may be exercised in more than one way. For this purpose a child is any person under the age of 18 years.
- 14 A person discharging such a function must do so in the manner that appears to that person to best secure the welfare of the child. The person must also take into account the matters set out in section 1 of the 2003 Act. For example, the views of the child and any carers should be taken into account in making decisions regarding the child. The importance of acting in the manner which involves the minimum restriction on the freedom of the child that is necessary in the circumstances must be considered.

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## **Equal opportunities**

- 15 Section 3 of the 2003 Act provides a duty which applies to specified persons who are exercising functions under that Act to ensure that the function is discharged in a manner which encourages equal opportunities and the observance of the equal opportunities requirements.
- 16 The 2003 Act refers to the meaning given to “equal opportunities” and “equal opportunities requirements” set out in the Scotland Act 1998. In terms of that Act, “equal opportunities” means the prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, on racial grounds, or on grounds of disability, age, sexual orientation, language or social origin, or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions. “Equal opportunity requirements” means the requirements of the law for the time being relating to equal opportunities.
- 17 The parties who are bound by the requirements of section 3 of the 2003 Act are the Scottish Ministers, the Mental Welfare Commission, local authorities, Health Boards, Special Health Boards, hospital managers, mental health officers, patients’ responsible medical officers, medical practitioners and nurses.

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## Children and young people

### Principles applying in the case of patients under 18: welfare of the child

- 18 Section 2 of the 2003 Act makes specific provisions to safeguard the welfare of any child. For this purpose, a child is any person under the age of 18 years.
- 19 Section 2 requires that any functions under the 2003 Act or the 1995 Act in relation to a child with mental disorder should be discharged in the way that best secures the welfare of the child. In particular it is necessary to take into account:
- the wishes and feelings of the child and the views of any carers;
  - the carer's needs and circumstances which are relevant to the discharge of any function;
  - the importance of providing any carer with information as might assist them to care for the child;
  - where the child is or has been subject to compulsory powers, the importance of providing appropriate services to that child;
  - the importance of the function being discharged in the manner that appears to involve the minimum restriction on the freedom of the child as is necessary in the circumstances.

### Can a child be made subject to the provisions in the 1995 Act and the 2003 Act which relate to mentally disorder offenders?

- 20 Yes, subject to the provisions contained in sections 41, 42(1) and 49(6) of the 1995 Act a child under the age of 18 years can be made subject to an assessment order, a treatment order, an interim compulsion order, a compulsion order (with or without a restriction order), a hospital direction or a transfer for treatment direction in the same way as an adult can, and the procedures for imposing such an order or direction are the same irrespective of whether the patient is a child or an adult. Where it becomes apparent to a medical practitioner that it may be appropriate to recommend, for example, a treatment order to the court with respect to a child, special consideration should be given to the effects of detention on the child and to ensuring that all other options have been fully explored. While these points are, of course, also relevant to the detention of adults, they should be given particular consideration where a child is being detained.



# chapter one

- 21 Best practice would be for the RMO responsible for the child's care to be a child specialist.

## **Consent to treatment under the provisions of the 2003 Act – under 18 years of age**

- 22 The principle that consent should be obtained whenever possible, applies to children suffering from mental disorder who are detained under the provisions of the 2003 Act or the 1995 Act. The treatment provisions and safeguards of Part 16 of the 2003 Act, including those relating to urgent treatment in emergencies, apply to child patients.
- 23 The medical practitioner attending the child must consider whether the child is capable of understanding the nature and possible consequences of the procedure or treatment. If the child is considered capable, the practitioner must seek the consent of the child rather than of the parent. Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 states:

*a person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.*

- 24 Where a child is capable of giving consent on their own behalf, best practice suggests that parents are still involved in discussions where possible. Unless there are confidentiality issues, it would be reasonable to involve parents, advocacy workers or other appropriate persons to assist the child to reach a decision.
- 25 There is a general presumption that a child aged 12 years or over will have the necessary maturity to understand and give consent.

## **A child's named person – under 16 years of age**

- 26 Where the patient is a child under 16 years of age, the 2003 Act makes provision at section 252 for a person who has parental rights and responsibilities for the child to be the child's named person. This section was amended by **The Mental Health (Care and Treatment)(Scotland) Act 2003 (Modification of Enactments) Order 2005** to refer to a "relevant person".

# chapter one

- 27 A “relevant person” must have parental responsibilities and parental rights as defined by sections 1(3) and 2(4) of the Children (Scotland) Act 1995 (c.36). and must be:
- a local authority; or
  - a person who has attained the age of 16 years of age.
- 28 Where two or more “relevant persons” have such rights and responsibilities, then they must decide between them who is to be the named person. If they reach agreement, then the named person will be the person who is the child’s primary carer.
- 29 However, if a local authority has parental rights and responsibilities in relation to the child by virtue of an order under section 86(1) of the Children (Scotland) Act 1995, then the local authority shall automatically be the child’s named person.
- 30 Where a child is in the care of a local authority by virtue of a care order made under section 31 of the Children Act 1989, then local authority shall be the child’s named person.

## Parental relations

- 31 Persons discharging functions under the 2003 Act must be aware of the duties placed on them by section 278 of that Act. This section applies where a child or a person with parental responsibilities is subject to any provisions of the 2003 Act or the 1995 Act. Persons discharging functions under these Acts must take all practicable and appropriate steps to mitigate any effects of the measures authorised by the Acts which might impair the personal relations or diminish direct contact between a child and a person with parental responsibilities. The patient’s designated MHO will play an important role in this process, particularly in relation to liaising closely with colleagues in the social work children and families teams.

## Provision of services and accommodation for certain patients under 18

- 32 Wherever possible, where a child is to be admitted to hospital for medical treatment, it would be best practice to admit that child to a unit specialising in child and adolescent psychiatry.

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- 33 Practitioners are reminded of the requirement which section 23(1)(b) of the 2003 Act places on Health Boards to provide “such services and accommodation as are sufficient for the particular needs of that child” who is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. The provision of services and accommodation must be sufficient for the particular needs of that child patient.
- 34 A child should only be admitted to an adult ward in exceptional circumstances, for example where no bed in a child or adolescent ward is immediately or directly available. If the detained child cannot be admitted to a unit specialising in child and adolescent psychiatry, special consideration should always be given to the environment to which they are to be admitted, and what impact that may have on the child concerned. Any risks to them should be identified in advance and a plan put in place to minimise such risks. For example, the allocation of a single room, with en-suite facilities may be prioritised, or special arrangements put in place to monitor the child’s general well-being within the ward environment. Particular consideration should be given to the likely impact on the child of the behaviour of other patients on the ward and also the need to protect them from exposure to distressing experiences. Other ward policies, such as visiting may also need modified to apply to children. Every effort should be made to provide for the child’s needs as fully as possible. Nursing staff with experience of working with children should also be available to provide direct input to care, and support and guidance to ward staff.
- 35 In the event of a child patient being admitted to an adult ward, it would be best practice for the hospital managers to notify the Mental Welfare Commission to enable the Commission to monitor the general provision of age-appropriate services under the Act.

## **Education**

- 36 Education authorities have a duty to make arrangements for the education of pupils unable to attend school because they are subject to measures authorised by the 2003 Act or, in consequence of their mental disorder, by the 1995 Act. (Section 277 of the 2003 Act amends the Education (Scotland) Act 1980 to that effect).

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## Definition of “mental disorder”

- 37 The 2003 Act and the provisions which it inserts into the 1995 Act refer to a person who has or appears to have a mental disorder. Section 328 of the 2003 Act provides that “mental disorder” means any mental illness, personality disorder, or learning disability however caused or manifested.
- 38 The definition of mental disorder has been drawn widely to ensure that the services provided for in the 2003 Act are available to anyone who needs them. A person with mental disorder will only be subject to compulsory measures under the 1995 Act and the 2003 Act if he/she meets the specific criteria for those measures as set out in those Acts. However sections 25 to 27 of the 2003 Act also provide for a range of local authority duties in relation to the provision of services for any person who has or has had a mental disorder.
- 39 Section 328(2) of the 2003 Act specifically states that a person is not mentally disordered by reason only of any of the following:
- sexual orientation;
  - sexual deviancy;
  - trans-sexualism;
  - transvestism;
  - dependence on or use of alcohol or drugs;
  - behaviour that causes or is likely to cause harassment, alarm or distress to any other person;
  - or by acting as no prudent person would act.
- 40 No person who suffers from mental disorder but who also falls within any of the above categories should be excluded from consideration for assistance treatment or services under the 2003 Act. For example, the provisions which the 2003 Act inserts into the 1995 Act may be imposed by the court in respect of persons with mental disorder involved in criminal justice proceedings who also have alcohol problems or misuse drugs. Section 328(2) of the 2003 Act ensures that a person is not regarded as mentally disordered *by reason only* of their sexual orientation, deviancy, trans-sexualism, transvestism or dependence on drugs and alcohol or by their behaviour.

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## Definition of “medical treatment”

- 41 Section 329 of the 2003 Act defines “medical treatment” as “treatment for mental disorder” and for this purpose “treatment” includes-
- (a) nursing;
  - (b) care;
  - (c) psychological intervention;
  - (d) habilitation (including education, and training in work, social and independent living skills); and
  - (e) rehabilitation (read in accordance with (d) above).
- 42 “Medical treatment” includes pharmacological interventions as well as other physical interventions (such as electro-convulsive therapy (“ECT”)) in addition to psychological and social interventions (including occupational therapy) made with respect to mental disorder. Any references to “medical treatment” in the 2003 Act, the provisions which it inserts into the 1995 Act and this Code of Practice should be read in light of the definition given at section 329 as outlined in the paragraph above.
- 43 Medical treatment for an unrelated physical disorder is not authorised by the 2003 Act. However, medical treatment for a physical disorder which is directly causing the mental disorder would be authorised. For example, where a patient has delirium (as a mental disorder secondary to a chest infection), then the administration of antibiotics would be a medical treatment (indirectly) for the mental disorder and so authorised by the 2003 Act. Other medically induced mental disorders could include starvation-induced depression, or hypothyroidism-induced depression. Self-harm (including overdose) as a result of a mental disorder may also be treated under the 2003 Act.
- 44 Where medical treatment for an unrelated medical disorder is required, and the patient is an adult and incapable of giving consent, then treatment under the Adults with Incapacity (Scotland) Act 2000 should be considered.
- 45 *For further information on “medical treatment” refer to Part 16 of the 2003 Act and Chapter 10 of Volume 1, of this Code of Practice.*

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## Overview of the amendments made to the 1995 Act by the 2003 Act

- 46 The diagrams on pages 27 and 28 show an overview of procedures for mentally disordered offenders as set out under the 1995 Act as amended by the 2003 Act.

### Pre-trial

- 47 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).
- 48 *For further information about an assessment order or a treatment order imposed at the pre-trial stage refer to Part 1, Chapter 2 of this Volume of the Code of Practice.*

### Insanity

- 49 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.

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- 50 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.
- 51 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 (as listed in subsection 57(2)) are: a compulsion order, a compulsion order and a restriction order, an interim compulsion order, a guardianship order, a supervision and treatment order or no order.
- 52 *For further information about the insanity procedures refer to Part 1, Chapter 3 of this Volume of the Code of Practice.*

## **Conviction**

- 53 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 in paragraphs 56 to 64 below.

## **Acquittal**

- 54 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 at this time the person may be kept in a place of safety for a period of 6 hours (section 60C) to allow for further medical 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.
- 55 *For further information about this process refer to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## **Post-conviction/Pre-sentence assessment**

- 56 Assessment orders (under sections 52B to J) and treatment orders (under sections 52K to S (see paragraphs 28 to 29 above) are available pre-sentence, as well as pre-trial, to allow further assessment prior to the court making an ultimate disposal.

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- 57 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 (which includes medication, psychological and social interventions).
- 58 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.
- 59 *For further information about post-conviction/pre-sentence assessment refer to Part 1, Chapter 4 of this Volume of the Code of Practice.*

## Sentencing

- 60 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.
- 61 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. This allows for the person to be subject to additional scrutiny and strict supervision as they progress through the mental health system.
- 62 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.

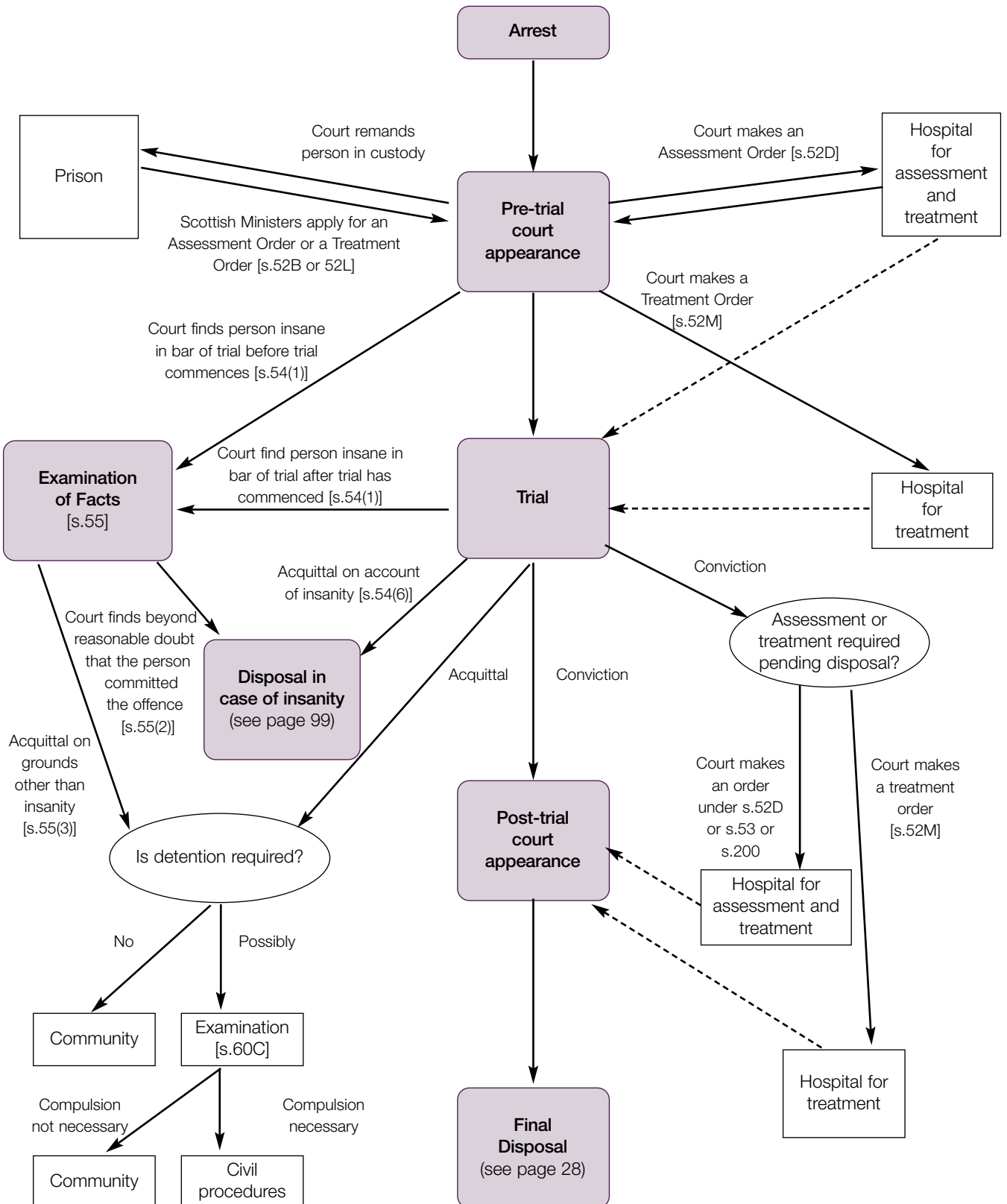


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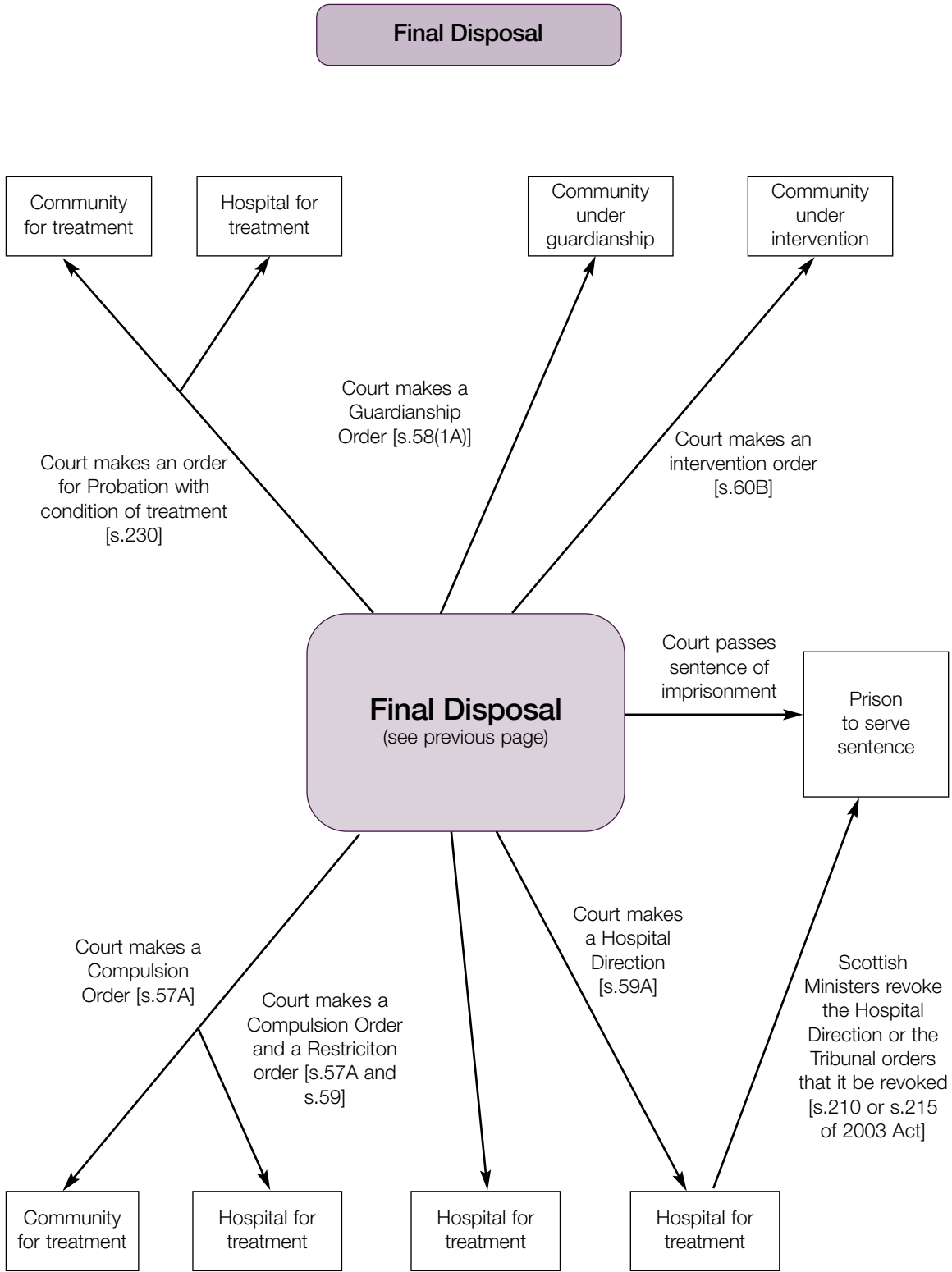
- 63 A guardianship order (section 58(1A)) may be imposed and confer powers set out in the Adults with Incapacity (Scotland) Act 2000, to appoint a welfare guardian.
- 64 Probation with a condition of treatment under section 230 remains available in cases where: a person's mental disorder is not such 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.
- 65 *For further information on these disposals refer to Part 1, Chapter 5 of this Volume of the Code of Practice.*
- 66 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. *For further information about these provisions refer to Part 2, Chapter 5 of this Volume of the Code of Practice.*

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## Overview of procedures when a person with mental disorder is involved in criminal proceedings



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## Stages of the criminal justice process

### Overview

- 67 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 prosecutor 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 32 and 33 set out the stages of the solemn and summary procedures. Not all cases will pass through all the stages.
- 68 Where a person has been charged in a district court with an offence punishable by imprisonment and it appears to the court that the person has a mental disorder, the district court must remit the person to the sheriff court in accordance with section 7(9) and (10) of the 1995 Act.

### Summary procedure

- 69 Summary procedure applies in the sheriff and district courts in which less serious offences are prosecuted. The prosecutor 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.
- 70 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 he/she is remanded in custody the trial must commence within 40 days from the date of the remand.
- 71 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.

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72 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**

73 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 prosecutor 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 prosecutor 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 prosecutor 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.

74 Where the accused person is remanded in custody, he/she must appear again in the sheriff court within eight days. At this stage the prosecutor 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 person is remanded in custody the trial must commence in the sheriff court within 110 days from the date of full committal and in the High Court within 140 days from the date of full committal.

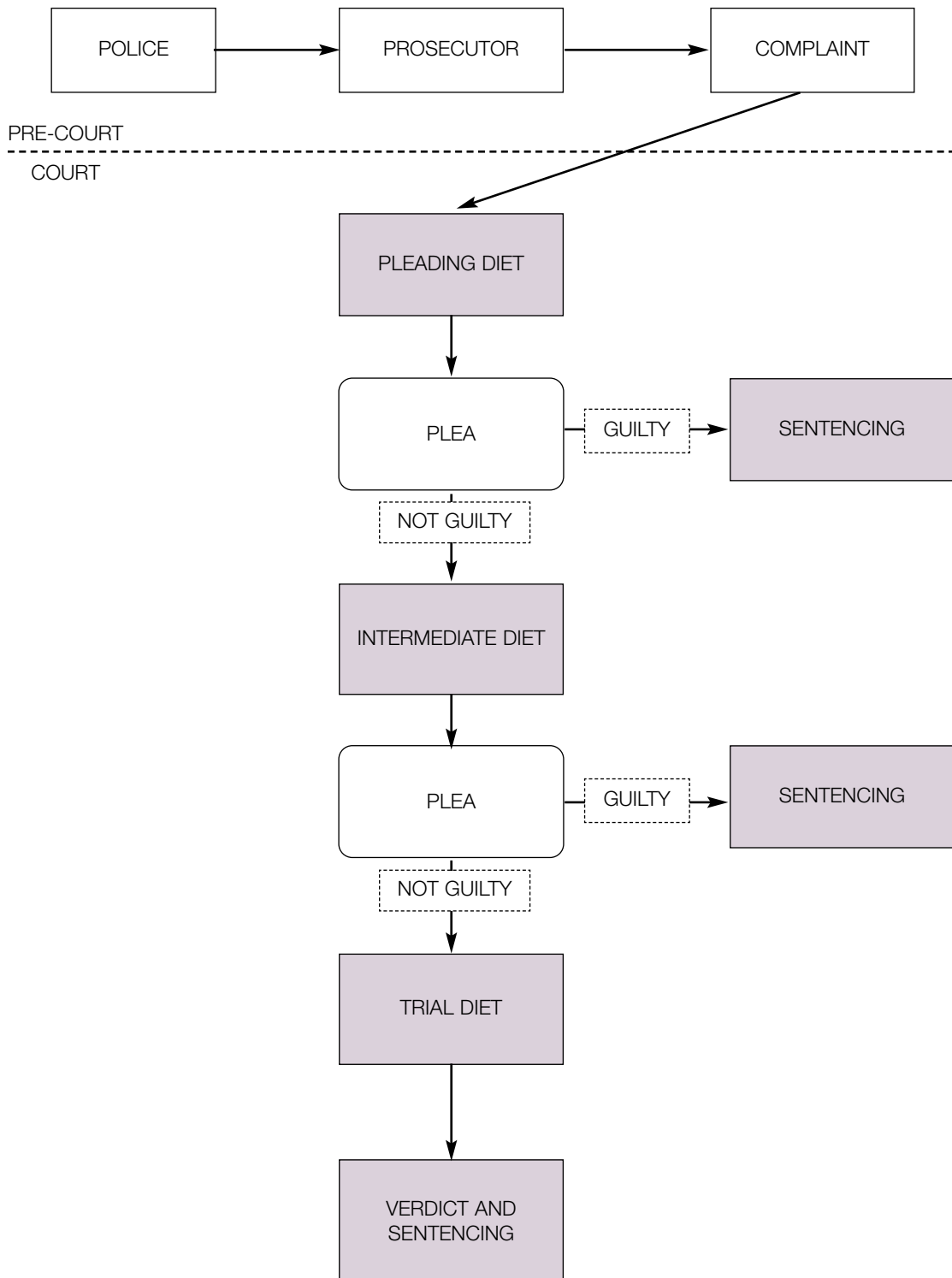
75 Prior to the trial, the prosecutor further investigates the case, which may involve interviewing witnesses, and assesses the available evidence and whether it is appropriate to proceed with a prosecution. These findings and recommendations are considered by Crown Counsel who decide whether to continue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

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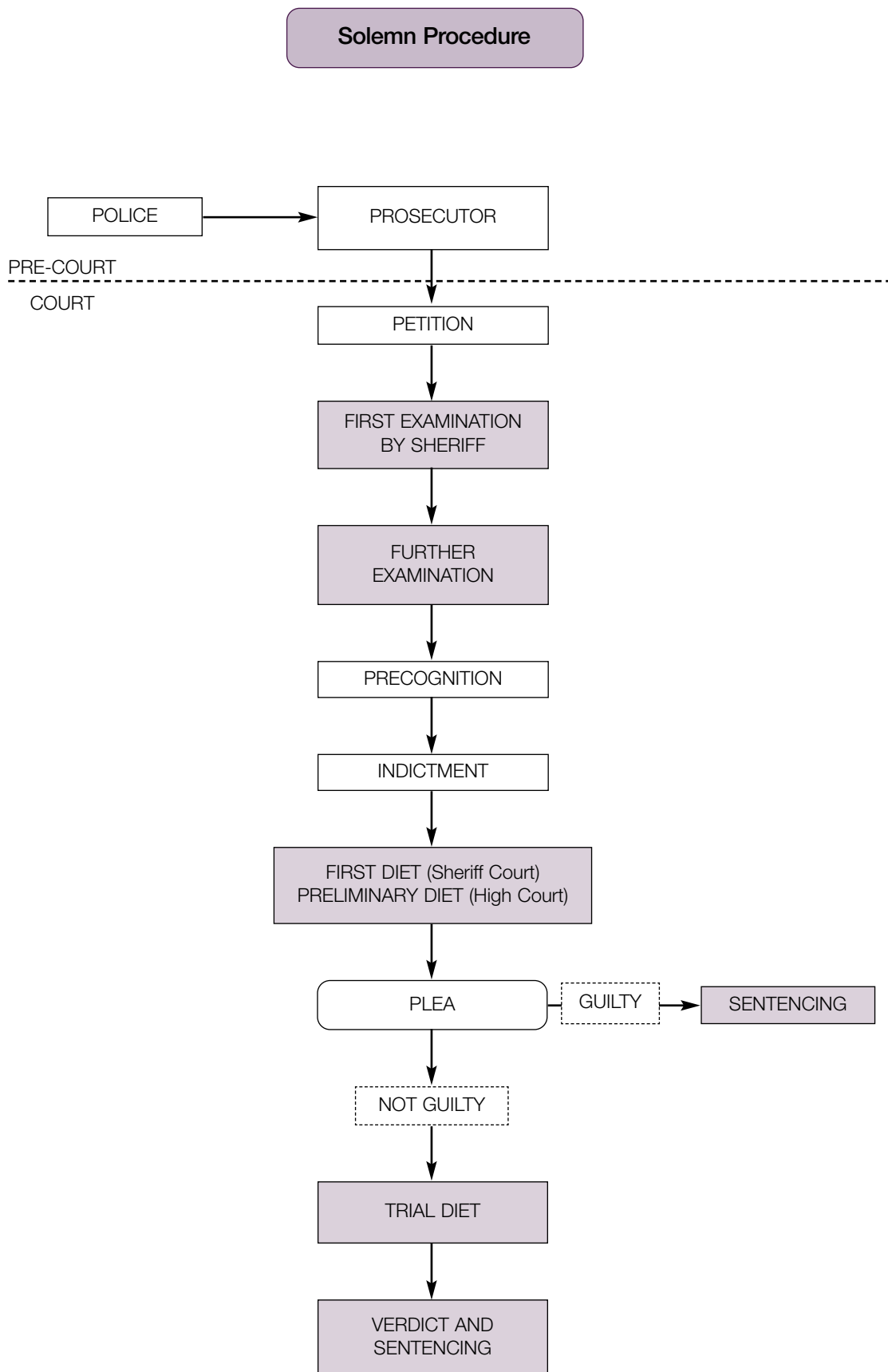
- 76 When solemn proceedings are taken in the sheriff court or High Court, an indictment is served on the accused person, which is the document containing details of the charge(s) and is presented in the name of the Lord Advocate.
- 77 Preliminary diets are held in all solemn cases prior to the date of the trial. These provide the court an opportunity to assess the state of preparation of the prosecution and defence for the trial and also allows an accused person to raise any legal challenge to the proceedings if he/she so wishes. In solemn proceedings in the sheriff court, this diet is called a “First Diet” and in the High Court it is called a “Preliminary Hearing”.
- 78 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.

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## Summary Procedure



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# chapter 2

## pre-conviction

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## 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.

The 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.

All section numbers in this chapter refer to the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") unless stated otherwise.

## Assessment of a person in custody

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

01 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.

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## Assessment of an accused in police custody

- 02 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 *Chapter 15 of Volume 1 of this Code of Practice* 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.
- 04 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 prosecutor. The PCS may also be able to seek an assessment by a mental health officer ("MHO").
- 05 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 prosecutor if one is submitted. A report may also be produced which may be submitted to the prosecutor for the person's first court appearance.
- 06 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

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about the person. Every effort should be made to also take account of the relevant sources that may be accessible such as a relative, significant other, carer or named person. (For further information about the named person refer to paragraphs 51 to 53 below.)

- 07 The main issues that would be expected to be addressed under these circumstances are:
- does the person appear to be suffering from mental disorder?
  - does he/she currently pose a risk to him/herself or other people?
  - does he/she require assessment or treatment in hospital?
  - if so, how urgently is this required?
  - is the person fit to be interviewed and if so, does he/she require 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?
- 08 The following options are available depending on the mental condition of the person, the urgency of his/her need for psychiatric treatment, his/her willingness to accept treatment, the nature of the alleged offence and the risk he/she poses:
- *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).

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

## Appropriate Adult

- 10 The police should always have an appropriate adult present when they interview a person with mental disorder. The role of the appropriate adult is to facilitate communication between the police and the person and to provide support for him/her.
- 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 should be 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 services.

## 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 carried out 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 should be referred for an urgent assessment in the same way as such an assessment would be requested from a general practitioner.

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- 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 prosecutor. This notwithstanding, the police would always be expected to provide full information to alert the prosecutor to such issues and allow consideration by the prosecutor 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 him/herself 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 above 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 may be 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 his/her first court appearance; this finding has to be determined by the court on the basis of evidence from two medical practitioners. Best practice would suggest that these two medical practitioners should be psychiatrists.
- 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 above.
- 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

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offence then it would usually be appropriate to use provisions under the 1995 Act rather than abandon 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 (sections 52B to J) or a treatment order (sections 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 may be insane in bar of trial;
  - the risk the person poses to him/herself 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



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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 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 refers him/herself, 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).

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## 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 recommended.
- 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 appropriate, 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 prosecutor 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 section 36 or 44 of the 2003 Act should be applied for, the police should report the case to the prosecutor and a report recommending an assessment order should be submitted to the prosecutor for the first court appearance.
- 33 Medical practitioners should not recommend that a person be remanded in custody or imprisoned.

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## 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 recommended 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 person appears to be mentally disordered at or before his/her 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 person 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 he/she poses to him/herself and/or others. A person should not be admitted to a secure ward or unit, solely on the ground of having been detained under section 52D or 52M.
- 39 Medical practitioners should not recommend that a person be remanded in custody or imprisoned.

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## Subsequent court appearances

- 40 It should be noted that although assessment prior to the first court appearance often requires to be carried out quickly, most subsequent assessment of the person should draw on the available multi-disciplinary skills base where relevant and appropriate, so that the person's health and social care needs can be fully investigated and comprehensive advice provided to the court to assist in decision making.
- 41 When assessing a person for a subsequent court appearance a medical practitioner should consider whether the person is sane and fit to plead; any 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.
- 42 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. *(For further information about the designation of an MHO refer to section 229 of the 2003 Act and Chapter 9, Volume 1 of this Code of Practice.)* The medical practitioner should contact this MHO to assist in the assessment and decision making process. The MHO may also have produced a Social Circumstances Report, ("SCR"), following the making of the previous order which should be used as a source of information. *(For further information about SCRs refer to Part 1, Chapter 6 of this Volume of the Code of Practice and Chapter 11 of Volume 1).*
- 43 In most cases where admission to hospital is indicated, the initial recommendation should be for an assessment order or a treatment order.
- 44 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.
- 45 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.

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- 46 If a mental health order is made then the person should be admitted to a unit of appropriate security considering the risk he/she poses to him/herself and/or others. A person should not be admitted to a secure ward or unit, solely on the ground of having been detained under provisions set out in the 1995 Act.
- 47 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. *(For further information about the appointment of the RMO refer to section 230 of the 2003 Act and Chapter 9 of Volume 1 of this Code of Practice).*
- 48 If a medical practitioner wishes to recommend an order which requires two medical recommendations, then he/she may suggest an appropriate medical practitioner, and inform the prosecutor or court that a second assessment is required and that he/she has 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. If the medical practitioner is unable to identify an appropriate medical practitioner, he/she should inform the prosecutor or court of the need for a second opinion, and the prosecutor or court should then seek a second medical practitioner.
- 49 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. *(For further information see Part 1, Chapter 6 of this Volume of the Code of Practice).*
- 50 Medical practitioners should not recommend that a person be remanded in custody or imprisoned.

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## **Named person**

- 51 The 2003 Act creates a new role – the “named person” – who has particular powers and rights in relation to persons who become subject to compulsory powers, whether under the 2003 Act or the 1995 Act. Broadly speaking, the role of the named person is to represent and safeguard the interests of the patient and he/she has similar rights to the patient to apply to the Mental Health Tribunal for Scotland (the “Tribunal”), and to appear and be represented at Tribunal hearings.
- 52 With respect to mentally disordered offenders the named person has no formal role under the 2003 Act prior to the court making a final disposal. However best practice would suggest that medical practitioners and mental health officers involved in the care and treatment of a person with mental disorder who is progressing through the criminal justice system should be aware of any views expressed by the named person.
- 53 *For further information on the named person refer to sections 250 to 258 of the 2003 Act and Chapter 6 of Volume 1 of this Code of Practice.*

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## 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)**

- 54 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 should 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.
- 55 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, e.g. police, defence agent, prosecutor, judge or sheriff, doctor, MHO, court social worker, named person, carer 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)**

- 56 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. The sheriff court may 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.

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## Assessment Orders and Treatment Orders

### Background

- 57 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.
- 58 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.
- 59 The 2003 Act inserts sections 52B to U into the 1995 Act which make 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 also be used after conviction before sentencing to assist the court in making the appropriate final disposal.

### Purpose

- 60 The key purpose of an *Assessment Order* is to allow the appropriate examination and assessment by an approved medical practitioner (“AMP”), of a person prior to trial or after conviction before sentencing. 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 (which includes medication, psychological and social interventions).
- 61 Within 28 days of the imposition of the assessment order the RMO has a duty in terms of section 52G to report back to the court on the person’s 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.



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It would be expected that the designated MHO and other members of the multi-disciplinary team where relevant and appropriate would contribute to this assessment.

- 62 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 medical treatment in certain circumstances (which includes medication, psychological and social interventions). Section 52R(2) and (3) sets out the circumstances in which the order ceases to have effect.
- 63 Within 21 days of the imposition of either an assessment order or a treatment order the MHO, (designated by the local authority in accordance with section 229 of the 2003 Act), is required to provide the RMO with a Social Circumstances Report (“SCR”) unless he/she considers that to do so would serve little or no practical purpose (section 321 of the 2003 Act). The purpose of this report is to contribute to the mental health assessment of the person and consideration of further recommendations in the case. All members of the multi-disciplinary team should participate in the assessment process where relevant and appropriate.

## Overview

- 64 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 and/or treatment, and to inform the court in the consideration of an appropriate disposal.
- 65 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.

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- 66 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.
- 67 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.
- 68 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. All members of the multi-disciplinary team should participate in the assessment process where relevant and appropriate.
- 69 It should be noted that a person who is subject to an assessment order or a treatment order is classed as a “restricted patient” in that the consent of the Scottish Ministers is required before the person may be granted a period where his/her detention in hospital is temporarily suspended. *(For further information about the suspension of detention provisions in the 2003 Act refer to sections 221 to 226 of that Act and Part 1, Chapter 6 of this Volume of the Code of Practice).* Although not a statutory duty under the 2003 Act it would be expected that the consent of the Scottish Ministers would also be sought prior to the RMO recommending to the court under section 52G(9) or 52Q(1)(b) respectively that an assessment order or treatment order be varied to allow the transfer of the person to another hospital (see paragraphs 97 to 100 and 150 to 153 below).

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## Assessment Order

### General – Sections 52B to J:

#### Procedure prior to the making of an assessment order

70 Prior to conviction, 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)

71 The prosecutor will apply for an assessment order having been alerted that a person may be suffering from mental disorder by a medical practitioner who has previously examined the person, or because of the person's conduct in court. A report must be available to the prosecutor recommending an assessment order as set out in section 52D(2)(a). If alerted that a person may be suffering from a mental disorder perhaps by the police or because of the person's conduct in court, the prosecutor would first instruct that a medical practitioner should assess the person.

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

72 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 and an application may be made to the court for an assessment order using the supporting recommendation from the medical practitioner. The application should be sent to the court which remanded the person, not to the court within which jurisdiction the prison or hospital is situated. As soon as reasonably practicable after the application is made the Scottish Ministers must inform:

- the person in respect of whom the application is made;
- any solicitor acting for that person; and
- where a “relevant disposal” in terms of section 52B has not been made, the prosecutor.

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

73 Should the court have evidence available from a medical practitioner recommending an assessment order (as set out in section 52D) it may make an assessment order. If the court suspects that a person appearing before it suffers from mental disorder without having the necessary evidence available, the court would instruct a medical practitioner to assess the person.

## **The role of the court (section 52D(2) and (4))**

74 For the court to impose an assessment order it must be satisfied:

- on the written or oral evidence of a medical practitioner as to the matters mentioned in subsection 52D(3); and
- that having regard to all the circumstances (including the nature of the offence with which the person is charged or, as the case may be, convicted) and any alternative means of dealing with the person, it is appropriate.

## **Criteria for making an assessment order (section 52D)**

75 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:

- does it appear that the person has a mental disorder? The category of mental disorder need not be specified.
- 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? These conditions are that:-
  - the person in respect of whom the application is made 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 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.
- 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?

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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.

- 76 The medical practitioner's recommendation must also address the following two issues:
- is a suitable hospital placement available which will be able to admit the person within 7 days of the order being made? (This 7 day period commences with the day on which the order is made. For example, if the order were imposed on Tuesday a bed in the specified hospital would require to be available to the person by the following Monday if not before). If it is the case, 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 he/she may pose.
  - 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 (sections 52D(2)(a) and (3))

- 77 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 75 and 76 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

- 78 The person should usually attend the court hearing at which the court decides whether to make an assessment order. However, if the 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

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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 (section 52D(10))**

79 As soon as practicable after an assessment order has been made, the court must 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; and
- the Mental Welfare Commission.

## **Duty of a local authority to appoint an MHO (section 229 of the 2003 Act)**

80 A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is reasonably practicable after an assessment order has been made. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless he/she records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the Mental Welfare Commission within 21 days of the order being made.

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

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## Effect of an Assessment Order

### Removal to a place of safety pending admission to hospital (section 52D(9))

- 82 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). In terms of section 307 of the 1995 Act this place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. However best practice would suggest that, in keeping with the principles set down in section 1 of the 2003 Act, the most appropriate place of safety in these circumstances would be a hospital. It would be expected that only in exceptional circumstances would the alternatives listed in section 307 of the 1995 Act be used as a place of safety.
- 83 The person should be conveyed from the place of safety to the specified hospital as soon as practicably possible by a person listed in section 52D(6)(a).

### Measures which may be authorised under an assessment order (section 52D(6))

- 84 The measures which may be authorised by an assessment order are:
- within 7 days of the making of the order the removal of the person to the specified hospital by any of the following: 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 section 52D(6)(a); 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 86 below).

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## Giving medical treatment under Part 16 of the 2003 Act

- 85 An assessment order may be made on the basis of evidence from one registered medical practitioner in terms of section 52D(2)(a).
- 86 Before medical treatment (which includes medication, psychological and social interventions) may be given under Part 16 of the 2003 Act to a person who is subject to an assessment order, certain requirements must be satisfied as set out in section 242(5) of the 2003 Act. An opinion must be sought from an AMP who is not the patient's RMO. If this AMP determines treatment to be in the 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. This AMP might be another doctor employed in the same hospital, but not working in the team responsible for the person's care.

## Advance Statement

- 87 Sections 275 and 276 of the 2003 Act enable a person to make an "advance statement". This is a written statement setting out how the person would wish to be treated, or wish not to be treated for mental disorder should he/she become mentally disordered in the future and his/her ability to make decisions about that treatment becomes significantly impaired. Where any person is giving medical treatment under the 2003 Act to a person with mental disorder who is subject to the 1995 Act, that person must have regard to any advance statement (which complies with the 2003 Act) made by the person and not withdrawn.
- 88 *For further information on advance statements refer to sections 275 and 276 of the 2003 Act and Chapter 6 of Volume 1 of this Code of Practice.*

## What should happen during an assessment order?

- 89 As soon as practicable after the patient's admission to hospital the hospital managers have a duty under section 260(5)(a) of the 2003 Act 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) of that Act, and also informed of the availability of independent advocacy services under section 259. *For further information on these procedures refer to Chapter 4 of Volume 1 of this Code of Practice.*



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- 90 An RMO and MHO must be allocated for the person under sections 230 and 229 of the 2003 Act respectively. A multi-disciplinary assessment should be undertaken to address the issues set out in paragraph 101 under 'Review of an Assessment Order'.
- 91 The designated MHO will prepare a Social Circumstances Report ("SCR") 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 the Mental Welfare Commission. 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) of the 2003 Act. *For further information see Part 1, Chapter 6 of this Volume of the Code of Practice and Chapter 11 of Volume 1.*

## **Suspension of detention (sections 221 to 223 of the 2003 Act)**

- 92 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 assessment order specifying detention of the person. *For further information on these procedures refer to sections 221 to 223 of the 2003 Act and Part 1, Chapter 6 of this Volume of the Code of Practice.*

## **Absconding**

- 93 The statutory procedures in relation to absconding by mentally disordered offenders are set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**. *For further information refer to these regulations and to Part 1, Chapter 6 of this Volume of the Code of Practice.*

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## Variation of an Assessment Order

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

- 94 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 it is inappropriate to do so, 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.
- 95 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:
- where there is 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.
- 96 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 of an assessment order after admission to hospital (section 52G(9))**

- 97 If at any point during the assessment order the RMO is satisfied that there has been a change of circumstances which justifies a variation of the order he/she must submit a report to the court. An example might be where it has become apparent that the risk which 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.

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- 98 It would be expected that where the RMO is thinking of making a recommendation for the variation of the order in the report, he/she should consult with the designated MHO who may have obtained information that could have a bearing on the matter.
- 99 In his/her report to the court, the RMO should set out the grounds for requesting a variation of the assessment order, and specify any variation. If admission to a different hospital is proposed, then although it is not a statutory duty, it would be expected that the RMO would seek the consent of the Scottish Ministers prior to the submission of the report. Arrangements should then be made with that hospital for the person to be admitted there following the variation of the assessment order by the court.
- 100 The court may in terms of section 52G(10) confirm, vary or revoke the assessment order.

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## Review of an Assessment Order

- 101 Before the expiry of the assessment order (that is within 28 days) the RMO must submit a written report to the court in accordance with section 52G 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)).
- 102 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). It would be expected that the RMO would consult with the designated MHO and the other members of the multi-disciplinary team where relevant and appropriate in the preparation of the report.
- 103 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.
- 104 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 where a person is detained pre-trial in summary cases the trial must be commenced within 40 days from the date of the remand, and an assessment order may last for a period of up to 28 days, it would make sense to combine the two.
- 105 This also applies where the assessment order is post-conviction given that disposal will occur directly or soon after the end of the assessment order. In other cases the two issues may be dealt with in separate reports. For example, in solemn cases pre-trial at the Sheriff Court, because the trial must be held within 110 days of the detention on full committal, or at the High Court, within 140 days of the detention on full committal, it may not make sense to combine the two as the end of the assessment order may be approximately 3 months before the trial.

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- 106 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.
- 107 Where the RMO is considering recommending a mental health disposal, he/she should 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.
- 108 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 may 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. 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 refer to Part 1, Chapter 5 of this Volume of the Code of Practice.*
- 109 Similarly, where the RMO is considering making a recommendation for the revocation of the assessment order it would be expected that he/she would consult with the designated MHO given that this 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.
- 110 Other issues which may require to be considered in the report if the assessment order is at the pre-trial stage are:
- insanity in bar of trial (see Part 1, Chapter 3 of this Volume);
  - insanity at the time of the offence (see Part 1, Chapter 3);
  - diminished responsibility (where the charge is murder) (see Part 1, Chapter 3);
  - the appropriate disposal if the person is found to have been insane at the time of the offence (see Part 1, Chapter 3);
  - the appropriate disposal if the person is convicted (see Part 1, Chapters 4 and 5).

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- 111 Other issues which may require 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 Part 1, Chapter 4);
  - whether a final mental health disposal should be made (see Part 1, Chapter 5):
    - compulsion order;
    - compulsion order and a restriction order;
    - hospital direction;
    - guardianship or intervention order;
    - probation order with a requirement for treatment.
- 112 The RMO must send a copy of the report to the person subject to the assessment order, his/her 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 designated MHO.
- 113 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 (section 52G(4))**

- 114 An assessment order may be extended once only for a period not exceeding 7 days. This should 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 the order should not be sought solely for administrative convenience. A 7 day extension to an assessment order authorises the same measures as the initial assessment order.

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## End of assessment order (section 52H)

115 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* (ended for the moment) or *simpliciter* (ended completely);
- 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).

116 In terms of section 52H(2)(a) and (c) and subsection (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.

## Prevention of delay in trials: assessment orders and treatment orders (section 52T)

117 It should be noted that **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005** made amendments to section 52T to take account of the relevant provisions of the Criminal Procedure (Amendment) (Scotland) Act 2004.

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## Treatment Order

### General: sections 52K – U

#### Procedure prior to the making of a treatment order

118 Prior to conviction, 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 (section 52K)

119 The prosecutor will apply for a treatment order having been alerted that a person may be suffering from mental disorder by a medical practitioner who has previously examined the person, or because of the person's conduct in court. A report must be available to the prosecutor recommending a treatment order as set out in section 52M. If alerted that a person may be suffering from a mental disorder perhaps by the police or because of the person's conduct in court, the prosecutor would first instruct that the required assessments are carried out by medical practitioners.

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

120 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.

121 These reports should be sent to the prison governor or his representative. The prison governor or his representative should then notify the Scottish Ministers and an application may be made to the court for a treatment order using the supporting recommendations from the medical practitioners. The application should be sent to the court which remanded the person, not to the court within which jurisdiction the prison or hospital is situated. As soon as reasonably practicable after the application is made the Scottish Ministers must inform:



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- the person in respect of whom the application is made;
- any solicitor acting for that person; and
- where a “relevant disposal” in terms of section 52B has not been made, the prosecutor.

## **Making of treatment order by court on its own initiative (section 52N)**

122 Should the court have evidence available from two medical practitioners recommending a treatment order (as set out in section 52M) it may make a treatment order under section 52N(1). If the court suspects that a person appearing before it suffers from mental disorder without having the necessary evidence available the court would instruct that the required assessments are carried out by medical practitioners.

## **The role of the court (section 52M(2) and (4))**

123 For the court to impose a treatment order it must be satisfied:

- on the written or oral evidence of two medical practitioner as to the matters mentioned in subsection 52M(3); and
- that having regard to all the circumstances (including the nature of the offence with which the person is charged or, as the case may be, convicted) and any alternative means of dealing with the person, it is appropriate.

## **Criteria for making a treatment order (section 52M)**

124 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:

- 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?
- is a suitable hospital placement available which will be able to admit the person within 7 days of the order being made? (This 7 day period commences with the day on which the order is made. For example, if the order were imposed on Tuesday a bed in the specified hospital would require to be available to the person by the following Monday if

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not before). 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 he/she may pose. Both medical practitioners should agree this and specify the hospital to which the person will be admitted. It would be expected that one of the medical practitioners would also inform the designated MHO.

- is there a reasonable alternative to enable the giving of medical treatment (which includes medication, psychological and social interventions) to the person? It would be expected that an MHO opinion would be sought to inform the consideration of alternatives.

125 The designated MHO and other members of the multi-disciplinary team where relevant and appropriate should contribute to this assessment to inform the decision making process.

## Medical evidence (section 52M(2)(a) and (3))

126 The person must be assessed by two medical practitioners, one of whom must be an AMP. If the medical practitioners are satisfied, having considered the points detailed in paragraph 124 that it is appropriate, 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 that 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

127 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)).

128 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.

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## **Notification by the court of the order being made (section 52M(9))**

129 As soon as practicable after a treatment order has been made, the court must 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 (section 229 of the 2003 Act)**

130 A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is reasonably practicable after a treatment order has been made. The designated MHO must complete an SCR in relation to the person in terms of section 231 of the 2003 Act unless he/she records why this would serve little or no practical purpose. A copy of the SCR must be sent to the RMO and the Mental Welfare Commission within 21 days of the order being made.

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

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## Effect of a Treatment Order

### Removal to a place of safety pending admission to hospital (section 52M(8))

132 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 307 of the 1995 Act this place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. However, best practice would suggest that, in keeping with the principles set down in section 1 of the 2003 Act, the most appropriate place of safety in these circumstances would be a hospital. It would be expected that only in exceptional circumstances would the alternatives listed in section 307 of the 1995 Act be used as a place of safety.

133 The person should be conveyed from the place of safety to the specified hospital as soon as practicably possible by a person listed in section 52M(6)(a).

### Measures which may be authorised under a treatment order (section 52M(6))

134 The measures that may be authorised by a treatment order are:

- within 7 days of the making of the order, the removal of the person to the specified hospital by any of the following: 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 section 52M(6)(a); 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 (which includes medication, psychological and social interventions).

### Advance Statement

135 Where any person is giving medical treatment under the 2003 Act to a person with mental disorder who is subject to the 1995 Act, that person must have regard to any advance statement (which complies with the 2003 Act) made by the person and not withdrawn. *For further information*

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*on advance statements refer to sections 275 and 276 of the 2003 Act and Chapter 6 of Volume 1 of this Code of Practice.*

## **What should happen during a treatment order?**

136 As soon as practicable after the patient's admission to hospital, the hospital managers have a duty under section 260(5)(a) of the 2003 Act 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) of that Act, and also informed of the availability of independent advocacy services in accordance with section 259 of the 2003 Act. *For further information on these procedures see Chapter 4 of Volume 1 of this Code of Practice.*

137 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 this should now be done. A multi-disciplinary assessment should be undertaken to address the issues set out in section 52Q(1).

138 The designated MHO should work in close collaboration with the RMO and other members of the multi-disciplinary team where relevant and appropriate. He/she must prepare an SCR 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 Mental Welfare Commission. However, even where the MHO considers that an SCR would serve little or no purpose, he/she will still require to comply with the duties in section 231(2)(b) of the 2003 Act. *For further information about Social Circumstance Reports see Part 1, Chapter 6 of this Volume of the Code of Practice and Chapter 11 of Volume 1.*

139 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 should 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 which may provide useful information. *For further information about SERs refer to Part 1, Chapter 6 of this Volume of the Code of Practice.*

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140 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 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.

141 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 Part 1, Chapter 3);
- insanity at the time of the offence (see Part 1, Chapter 3);
- diminished responsibility (where the charge is murder) (see Part 1, Chapter 3);
- the appropriate disposal if the person is found to have been insane at the time of the offence (see Part 1, Chapter 3);
- the appropriate disposal if the person is convicted (see Part 1, Chapters 4 and 5).

142 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 Part 1, Chapter 4)
- whether a final mental health disposal should be made (see Part 1, Chapter 5):
  - compulsion order;
  - compulsion order and a restriction order;
  - hospital direction;
  - guardianship order;
  - probation order with a requirement for treatment.

143 Where the RMO is considering recommending a final mental health disposal, he/she should 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.

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144 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 may 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. 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 imposition of a compulsion order see Part 1, Chapter 5 of this Volume of the Code of Practice.*

## **Suspension of detention (sections 224 to 226 of the 2003 Act)**

145 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 person. *For further information on these procedures refer to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## **Absconding**

146 The statutory procedures in relation to absconding by mentally disordered offenders are set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**. *For further information refer to these regulations and to Part 1, Chapter 6 of this Volume of the Code of Practice.*

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## Variation of a Treatment Order

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

147 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 it is inappropriate to do so, 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.

148 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:

- there is 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.

149 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.

### **Variation of a treatment order after admission to hospital (section 52Q(1))**

150 If at any point during the treatment order the RMO is satisfied that there has been a change of circumstances which makes the continued detention of the person in the specified hospital inappropriate he/she must submit a report to the court. An example might be where it has become apparent that the risk which 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.



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- 151 It would be expected that where the RMO is thinking of making a recommendation for the variation of the order in the report, he/she should consult with the designated MHO who may have obtained information that could have a bearing on the matter.
- 152 In his/her report to the court, the RMO should set out the grounds for requesting a variation of the treatment order, and specify any variation. If admission to a different hospital is proposed then, although it is not a statutory duty, it would be expected that the RMO would seek the consent of the Scottish Ministers prior to the submission of the report. Arrangements should then 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.
- 153 The court may in terms of section 52Q(2) confirm, vary or revoke the treatment order.

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## Revocation of a Treatment Order

154 If at any point during the treatment order the RMO is satisfied that any of the conditions mentioned in section 52D(7) are no longer met he/she must submit a report to the court in accordance with section 52Q(1). Examples of circumstances in which such a report may be submitted might include where it has become clear during the treatment order that:

- the person does not have a 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.

155 It would be expected that where the RMO is considering making a recommendation for the revocation of the treatment order in the report, he/she should consult with the designated MHO because such a recommendation 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.

156 In his/her report the RMO should set out the grounds for requesting the revocation of the treatment order.

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

### End of a treatment order (section 52R)

158 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* (ended completely) (but not *pro loco et tempore* (ended for the moment));
- 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).

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159 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.

## **Prevention of delay in trials: assessment orders and treatment orders (section 52T)**

160 It should be noted that **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005** made amendments to section 52T to take account of the relevant provisions of the Criminal Procedure (Amendment) (Scotland) Act 2004.

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## insanity

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## 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 in Part VI of the 1995 Act including the imposition of a temporary compulsion order.

All section numbers in this chapter refer to the the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") unless stated otherwise.

## Overview of psychiatric issues of relevance at trial

- 01 At the trial a sheriff (in summary cases) or a jury (in solemn cases) decides a verdict. Many 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:

### *Insanity in bar of trial*

- 02 If a person's mental disorder is such that he/she 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)).

### *Insanity at time of offence*

- 03 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

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section 55(3) and (4), where the trial diet has been discharged and an Examination of Facts has taken place.

## *Diminished responsibility (only applicable where the charge is murder)*

- 04 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.
- 05 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.
- 06 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.
- 07 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.
- 08 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 later in this chapter where the common law basis for these two forms of legal insanity are set out.
- 09 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 2 of this Code of Practice*).

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- 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.

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## 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 18 to 20, 23 to 24, and 28 to 29 of this chapter 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 In some circumstances an assessment by an appropriately qualified psychologist may be useful e.g. potential diminished responsibility resulting from a personality disorder.
- 15 Limited information may be available. When carrying out an assessment medical practitioners should be aware that the MHO may be able to provide useful information about the person. 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. Every effort should also be made to take account of the relevant sources that may be accessible such as a relative, significant other, carer and named person.
- 16 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 insane at the time of the offence.
- 17 The legal criteria do not translate easily into clinical terms. Some guidance is given in paragraphs 21 to 22, 25 to 27, and 30 to 31 below 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.



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## Insanity in bar of trial

### Legal criteria

- 18 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*

- 19 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.*

- 20 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

- 21 The assessment of fitness to plead is concerned with the mental state and ability of an accused person 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 person to give instructions for his/her 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.
- 22 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).

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## Insanity at the time of the offence

### Legal criteria

23 *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.*

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

### Clinical assessment

25 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.

26 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.

27 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.

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## Diminished responsibility

### Legal criteria

28 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.*

29 '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

30 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 in paragraphs 25 to 27 above, including reference to the SCR where one is available.

31 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 than those for insanity. It would be expected that the medical practitioner or other appropriate expert 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 or other appropriate expert should not state if the person's responsibility was diminished; this is an issue for the jury.

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## Addressing insanity in pre-trial reports

### Insanity in bar of trial

- 32 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. 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.
- 33 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 2 of this Code of Practice*).
- 34 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 must be approved in terms of section 22 of the 2003 Act) would be considered.
- 35 The importance of this is that if one medical practitioner prepares a report stating that he/she considers 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).
- 36 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 56 to 66 below), 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.

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- 37 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 56 below).

## **Insanity at the time of the offence**

- 38 At the very early stages of the pre-trial process (police custody and first court appearance, see *Part 1, Chapter 2 of this Volume 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.
- 39 It would be expected that in all other pre-trial reports the issue of insanity at the time of the offence would 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.

# chapter three

## Recommendation of disposal in insanity cases

- 40 In any case where it is likely that a person may be found insane in bar of trial or acquitted on the ground of insanity by the court, 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. (*For further information see Part 1, Chapter 5 of this Volume of the Code of Practice.*) 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.
- 41 The recommended disposal will depend on the nature of the person's mental disorder, his/her needs and the risk he/she poses to others. The issues here are identical to those at the post-conviction stage for persons who are convicted. The options as set out under section 57(2) are:
- a compulsion order;
  - a compulsion order and a restriction order;
  - an interim compulsion order;
  - a guardianship order;
  - a supervision and treatment order;
  - no order.
- 42 The assessment as to the appropriateness of each of the options in paragraph 41 above is identical to that set out in Part 1, Chapters 4 and 5 of this volume of the Code of Practice, with the exception of the supervision and treatment order (section 57(2)(d)) which is unique to insanity procedure.

# chapter three

## Insanity in bar of trial

## Insanity at the time of the offence

### Background

43 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

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

45 Following a finding of insanity in bar of trial, an EOF allows the court to determine whether the person committed the offence(s) with which he/she was charged (on indictment or complaint) 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, his/her needs and the risk the person poses to him/herself or others to be taken into account.

### Overview

46 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. Usually, the issue is determined before trial commences, but it may become apparent after the trial has started.

47 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. 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. The exception to this as already mentioned, is an acquittal on the grounds of insanity at the time of the offence.

# chapter three

48 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.

49 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 are available:

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



# chapter three

## Insanity in bar of trial

### General: section 54

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

- 50 Section 54 sets out procedures relating to a court's finding of insanity in bar of trial or at the time of the offence. Subsection (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). Subsection (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. Subsection (5) allows for the hearing regarding insanity in bar of trial to proceed in the person's absence. Subsections (2A)), (2B) and (4) set out procedures related to the temporary compulsion order. Subsection (7) sets out requirements for notice to be given if insanity in bar of trial is to be put forward. Subsection (8) defines terms used in section 54.
- 51 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 him/her to appear, and he/she (or the person acting on his/her behalf) has no objection (section 54(5)).
- 52 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.
- 53 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.
- 54 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)).

# chapter three

55 Following the finding in terms of section 54(1)(a) that the accused person 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* (ended for the moment) on the application of the prosecutor (section 54(2)).

## Criteria for making a temporary compulsion order (section 54(1)(c))

56 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).

## Effect of a temporary compulsion order section 54(2B)

57 Measures which may be authorised are:

- that the person be conveyed to the specified hospital within 7 days of the making of the order by any of the following: 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 54(2B), or another specified person;
- the detention of the person in the specified hospital;
- the giving to the person of medical treatment in accordance with Part 16 of the 2003 Act (which includes medication, psychological or social interventions).

# chapter three

## **Advance Statement**

58 Where any person is giving medical treatment under the 2003 Act to a person with mental disorder who is subject to the 1995 Act, that person must have regard to any advance statement (which complies with the 2003 Act) made by the person and not withdrawn. *For further information about advance statements see Chapter 6 of Volume 1 of this Code of Practice.*

## **What should happen during a temporary compulsion order?**

59 As soon as practicable after the patient's admission to hospital the hospital managers have a duty under section 260(5)(a) of the 2003 Act 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) of that Act, and also informed of the availability of independent advocacy services under section 259. *For further information on these procedures see Chapter 4 of Volume 1 of this Code of Practice.*

60 Although a temporary compulsion order does not qualify as a "relevant event" in terms of section 232 of the 2003 Act, 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's case, this action should be considered by the hospital managers and the local authority respectively.

61 It would be expected that the allocated MHO would work in close collaboration with the RMO and other members of the multi-disciplinary team and prepare a Social Circumstances Report (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.

62 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 other members of the multi-disciplinary team where relevant and appropriate.

# chapter three

63 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 (section 54(4))**

64 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 should report this to the prosecutor and have them seek to have the order varied or revoked. Examples of such circumstances may include the following:

- it has become clear during the temporary compulsion order that the person does not have a mental disorder;
- it is apparent that the risk that 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. This decision would be made by the RMO in consultation with the MHO and the other members of the multi-disciplinary team where relevant and appropriate.

65 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.

66 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.

# chapter three

## Insanity at the time of the offence

### General: sections 54 and 55

67 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 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 (EOF)

68 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 person 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.

69 Section 56 sets out supplementary procedures to be followed: where an accused is found insane in bar of trial after the trial has commenced and the citation of the person and witnesses in those circumstances (subsection (1)); legal representation (subsection (3)); 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 already been established that they committed at an EOF (subsection (7)).

70 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 any grounds for acquitting him/her.

# chapter three

- 71 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)).
- 72 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. *(For further information about this procedure see Part 1, Chapter 6 of this Volume of the Code of Practice).*
- 73 The diagram on page 98 shows the different findings that a court may make at an EOF.
- 74 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 accused found to be insane (section 57)**

- 75 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.
- 76 The diagram on page 99 illustrates the range of disposals in the case of insanity. All of these disposals, except (d) above 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 with respect to (a), (b), (bb) and (c) above medical practitioners should refer to Part 1, Chapters 4 and 5 of this Volume of the Code of Practice.*

# chapter three

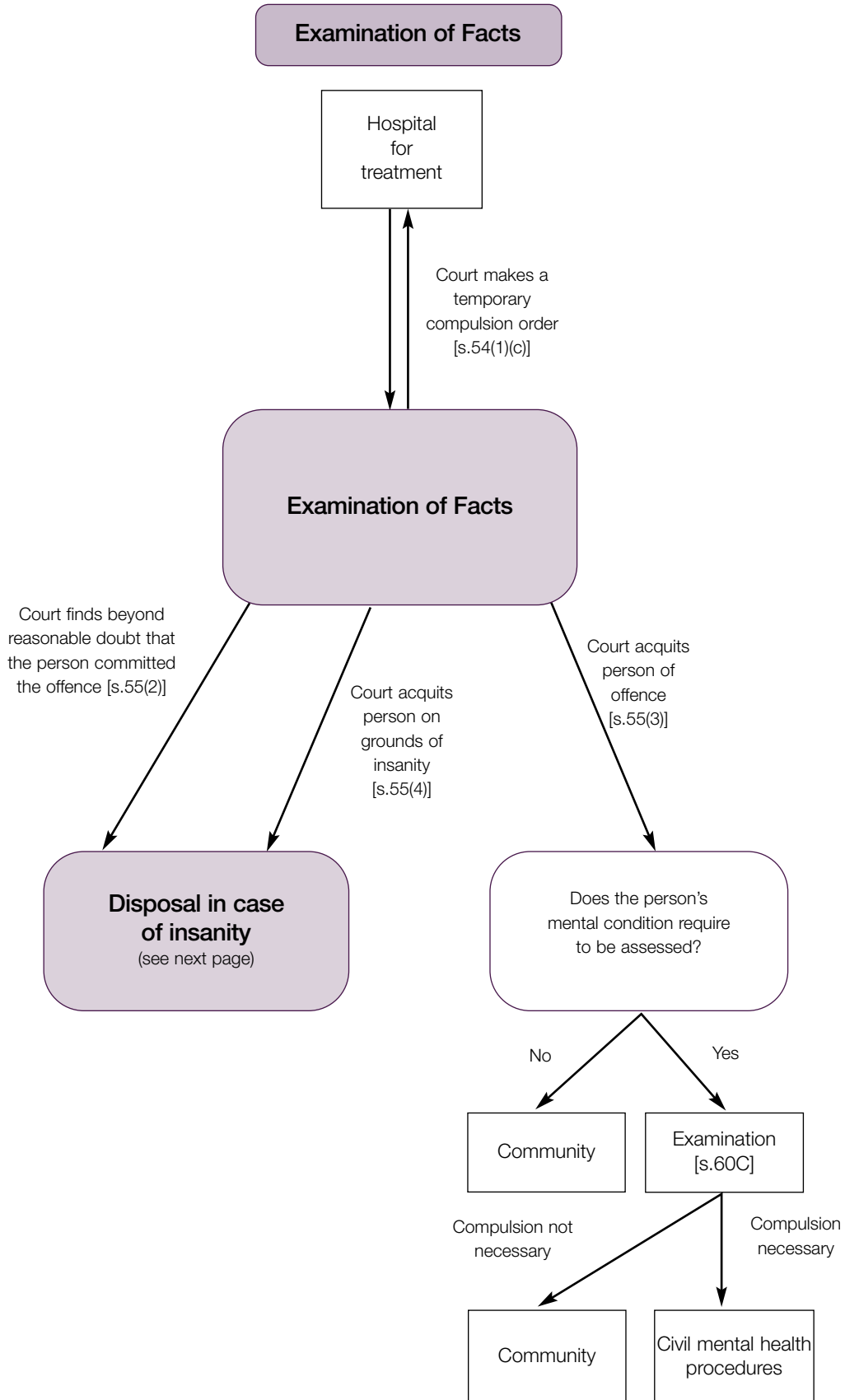
- 77 The 2003 Act makes no change to the supervision and treatment order (“STO”) and so guidance about this order is not included in this Code of Practice. However given that both an STO and a compulsion order (“CO”) provide for treatment and supervision in the community it should be noted that only the CO allows compulsory treatment for mental disorder under the 2003 Act as well as compulsory admission to hospital if the person is non-compliant. The choice between these two orders will therefore depend on the individual circumstances in each case. If the person meets the criteria for a CO authorising compulsory measures in the community and the less restrictive alternative of an STO is not appropriate or feasible considering the likely risk to the person or others and/or the likelihood and consequences of non-compliance, then it would be expected that a CO would be the appropriate disposal. Where this is not the case an STO would be expected to be the appropriate disposal.
- 78 Section 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. This notwithstanding a record would still be made on the person’s Scottish Criminal Records Office data. If the offending behaviour was sexual, the person may also be subject to the notification provisions of the Sexual Offences Act 2003 or to a Sexual Offences Prevention Order under that Act.
- 79 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).
- 80 If a compulsion order and a restriction order are 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.

# chapter three

- 81 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.
- 82 A guardianship order would be made according to the same criteria as set out under section 58 for convicted persons.
- 83 Section 57(5) refers to Schedule 4 of the 1995 Act, which sets out procedures relating to the supervision and treatment order.

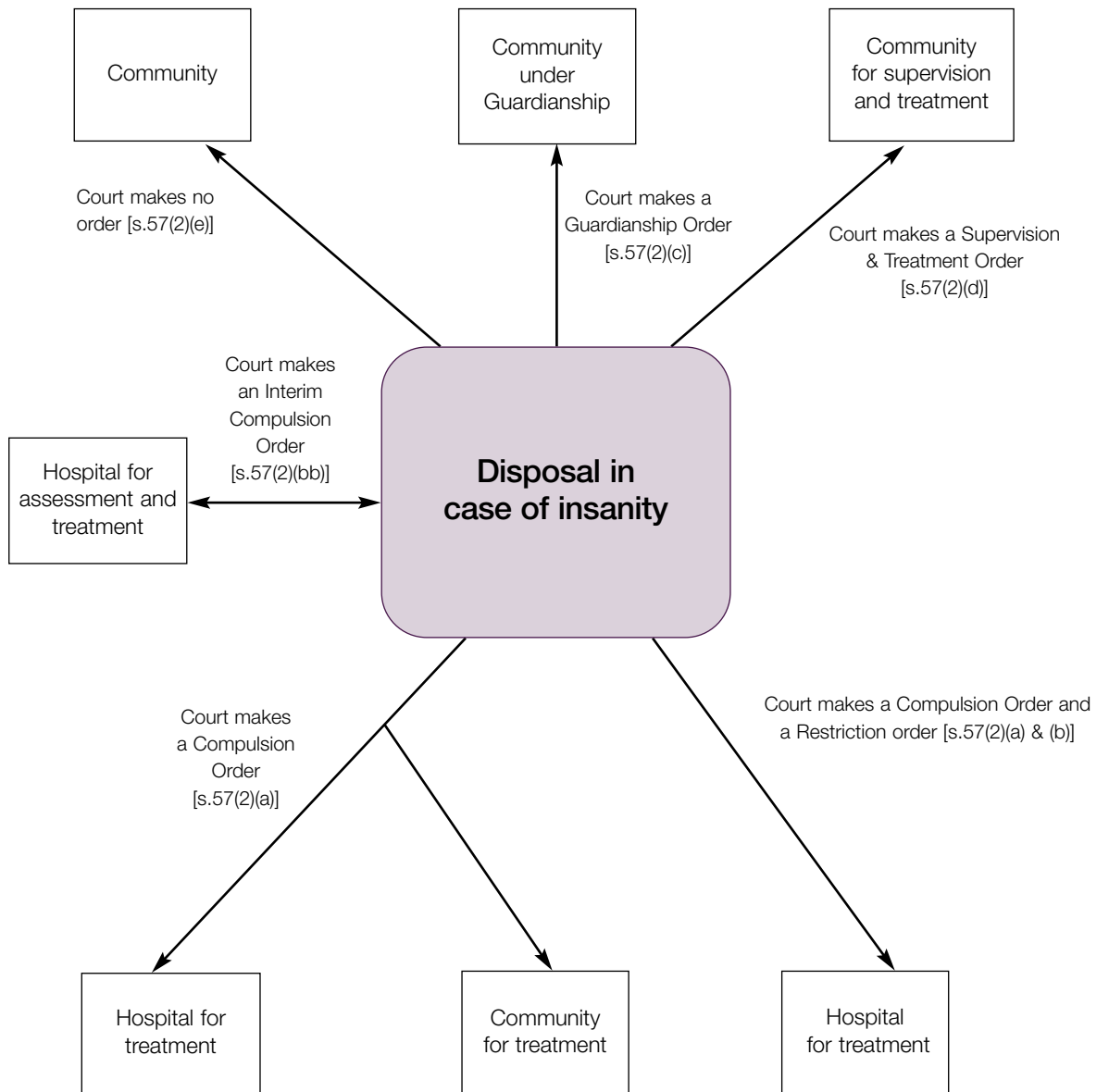


# chapter three



# chapter three

## Disposal in case of insanity





# chapter 4

post conviction, pre-disposal

# chapter four

## 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.

All section numbers in this chapter refer to the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”) unless stated otherwise.

## Overview

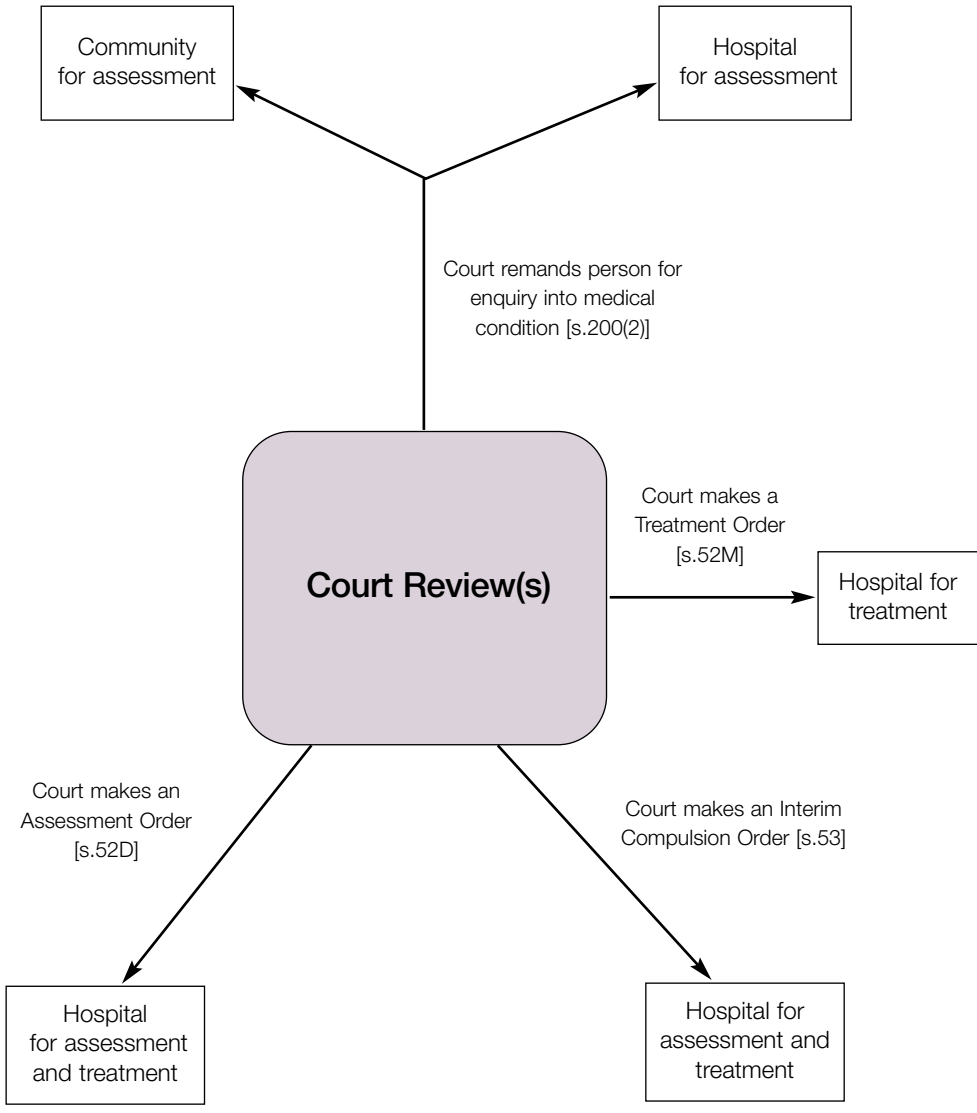
- 01 Orders are available post-conviction to allow for the assessment and/or treatment of a mentally disordered offender before a final disposal is made. These orders are:
  - interim compulsion order (section 53);
  - assessment order (section 52D);
  - treatment order (section 52M);
  - committal to hospital (section 200).
- 02 The diagram on page 104 illustrates the range of orders.
- 03 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 because the person has been convicted);
  - the response of the mental disorder to treatment;
  - the risk that the person poses and the contribution made to this risk by mental disorder;
  - ongoing mental health and care needs and how these might best be met.
- 04 Clarification of these issues will inform the ultimate disposal of the case. *(For further information see Part 1, Chapter 5 of this Volume of the Code of Practice.)*

# chapter four

- 05 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, 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.
- 06 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.
- 07 In all of the most serious cases, where a restriction order added to a compulsion order or hospital direction is being considered, it would be expected that there would be a period of assessment and treatment on an interim compulsion order, 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.
- 08 Assessment orders and treatment orders 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. It would be expected therefore that an order under section 200 which allows for a person to be remanded for inquiry into his/her mental or physical condition would only be used in exceptional circumstances to remand a person to hospital for reports.
- 09 Section 200 is changed very little by the 2003 Act other than to amend subsection (9) with the effect that:
- a person remanded under this section has a right of appeal against the court's refusal to grant bail or against the conditions imposed by the court within the first 24 hours of his/her remand; and
  - a person committed to hospital under this section may appeal against the order of committal and against its renewal at any time while the order (including where it has been renewed) is in force.

# chapter four

**Post conviction assessment and/or treatment**



# chapter four

## Interim Compulsion Order

### Background

- 10 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 28 days;
  - the order may be used even if it is not considered likely that the person will require to be detained in a state hospital (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;
  - 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

- 11 The purpose of the interim compulsion order in general terms is to allow a prolonged period of in-patient assessment before a final disposal is made with respect to 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. All members of the multi-disciplinary team should participate in the assessment process where relevant and appropriate.

### Overview

- 12 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.



# chapter four

- 13 Two medical recommendations are required and the criteria for making the order are similar to, but less stringent than, those for a compulsion order.
- 14 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, which may be renewed every 12 weeks up to a total of 12 months. At the end of an interim compulsion order the court may make any disposal it sees fit (mental health or penal).
- 15 It should be noted that although there is the option to detain the person in any hospital which is suitable in terms of section 53(3)(b) and not just in a state hospital, there is no provision to transfer the patient to a different hospital once he/she is admitted to the one specified in the order. This also applies where the order is extended by the court under section 53B(4).
- 16 Compulsory medical treatment in terms of Part 16 of the 2003 Act may be given under this order (which includes medication, psychological and social interventions).
17. It should be noted that a person who is subject to an interim compulsion order is classed as a “restricted patient” in that the consent of the Scottish Ministers is required before the person may be granted a period where his/her detention in hospital is temporarily suspended. *(For further information about the suspension of detention provisions in the 2003 Act refer to sections 221 to 226 of that Act and Part 1, Chapter 6 of this Volume of the Code of Practice.)*

# chapter four

## General: Sections 53 and 53A to D

### Criteria for making an interim compulsion order

18 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 (section 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 (sections 53(3)(a)(i) and 53(5)(a));
    - 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”) (sections 53(3)(a)(i) and 53(5)(b));
    - the making of an interim compulsion order is necessary (sections 53(3)(a)(i) and 53(5)(c));
  - 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 and a restriction order
    - a hospital direction (sections 53(3)(a)(ii) and 53(6));
  - to assess these issues a suitable, specified hospital placement is available within 7 days (sections 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)).

# chapter four

## Medical evidence (sections 53(2) and (3))

19 The medical recommendations must address the issues set out above in paragraph 18:

- does the offender suffer from mental disorder?
- are there reasonable grounds for believing it is likely that:
  - the treatability criteria are met? (see paragraph 18)
  - the risk criteria are met? (see paragraph 18)

(Note: the criteria for the above two issues are as for compulsion under civil procedures, but rather than being certain about their 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 risk of serious harm to the public if set at large (the 'risk criteria' for a restriction order); consideration should 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.
- is a suitable hospital placement available within 7 days of the order being made? (This 7 day period commences with the day on which the order is made. For example, if the order were imposed on Tuesday a bed in the specified hospital would require to be available to the person by the following Monday if not before). 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 he/she 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)). When considering whether the person requires conditions of special security that can only be provided by a state hospital, it would be expected that reference would be made to section 102(1) of the National Health Service (Scotland) Act 1978.
- is there a reasonable alternative to enable the assessment to be undertaken rather than by making an interim compulsion order?

# chapter four

20 If the person had previously been subject to an assessment order or a treatment order the MHO designated under section 229 of the 2003 Act may be able to provide useful information about the person and the medical practitioner should contact him/her to assist in the assessment and decision making process. If a Social Circumstances Report (“SCR”) had previously been prepared in terms of section 231 of the 2003 Act this should 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. Every effort should also be made to take account of the relevant sources that may be accessible such as a relative, significant other, carer and named person. *(For further information on the named person refer to sections 250 to 258 of the 2003 Act and Chapter 6 of Volume 1 of this Code of Practice.)*

## Attendance at court

- 21 The person should usually attend the 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.
- 22 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.

# chapter four

## **Notification by the court of the order being made (section 53(11))**

23 As soon as is reasonably practicable after imposing an interim compulsion the court must 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; and
- the Mental Welfare Commission.

## **Duty of a local authority to appoint an MHO (section 229 of the 2003 Act)**

24 A local authority has a duty to designate an MHO to be responsible for the person's case as soon as is reasonably practicable after an interim compulsion order has been made. The designated MHO must complete a Social Circumstances Report ("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 Mental Welfare Commission within 21 days of the order being made.

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

# chapter four

## Effect of an Interim Compulsion Order

### Removal to a place of safety (section 53(9))

- 26 An interim compulsion order may include such directions as the court thinks fit for the removal of the person 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 53(9). In terms of section 307 of the 1995 Act this place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. However, best practice would suggest that, in keeping with the principles set down in section 1 of the 2003 Act, the most appropriate place of safety in these circumstances would be a hospital. It would be expected that only in exceptional circumstances would the alternatives listed in section 307 of the 1995 Act be used as a place of safety.
- 27 The person should be conveyed from the place of safety to the specified hospital as soon as practicably possible by a person listed in section 53(8)(a).

### Measures which may be authorised under an interim compulsion order (section 53(8))

- 28 The measures that can be authorised by the interim compulsion order are:
- within 7 days of the making of the order the removal of the person to the specified hospital by any of the following: 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;
  - the detention of the person in the specified hospital for up to 12 weeks initially;
  - during that 12 week period the giving to the person of medical treatment in accordance with Part 16 of the 2003 Act (which includes medication, psychological and social interventions).

### Advance Statement

- 29 Where any person is giving medical treatment under the 2003 Act to a mentally disordered person who is subject to the 1995 Act, that person must have regard to any advance statement (which complies with the 2003 Act) made by the person and not withdrawn. *For further information on advance statements refer to sections 275 and 276 of the 2003 Act and Chapter 6 of Volume 1 of this Code of Practice.*

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## What should happen during an interim compulsion order?

- 30 As soon as practicable after the patient's admission to hospital, the hospital managers have a duty under section 260(5)(a) of the 2003 Act 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) of that Act, and also informed of the availability of independent advocacy services under section 259. *For further information on these procedures refer to Chapter 4 of Volume 1 of this Code of Practice.*
- 31 An RMO and an MHO must 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 (sections 230 and 229 of the 2003 Act). The patient should receive appropriate treatment for the mental disorder in terms of Part 16 of the 2003 Act which includes medication, psychological and social interventions (section 329 of the 2003 Act). A multi-disciplinary assessment should be undertaken to address the issues set out in paragraph 33 below and inform the RMO's report to the court under section 53B(1).
- 32 The designated MHO should work in close collaboration with the RMO and other members of the multi-disciplinary team where relevant and appropriate, and inform and assist in the 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 the Mental Welfare Commission within 21 days of the order being made. 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). *For further information refer to Part 1, Chapter 6 of this Volume of the Code of Practice and Chapter 4 of Volume 1.*

## Assessment during an interim compulsion order

- 33 Assessment of the person must be undertaken so that a written report can be prepared for the court by the RMO 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 person's mental disorder?
  - what is the prognosis of the mental disorder and the likely response to treatment?

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- 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 his/her mental health and social care needs and the assessment of risk?

34 At the time of writing it is anticipated that section 1 of the Criminal Justice (Scotland) Act 2003 will insert new provisions into section 210 of the 1995 Act in relation to persons who have been convicted of a serious violent or sexual offence. These are not yet in force but when they do become operational, where the person has been convicted of a such an offence the medical practitioner should have regard to these provisions and in particular to the risk criteria in section 210E which may have implications for the final disposal. For further information about these provisions contact the Risk Management Authority.

## **Suspension of detention (sections 221 to 223 of the 2003 Act)**

35 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 person. *For further information refer to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## **Absconding**

36 The statutory procedures in relation to absconding by mentally disordered offenders are set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**. *For further information refer to these regulations and to Part 1, Chapter 6 of this Volume of the Code of Practice.*



# chapter four

## Variation of an Interim Compulsion Order

### Change to the hospital specified in the order within 7 days of the order being imposed (section 53A)

- 37 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.
- 38 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.
- 39 This alternative should only be made because of emergency or other special circumstances. Examples of situations where this may arise are:
- there is 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.
- 40 When such circumstances are alerted to the court or the Scottish Ministers, 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. As soon as reasonably practicable after making a direction under section 53A(1) the Scottish Ministers must notify the court and any person having custody of the person. It would be expected that they would also inform the prosecutor.
- 41 It should be noted that other than the specific circumstance set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005** with respect to a person subject to an interim compulsion order who has absconded, there is no provision for an interim compulsion order to be varied once the person is admitted to the hospital specified in the order. This also applies where the order is extended by the court under section 53B(4).

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## Review, extension and revocation of an Interim Compulsion Order

### Review and extension of an interim compulsion order (section 53B)

- 42 Before the expiry of the interim compulsion order the RMO must submit a written report under section 53B(1) to the court addressing:
- whether the conditions mentioned in section 53(5) are met in respect of the person;
  - the type (or types) of mental disorder that the person has;
  - 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; and
  - any other matters that may have been specified by the court under section 53(2) as requiring to be included in the report.
- 43 However, the report should also address the issues outlined in ‘Assessment during an interim compulsion order’ in paragraphs 33 to 34 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 the interim compulsion order.
- 44 In addition, the recommendations in the report should address the specific issues relevant to appropriate disposal at the end of the interim compulsion order (see paragraph 51 below).
- 45 The RMO should consult with the designated MHO and other members of the multi-disciplinary team where appropriate and relevant to inform the assessment and decision making process.
- 46 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. If a compulsion order and a restriction order, or a hospital direction is being recommended, two reports should be provided, as is the requirement under sections 57A(2)(a) or 59A(2)(a) respectively.
- 47 The RMO must send a copy of his/her report 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.

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## **Revocation of an interim compulsion order**

- 48 Before the expiry of the interim compulsion order the RMO may submit a report to the court under section 53B(1) seeking to have the order revoked. Where the RMO is considering making such a recommendation to the court, he/she should consult with the designated MHO, and take into consideration the SCR which may have been provided under section 231 of the 2003 Act.
- 49 An example of where such a report would be submitted would be where it has become clear during the interim compulsion order that the person no longer has a mental disorder.
- 50 Section 53B(1) sets out the matters that must be addressed in the RMO's report to the court.

## **Options for disposal at the end of an interim compulsion order (section 53C)**

- 51 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 should be recommended if there has been insufficient time to address the relevant issues;
  - a compulsion order and 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. (Medical practitioners should not recommend that a person be made subject to a prison sentence).

*For further information regarding the various mental health disposals available at sentencing refer to Part 1, Chapter 5 of this Volume of the Code of Practice.*

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## **End of interim compulsion order (section 53C)**

52 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).

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## Assessment Orders and Treatment Orders post conviction

53 Assessment orders (section 52D) and treatment orders (section 52M) at the pre-trial stage are described in detail in Part 1, Chapter 2 of this volume of the Code of Practice. 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 section 52C or 52L, or at the initiative of the court under section 52E or 52N.
- an assessment order may continue for a period of 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 is the case 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).

54 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.

55 *For further information about assessment orders and treatment orders refer to Part 1, Chapter 2 of this Volume of the Code of Practice.*

# chapter 5

## final disposal

# chapter five

## 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) and the hospital direction (section 59A).

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)).

All section numbers in this chapter refer to the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") unless stated otherwise.

## Introduction

### Overview

01 Most mentally disordered offenders do not plead insanity and, if convicted of an offence, are given the relevant disposal on sentence. A few are found insane in bar of trial or acquitted on account of insanity. *(For further information refer to Part 1, Chapter 3 of this Volume 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

02 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. *(For further information refer to Part 1, Chapter 6 of this Volume of the Code of Practice.)* Where a compulsion order is under consideration, the court may request a report from an MHO (see paragraphs 32 to 44 below).

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- 03 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**

- 04 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 (except for probation orders with a condition of psychiatric treatment under section 230). Where it is anticipated that the proposed mental health disposal will involve psychological interventions as a major aspect of treatment, a psychologist or other appropriately qualified person making that psychological intervention should be consulted as part of the assessment.
- 05 In most cases where a hospital disposal is being considered, it would be expected that a multi-disciplinary in-patient assessment before and/or after conviction would 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, should be clarified through a period of assessment (on an assessment order under section 52D, a treatment order under section 52M or an interim compulsion order under section 53 – *for further information refer to Part 1, Chapter 4 of this Volume of the Code of Practice*).
- 06 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 before a hospital direction or a compulsion order with a restriction order is imposed, unless there is a good reason to do otherwise.



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## Mental health disposals available to the court

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

*If further assessment and/or treatment is required prior to a final disposal being made:*

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

*Final mental health disposals available are:*

- Hospital disposals:
  - compulsion order (section 57A);
  - compulsion order and a restriction order (sections 57A and 59);
  - hospital direction (section 59A).
- Community disposals:
  - compulsion order (section 57A);
  - guardianship order (section 58(1A));
  - treatment as a condition of probation (section 230);
  - voluntary treatment.

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

- prison sentence;
- probation order;
- community service order;
- fine;
- deferred sentence.

In some cases offenders may be admonished.

08 The 2003 Act makes no change to the guardianship order under section 58(1A). A general summary of this order is included at paragraphs 133 to 139 below.

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- 09 The 2003 Act makes two minor changes to the probation order requiring treatment for mental condition under section 230 which are detailed below. The two changes are:
- the 12 month time limit is removed so that the potential maximum duration of this order is the full 3 years for which any probation order may apply (section 230(1)); and
  - before making the order the court must be satisfied on the evidence of the medical practitioner or chartered psychologist under whom the treatment will be given that the relevant services are available and appropriate (section 230(3)).

No further guidance about an order made under section 230 is included in this Code of Practice.

- 10 The diagram on page 125 illustrates the range of final disposals that the court can make after conviction.

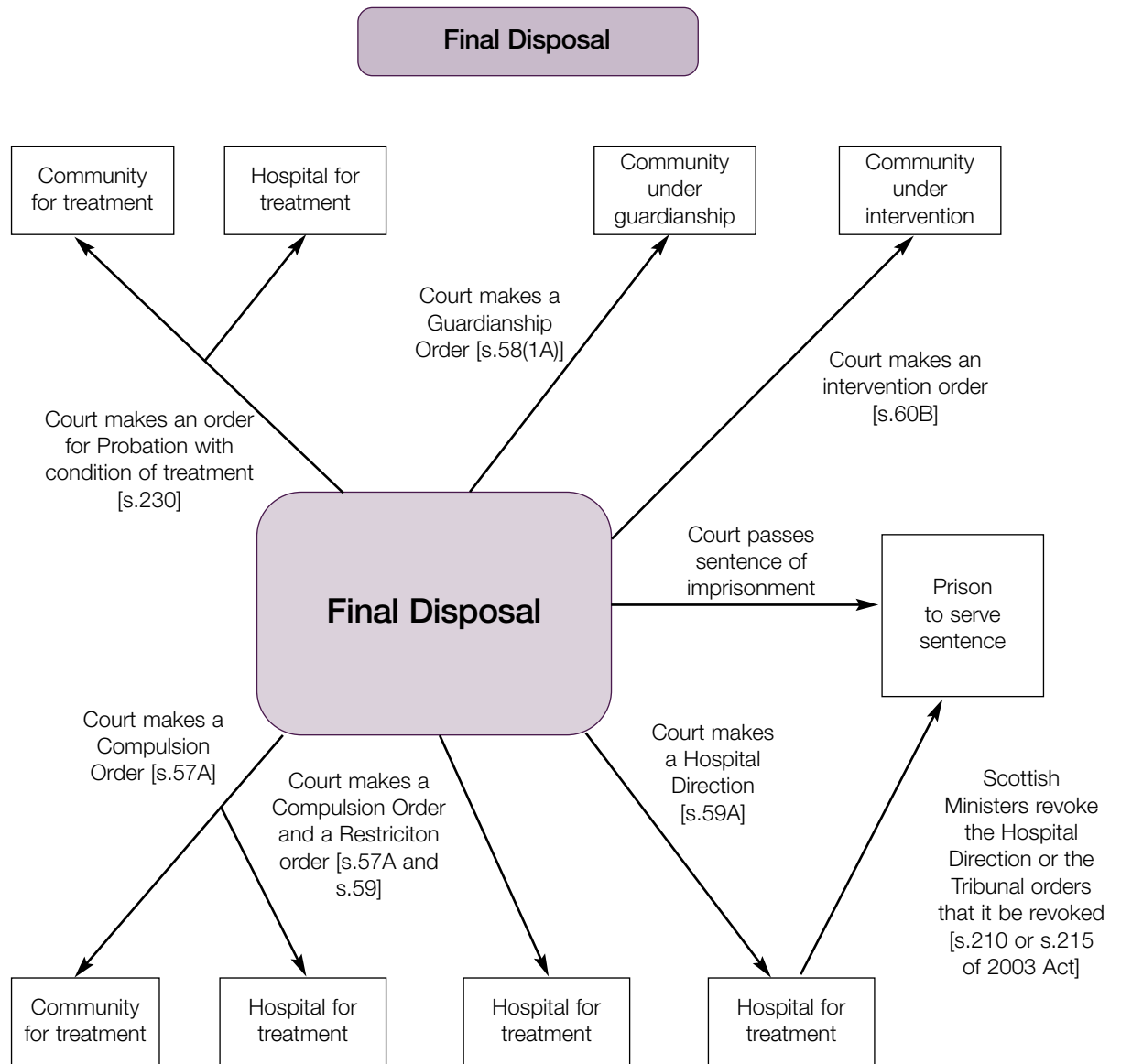
## Recommendations for final disposal

- 11 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)).
- 12 The following issues should be considered by a medical practitioner when making 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 before a final disposal is recommended. *(For further information refer to Part 1, Chapter 4 of this Volume of the Code of Practice.)*
  - 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 best practice with respect to the preparation of reports:

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- in cases where the person is already under the care of a RMO (for example he/she has been detained in hospital on an assessment order, a treatment order, an interim compulsion order, or perhaps under civil proceedings (section 36 or 44 of the 2003 Act), then one of the reports should be prepared by this RMO or, in consultation with the RMO, by another AMP working at the same hospital.
- 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 may also be preparing a report for the court for that case under section 57C or 59B 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 resided or is likely to reside on discharge from the state hospital.
- the disposal recommended should be the least restrictive 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 his/her 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.
- does the recommendation comply with the principles set out in section 1 of the 2003 Act?

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## Compulsion Order

### Background

- 13 The compulsion order under sections 57A to C 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 compulsory treatment order under section 64 of the 2003 Act), in particular a compulsion order may authorise compulsory treatment either in hospital or the community, unlike its predecessor the hospital order.

### Purpose

- 14 In general terms the purpose of the compulsion order (“CO”) is to provide a disposal that is almost identical to a compulsory treatment order (“CTO”) already described above where a person has been convicted of an offence but has a mental disorder. The court can authorise a range of measures in a CO including detention in hospital or treatment and care in the community. For the avoidance of doubt under no circumstances should compulsory treatment for mental disorder by way of a CO (or a CTO) which authorises compulsory measures in the community be appropriate whilst a person is serving a sentence in prison.

### Overview

- 15 A CO may be imposed by the court in accordance with section 57A(2) following consideration of oral or written evidence from two medical practitioners, (one of whom must be approved under section 22 of the 2003 Act), and after having regard to the matters mentioned in section 57A(4). The medical criteria to be considered and which are set down in section 57A(3) are:

- that the offender has a 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 offender;
- that if the offender 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; and
- that the making of the compulsion order in respect of the offender is necessary.

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16 The matters which the court must have regard to in accordance with section 57A(2)(b) and which are set down in sections 57A(4) are:

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

17 The main differences in general terms between the criteria for a CO and those for a CTO are that for a CO there is no criterion relating to the person's ability to make decisions about medical treatment (see section 64(5)(d) of the 2003 Act in relation to a CTO), the person needs to have been convicted of an offence punishable by imprisonment other than murder, and the sentencing court must be satisfied that a CO is necessary taking into consideration the circumstances of the case (i.e. the nature of the offence and the antecedents of the offender) and the other sentencing options available.

18 In certain cases the CO may authorise detention at a state hospital or other secure psychiatric hospital facility and may have a restriction order added to it. A CO allows a person to be given medical treatment under Part 16 of the 2003 Act (which includes medication, psychological and social interventions) and may authorise detention in hospital or compulsory measures in the community.

19 The order may 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 further information about the renewal procedures refer to Part 2, Chapter 1 of this Volume of the Code of Practice*).

20 The person has a 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).

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## General: Sections 57A to D

### Criteria for making a compulsion order

- 21 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.
- 22 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));
  - in a case where detention in hospital is to be authorised:
    - 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 order being made (section 57A(5)). (This seven day period commences with the day on which the order is made. For example, if the order were imposed on Tuesday a bed in the specified hospital would require to be available to the person by the following Monday if not before).
  - 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
    - such conditions of special security can be provided only in a state hospital (section 57(3)(6)). (When considering whether conditions of special security are required it would be expected that reference would be made to section 102(1) of the National Health Service (Scotland) Act 1978).

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- 23 These issues should be addressed in the same way as they would be addressed in determining the appropriateness of a CTO under civil procedure. *(For more information see Chapter 3 of Volume 2 of this Code of Practice.)*
- 24 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 (section 57A(2) and (3))**

- 25 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.
- 26 At least one of the two medical practitioners must be approved under section 22 of the 2003 Act (section 61(1)).
- 27 Both medical practitioners must agree that the person suffers from the same category of mental disorder (section 57A(14)(a)(i)).
- 28 The medical practitioners should 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 51 below).
- 29 If detention in hospital is recommended the medical practitioners should provide the court with reasons as to why compulsory powers in the community are not appropriate.
- 30 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 the reports should 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).



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- 31 Best 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, the designated MHO and other relevant care workers, well in advance of the psychiatric reports being submitted to the court. It would be expected that the RMO would be required 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 (section 57C)**

### *Overview*

- 32 One of the matters which the court must have regard to prior to imposing a CO is the MHO's report prepared in accordance with section 57C.
- 33 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);
  - interim compulsion order (section 53).
- 34 In all of the scenarios mentioned in the paragraph above a local authority will have previously designated an MHO as responsible for the person'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 see Chapter 9 of Volume 1 of this Code of Practice.*
- 35 As mentioned in paragraph 31 above, for the MHO to be able to fulfil the requirements of a report under section 57C, the RMO and the MHO should 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, the MHO should make him/herself known to the RMO.

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- 36 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 that the MHO considers relevant to the recommendations for a CO.
- 37 The MHO should also set out in his/her report under section 57C the compulsory measures in terms of section 57(8) which he/she considers should be authorised by the order (see paragraph 51 below).
- 38 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 appropriateness and feasibility of the powers being sought under the CO;
  - a description of the proposed plan of care as agreed by the multi-disciplinary team;
  - where the recommendation is for a CO which authorises hospital detention, the appropriateness of the level of security being recommended;
  - where the recommendation is for a CO which authorises compulsory powers in the community, the feasibility of the proposed community care services and confirmation that arrangements are in place for their provision by the relevant local authority;
  - whether any MHO duties to be specified in the order are appropriate and can be fulfilled;
  - 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 (refer to paragraphs 88 to 92 below for further information about the report where a restriction order is being recommended);

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- if the MHO does not consider that a CO is the appropriate mental health disposal he/she should draw the court's attention to any alternative considered feasible. The MHO may suggest that consideration is given by the court to request a Social Enquiry Report to further inform the suitability and viability of other alternatives. *(For further information about these reports refer to Part 1, Chapter 6 of this Volume of the Code of Practice.)*

- 39 There may be an overlap in the information contained in the recommendations made by the two medical practitioners and the information contained in the MHO report.
- 40 Where a CO which authorises compulsory powers in the community is being recommended there should be close consultation between the MHO and the RMO well in advance of such a recommendation being made to the court to ensure that there is no delay in the court being in a position to make a disposal in the case.

## *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 should 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 and 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 The report should 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.

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## Effect of a Compulsion Order

### Removal to a place of safety (section 57A(14)(b))

- 45 A compulsion order may include such directions as the court thinks fit for the removal of the person to, and the detention of the person in, a place of safety pending the person's admission to the hospital specified in terms of section 57A(8)(a) or, as the case may be, specified place in terms of section 57A(8)(e). In terms of section 307 of the 1995 Act this place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. However best practice would suggest that, in keeping with the principles set down in section 1 of the 2003 Act, the most appropriate place of safety in these circumstances would be a hospital. It would be expected that only in exceptional circumstances would the alternatives listed in section 307 of the 1995 Act be used as a place of safety.
- 46 The person should be conveyed from the place of safety to the specified hospital as soon as practicably possible by a person listed in section 57B.

### Change of hospital prior to admission and within 7 days of order being made (section 57D)

- 47 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.
- 48 It would usually be the medical practitioner who had recommended the CO, 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 medical practitioner or someone else (e.g. hospital manager) depending on the circumstances.
- 49 This alternative should only be made because of emergency or other special circumstances. Examples of these circumstances might include:
- where there has been 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.

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- 50 Where such circumstances are alerted to the court or the Scottish Ministers, 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.

## **Measures which may be authorised under a compulsion order (section 57A(8))**

- 51 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) 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.

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- 52 In relation to section 57A(8)(e), if the specified place is a care home 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.
- 53 A CO allows the court, within 7 days of the making of the order, to remove the person to the hospital or place specified in the order by any of the following: 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)).
- 54 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 2003 Act (which includes medication, psychological and social interventions), either in hospital or in the community, for a period of 6 months beginning on the day on which the order was made (section 57A(2)).
- 55 If a restriction order is imposed in addition to the order then the measures specified in the order are authorised without limit of time (section 57A(7)).
- 56 The measures that may be authorised by a CO mirror those available under civil procedure for CTOs – *for further information refer to Chapter 3 of Volume 2 of this Code of Practice.*
- 57 *For information about the statutory procedures to be followed in the review, variation, extension and revocation of a CO as laid out in Part 9 of the 2003 Act refer to Part 2, Chapter 1 of this Volume of the Code of Practice.*

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

58 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.

59 Where a restriction order is under consideration, it is very important that there is a thorough assessment of risk, mental disorder and their relationships to the offence. For a restriction order to be recommended to the court it would be expected that there would be a significant 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 recommendation would be for a hospital direction under section 59A.

60 In any case where a mentally disordered offender appears to pose a significant risk to others such that consideration is being given to recommending a restriction order with a compulsion order or a hospital direction, it would be expected that an interim compulsion order would be recommended 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.

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- 61 The conclusion of the risk assessment should consider the nature of the risk that the person might pose in the future and the circumstances that might exacerbate or mitigate that risk. 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. For further information and best practice points in relation to risk assessment refer to paragraphs 64 to 72 below.
- 62 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.
- 63 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 and/or a treatment order, and it is clear that the risk that the person 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 recommended without detention under an interim compulsion order.

## **Risk Assessment**

- 64 There are two statutory definitions of risk criteria that may need to be considered in any particular case.
- 65 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 compulsory treatment order is applied for. This risk criterion is concerned with the risk to self and others: “... *significant risk to the health, safety or welfare of the offender; or to the safety of any other person;*...” This would be expected to be interpreted in an identical way to civil procedures under section 36(5)(b) or 44(4)(d) or 64(5)(c) of the 2003 Act. *For further information refer to Chapter 3 of Volume 2 of this Code of Practice.*



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- 66 The criteria for a restriction order are set down in section 59(1). This criterion is concerned only with risk to others: “...*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.
- 67 At the time of writing it is anticipated that the Criminal Justice (Scotland) Act 2003 will insert new provisions into section 210 of the 1995 Act in relation to persons who have been convicted of a serious violent or sexual offence. These are not yet in force but when they do become operational and a risk assessment is being carried out with respect to a person who has been convicted of such an offence practitioners should have regard to these provisions, and in particular to the risk criteria set out in section 210E which may have implications for the final disposal. For further information about these provisions contact the Risk Management Authority.

## Best practice points

- 68 Risk assessments may be carried out using protocols or assessment tools that have proven validity for the category of people that the assessed person falls into (e.g. mentally disordered offenders, prisoners, sex offenders).
- 69 In most cases where mental disorder is also an issue, the assessment should consider not just statistical (or actuarial) assessment but attempt to place the risk the person presents in the context of his/her past history and current offending (clinical risk assessment). More specifically this means:
- personal and family history;
  - criminal history and history of violence;
  - substance misuse;
  - psychiatric history;
  - assessment of personality;
  - other relevant risk factors for the population group which the person falls into (e.g. sex offender risk factors).

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- 70 Wherever possible, risk assessment should be based on information from as many sources as possible. Practitioners should be aware of large volumes of notes which simply reiterate self-report from interviews with others. Strenuous attempts should therefore be made to source collateral information from family members, police reports, criminal records and contemporary accounts of previous violent incidents that may be contained in other records (e.g. nursing notes of past violent incidents).
- 71 A good assessment of risk should never define a person simply in terms of high/medium or low risk. Although these terms may reasonably be used, such assessment should also include an attempt to characterise the nature of the violence the person may perpetrate in the future. For example this would include:
- the kind(s) of violence the person is capable of perpetrating;
  - the likely level of physical or psychological harm;
  - the situation(s) in which the person is most likely to be violent;
  - the likely victim(s) of that violence;
  - the warning signs that the person may be at risk of being violent;
  - the management strategies that need to be put in place to manage the risk of violence in the short term;
  - the least restrictive environment in which the person's violence can be easily be managed;
  - the psychological, psychiatric or social treatments that may be given to help decrease the person's risk of violence in the long-term.
- 72 Such an assessment should involve the multi-disciplinary team and once formal assessments have been carried out by the professionals involved in the multi-disciplinary team, the RMO and the MHO should hold regular risk management meetings to consider the risk that the person poses. These meetings should form a formal part of any care planning process.

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## Restriction Order

### Background

73 The 2003 Act makes very little change to section 59 of the 1995 Act which allows a court to impose a restriction order with respect to a person who has been made subject to a CO.

### Purpose

74 In general terms a restriction order allows additional scrutiny of a mentally disordered offender who may potentially pose a risk of serious harm to others, as he/she progresses through rehabilitation, so as to protect the public from this risk.

### Overview

- 75 To make a restriction order the court must hear oral evidence from one of the medical practitioners recommending the accompanying CO.
- 76 If the person has not previously undergone a period of assessment on an interim compulsion order, 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.
- 77 The court must be satisfied that the criteria for making a restriction order as set out in section 59(1) are met.
- 78 For a restriction order to be recommended to the court it would be expected that there would be a significant link between the mental disorder specified in the CO and the offence and/or the future risk posed.
- 79 A compulsion order with a restriction order ("CORO") authorises the detention of the person in hospital (a restriction order cannot be made with a CO which authorises compulsory powers in the community) and the duration of compulsion is indefinite. A restriction order cannot be made for a time limited period.

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## General: Sections 59 and 57C

### Criteria for making a restriction order

80 For a restriction order to be added to a CO which authorises 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, without limit of time.

81 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 that these criteria are met even if oral medical evidence does not support a restriction order.

82 For the recommendation of a restriction order to be made to the court, 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 should play a substantial part in determining risk to others, and it would be expected that 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.

83 Therefore, before a CORO may be imposed it would be expected that the court would consider the following matters:

- has the risk which the person poses been thoroughly assessed during an interim compulsion order? If not, is adequate information available to address the following questions so that an interim compulsion order is unnecessary?

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- if a restriction order is not imposed may there be a risk of serious harm to others in the future?
- does the person's specified mental disorder play a substantial part in determining this risk?

84 If the person appears to pose a significant risk, but the specified mental disorder is not a major factor determining this risk, or where treating the specified mental disorder is unlikely to significantly reduce this risk, then it would be expected that a hospital direction (under section 59A) would be a more appropriate recommendation to make to the court. Consideration of these matters should be characterised by multi-disciplinary working between the medical practitioners, the MHO and other relevant parties where appropriate.

## **Medical Evidence**

- 85 Oral evidence is required from an AMP whose evidence has been the basis for the accompanying compulsion order (section 59(2)).
- 86 In all but exceptional cases, a recommendation for a CORO would be expected to follow a prolonged period of multi-disciplinary in-patient assessment under an interim compulsion order. If it then appears to the reporting medical practitioners that a CORO 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).
- 87 It would be expected that the SCR where previously prepared by the designated MHO under section 231 of the 2003 Act following the making of the interim compulsion order would contribute to the consideration of the level of risk posed by the person and the relationship between this risk and the mental disorder.

## **Mental Health Officer's report for the court under section 57C where a restriction order is under consideration**

- 88 Reference should be made to "MHO's report to the court under section 57C" in relation to a compulsion order without a restriction order in paragraphs 32 to 44 above.

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- 89 In addition, where a restriction order is being considered, the MHO's report for the court should 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 his/her 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 for mental disorder.
- 90 The MHO should also consider if there are less restrictive alternatives which 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.
- 91 In assessing whether a restriction order is necessary and appropriate, the MHO should bear in mind the broad range of powers that are available under a compulsion order without a restriction order, including powers to require treatment in the community, determination of residence, and powers of access for the purposes of supervision and treatment.
- 92 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 it would be expected that the MHO's report would contribute to the consideration of matters detailed in b) and c) of the criteria for making a restriction order mentioned in paragraph 80 above.

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## Effect of a Restriction Order

- 93 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)).
- 94 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 under section 193 of the 2003 Act.
- 95 The approval of the Scottish Ministers is required before the person may be granted a period of suspension of detention (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 a state hospital.
- 96 *For information about the statutory procedures to be followed in the review of a CORO, and in the discharge of a person who is subject to a CORO as laid out in Part 10 of the 2003 Act refer to Part 2, Chapters 2 to 4 of this Volume of the Code of Practice.*

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## Hospital Direction

### Background

97 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

98 In general terms the hospital direction allows the person to receive the appropriate medical treatment for mental disorder in hospital in accordance with Part 16 of the 2003 Act (which includes medication, psychological and social interventions), and then to be transferred to prison to complete the prison sentence imposed at the time of the making of the hospital direction. The period during which the person is subject to the direction counts as time served in relation to the sentence.

### Overview

99 A hospital direction may be imposed by the court in accordance with section 59A(2) following consideration of the oral or written evidence from two medical practitioners (one of whom is approved under section 22 of the 2003 Act) and after having regard to the matters mentioned in section 59A(5). The medical criteria to be considered and which are set down in section 59A(3) are:

- that the offender has a 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 offender;
- that if the offender were not provided with such treatment there would be a significant risk to the health, safety or welfare of the offender or to the safety of any other person; and
- that the making of the hospital direction in respect of the offender is necessary



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100 The matters which the court must have regard to in accordance with section 59A(2)(b) and which are set down in section 59A(5) are:

- the MHO report prepared in accordance with section 59B in respect of the offender
- all the circumstances of the case, including:
  - the nature of the offence of which the offender was convicted; and
  - the antecedents of the offender; and
- any alternative means of dealing with the offender

101 The court must be satisfied that a hospital direction is appropriate taking into consideration the mental health officer's report prepared in accordance with section 59B, all the circumstances of the case and the alternative sentencing options available.

102 As with restriction orders, assessment of the person prior to the making of a hospital direction should be undertaken during an interim compulsion order except where this is clearly not appropriate.

103 It would be expected that a recommendation for a hospital direction would be made to the court in cases where persons convicted on indictment meet the criteria for a CO 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 that the person poses to the public as a result of mental disorder.

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## General: sections 59A to C

### Criteria for making a hospital direction

104 A court may impose 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)).

105 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.

106 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)) (This seven day period commences with the day on which the direction is made. For example, if the direction were imposed on a Tuesday a bed in the specified hospital would require to be available to the person by the following Monday if not before).
- 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
  - such conditions of special security can be provided only in a state hospital (section 59A(6)). (When considering whether conditions of special security are required, it would be expected that reference would be made to section 102(1) of the National Health Service (Scotland) Act 1978).

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107 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)).

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

- has the risk the 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?

## **Medical Evidence (section 59A(2) and (3))**

109 The statutory criteria regarding the medical evidence necessary for a court to make a hospital direction are identical to those for a CO which authorises detention in hospital and should be addressed in an identical way (see paragraphs 25 to 31 above). However three additional factors should also be considered in such cases:

- as with a CORO, 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 CO were being considered, a recommendation for a restriction order would also be likely;
- in contrast to the CO it would be expected that the link between the specified mental disorder and the index offence and/or the risk of further serious harm to the public would be weak.

In considering these matters the RMO and the MHO should consult closely before a recommendation for a hospital direction is made to the court.

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- 110 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 should be rare.
- 111 At least one of the two medical practitioners must be approved under section 22 of the 2003 Act (section 61(1)). The medical evidence must address the matters set out above in paragraphs 106 and 108.
- 112 Both medical practitioners must agree that the person suffers from the same category of mental disorder (section 59A(9)(a)). There should be a statement in the reports to the effect 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).
- 113 In all but exceptional cases, or cases where the person has been convicted of murder, it would be expected that a recommendation for a hospital direction would follow a prolonged period of multi-disciplinary in-patient assessment whilst the person is detained under an interim compulsion order.
- 114 If, following this period, it appears to the reporting medical practitioners that a hospital direction is the appropriate disposal, 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).
- 115 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. If the person appears to pose a substantial risk, but the specified mental disorder is not a major factor determining this risk, or where treating the specified mental disorder is unlikely to significantly reduce this risk, then it would be expected that a hospital direction would be the appropriate recommendation to make to the court. Consideration of these matters should be characterised by multi-disciplinary working between the medical practitioners, the MHO and other relevant parties where relevant and appropriate.

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## **Mental Health Officer's report for the court (section 59B)**

- 116 One of the matters which the court must have regard to prior to imposing a hospital direction is the MHO's report prepared in accordance with section 59B .
- 117 Reference should be made to paragraphs 32 to 44 ("Mental Health Officer's report (section 57C)") and paragraphs 88 to 92 ("Mental Health Officer's report for the court under section 57C where a restriction order is under consideration").
- 118 However, unlike COs 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.
- 119 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 CORO. This will involve consulting with multi-disciplinary colleagues and communicating with potential providers of treatment for the person as appropriate.
- 120 Alternatively the MHO will wish to be satisfied that the person's circumstances do merit detention and treatment in hospital at the point of disposal.
- 121 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.

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## Effect of a Hospital Direction

### Removal to a place of safety (section 59A(9)(b))

122 A hospital direction 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 the hospital specified in terms of section 59A(7)(b). In terms of section 307 of the 1995 Act this place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. However best practice would suggest that, in keeping with the principles set down in section 1 of the 2003 Act, the most appropriate place of safety in these circumstances would be a hospital. It would be expected that only in exceptional circumstances would the alternatives listed in section 307 of the 1995 Act be used as a place of safety.

123 The person should be conveyed from the place of safety to the specified hospital as soon as practicably possible by a person listed in section 59A(7)(a).

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

124 Under section 59C, if within 7 days of the hospital direction being imposed 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.

125 It would 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.

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126 This alternative should only be made because of emergency or other special circumstances. Examples of these circumstances might include:

- where there has been a deterioration in the mental condition of the person such that the specified hospital is no longer be an appropriate placement;
- a bed being unavailable in the specified hospital due to emergency circumstances.

127 Where such circumstances are alerted to the court or the Scottish Ministers, 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.

## Measures which may be authorised under a hospital direction

128 Section 59A(7) sets down the measures which may be specified in a hospital direction. Quoting from that subsection of the 1995 Act, these are:

- (a) in the case of an offender who, when the hospital direction is made, has not been admitted to the specified hospital, the removal, before the expiry of 7 days beginning with the day on which the direction is made, of the offender to the specified hospital by–
- (i) a constable;
  - (ii) 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
  - (iii) a specified person;
- (b) the detention of the offender in the specified hospital; and
- (c) 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.

129 A hospital direction allows the court, within 7 days of the imposition of the direction, to remove a person to the hospital specified in the direction by any of the following: 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 (section 59A(7)).

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- 130 It allows a person to be given compulsory treatment for mental disorder in hospital in accordance with Part 16 of the 2003 Act (which includes medication, psychological and social interventions).
- 131 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).
- 132 *For information about the statutory procedures to be followed after a hospital direction has been imposed, in the review of a hospital direction, and in the discharge of a person who is subject to such a direction as laid out in Part 11 of the 2003 Act refer to Part 2, Chapters 6 to 8 of this Volume of the Code of Practice.*



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## Intervention Orders and Guardianship Orders under the Adults with Incapacity (Scotland) Act 2000 as applied to mentally disordered offenders

### Background

133 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).

134 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

135 In general terms, the purpose of an intervention 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.

136 In general terms, a guardianship order 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.

# chapter five

## Overview

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

138 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 may be made through an application under the 2000 Act.

139 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.*



# chapter 6

## over-arching issues

# chapter six

## 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

All section numbers in this chapter refer to the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”) unless stated otherwise.

## Situations where the criminal justice process ends unexpectedly or prematurely

### Introduction

- 01 Much of the information in Part 1 of this volume of the 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* (the case is deserted forever)) 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 upon). In some cases a court may decide not to act on a recommendation for a specific mental health disposal.
- 02 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 (section 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.

# chapter six

03 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.

04 There is specific statutory provision under section 60C 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*

05 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, consideration should 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*

06 Such circumstances would be expected to be rare because 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).

# chapter six

## *Measures to be put in place*

- 07 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 powers under civil procedure as compared to that through criminal procedure it may not be possible to put very closely similar measures in place. (The criteria for compulsory powers under civil procedures include an additional criterion to those under criminal justice proceedings in that the person's ability to make decisions about medical treatment for mental disorder requires to be significantly impaired as a result of his/her mental disorder (see sections 36(4)(b) and 44(4)(b) of the 2003 Act). The measures to be put in place will depend on the needs of the person and the risk he/she may pose to him/herself or others. Each case will require to be considered on its facts.

# chapter six

## Urgent detention of acquitted persons under section 60C

### Background

08 Section 134 of the 2003 Act inserts section 60C into the 1995 Act, which allows 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) and that it is not possible to arrange an immediate examination of the person by a medical practitioner.

09 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 because 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 following an acquittal (beginning with the time at which the order under section 60C was made), provided that there have been medical recommendations available to the court which recommended 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.



# chapter six

## 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 under section 22 of the 2003 Act) 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 medical practitioners 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 he/she is acquitted. These are:
- treatment order (section 52D);
  - interim compulsion order (in some circumstances – see paragraph 13 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.

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## **Removal to a place of safety**

- 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)). In keeping with the principles in section 1 of the 2003 Act the most appropriate place of safety in these circumstances would be a hospital, preferably the one where the person was due to be admitted although 6 hours may be too short a time period for this. It would be expected that only in exceptional circumstances would the court holding cells be used.

## **The medical examination during detention under section 60C**

- 15 The medical practitioner carrying out the medical examination under section 60C should follow the information in Chapters 2 and 7 of Volume 2 of this Code of Practice about examinations in relation to emergency and/or short-term detention. Ideally the medical practitioner assessing the person should be one of the practitioners 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 should where practicable consult one or both of the medical practitioners who had made the initial recommendations. The designated MHO who may have prepared an SCR in terms of section 231 of the 2003 Act should also be consulted.
- 16 In general, the hospital in which the person should be detained under the emergency or short-term detention order, should be the same as the one where he/she 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 level of security.

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- 17 Medical examinations in these circumstances must follow the information and guidance in Chapters 2 and 7 of Volume 2, of the Code of Practice 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. Given the short timescale the MHO should be contacted at the earliest opportunity where it is anticipated that detention under section 60C is likely.

## **Medical treatment**

- 18 Medical treatment under Part 16 of the 2003 Act cannot be given during the 6 hour period because the person is not detained in hospital (but 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 for mental disorder during detention under section 60C then this may be given under common law.

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## Transporting persons subject to these provisions between prison, court and hospital

- 19 Prior to conviction, the prosecutor would be expected to arrange for an accused person 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 person, whether before or after conviction, would usually be carried out by the Prisoner Escort and Court Custody Service.
- 20 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 person.

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## Suspension of Detention

### Overview

- 21 Suspension of detention was generally referred to as ‘leave of absence’ under the 1984 Act. Part 13 of the 2003 Act sets out the statutory procedures for the temporary suspension of the measure in the order or direction specifying detention of a person who is subject to:
- (i) an assessment order (section 52D of the 1995 Act);
  - (ii) a treatment order (section 52M of the 1995 Act);
  - (iii) an interim compulsion order (section 53 of the 1995 Act);
  - (iv) a compulsion order and a restriction order (sections 57A and 59 of the 1995 Act);
  - (v) a hospital direction (section 59A of the 1995 Act);
  - (vi) a transfer for treatment direction (section 136 of the 2003 Act).
- 22 Paragraphs 24 to 27 below outline the procedures for suspending the detention of a patient who is subject to an order or direction listed in paragraph 21. All section numbers in these paragraphs refer to the 2003 Act unless stated otherwise.
- 23 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. It applies, with certain modifications, the relevant sections of the 2003 Act which set out the statutory procedures for the suspension of detention of a compulsory treatment order. *For further information about these procedures refer to section 179 and Chapter 4 of Volume 2 of this Code of Practice.* It should be noted that **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modifications of Enactments) Order 2005** amended section 179 so that the suspension of detention provisions also apply where an interim order has been made by the Tribunal with respect to a compulsion order in accordance with section 168 or 169 of the 2003 Act.
- 24 Suspension of detention allows for the hospital detention requirement in the order or direction to which the person is subject to be suspended for a limited period of time (and thereby suspend the person’s detention in hospital) without the order or direction being revoked in its entirety. Suspension of detention may be granted for a number of reasons, such as:

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- rehabilitation including pre-transfer visits to another hospital;
  - quality of life;
  - compassionate visits;
  - scheduled treatment in hospital;
  - emergency treatment in hospital;
  - attendance at court;
  - attendance at Tribunal hearings which are held outwith the hospital grounds.
- 25 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.
- 26 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. There may be circumstances however in which such consultation may not be realistic or necessary, for example, where the period of suspension is for a short escorted trip to attend another hospital or for emergency treatment. In these circumstances the RMO should ensure that he/she takes into account any relevant victim issues, possible community concerns related to the index offence and any child protection matters.
- 27 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 should also take into account any relevant victim issues or community concerns related to the index offence. Any child protection matters should be considered. The MHO should take into account any notification requirements which may be imposed on the patient under Part 2 of the Sexual Offences Act 2003 (or “sex offender registration” as the requirements are commonly known), and what, if any, impact the need to comply with these requirements may have on him/her.

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- 28 At the time of writing it is anticipated that regulations may be made under section 96 of the Sexual Offences Act 2003 placing a duty on hospital managers to notify other parties of certain information relating to the release from detention for a period of 3 days or more of a patient who is subject to the notification requirements under Part 2 of that Act. These are not yet in force but when they do become operational hospital managers must check their responsibilities in this area and comply with any duties imposed.

## **Granting the certificate (sections 221(3) and 224(2))**

### *Consent of the Scottish Ministers*

- 29 The RMO may grant a certificate suspending for a period the measure in the order or direction which authorises detention after having obtained the consent of the Scottish Ministers in accordance with section 224(3). This applies to both escorted and unescorted periods of suspension. Where the person is subject to one of the orders or directions listed in paragraph 21(ii) to (vi) above this period must not exceed 3 months.
- 30 Best practice would suggest that the Scottish Ministers' consent should be sought in good time before any proposed period of suspension to allow for any potential concerns to be identified and resolved. For example, where consideration is being given to a patient being granted a period of suspension for the first time to allow a compassionate visit to the home of family members or friends, the Scottish Ministers will require to be assured that all relevant matters have been identified and taken into account in the planning for the visit.
- 31 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(2) to (6) with respect to an assessment order and sections 224(4) to (7) with respect to the orders or directions listed in paragraph 21(ii) to (vi) above. However 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.

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## *The certificate*

- 32 Having obtained the approval of the Scottish Ministers the RMO may grant a certificate specifying a period during which the relevant order or direction does not authorise detention in hospital. In terms of sections 221(4) or 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.
- 33 Where the patient is subject to an order or direction listed in paragraph 22(ii) to (vi) above 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. This is to prevent a patient being subject to suspension certificates for unnecessarily long periods of time. The expiry date of the certificate must not go beyond the expiry date (where applicable) of the order or direction to which the patient is subject.
- 34 Conditions may be included in the certificate where the RMO considers it necessary in the interests of the patient, or for the protection of any other persons (sections 221(5) or 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 sections 221(6)(a) or 224(7)(a) (such as a nurse or family member) or other conditions as may be specified by the RMO in terms of sections 221(6)(b) or 224(7)(b).
- 35 It would be best practice for the RMO to ensure that the designated MHO and other members of the multi-disciplinary team are informed of any conditions attached to the suspension certificate, and to ensure that procedures and contingency plans are put in place for any occasion where the conditions are not complied with.
- 36 The patient's RMO should give full consideration to the need for a multi-disciplinary assessment of the impact on the health and welfare of the patient and others of a proposed stay in the community. Any proposed suspension of detention and its objectives should concord fully with the patient's agreed care plan and its objectives. In coming to a conclusion on the appropriateness of the proposed suspension certificate, it will be important that the RMO involve fully the designated MHO and other members of the multi-disciplinary team. Practitioners involved in this



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process should also have regard to the principles of the 2003 Act, as laid out in sections 1 to 3, when deciding whether or not to grant a suspension certificate. Particularly important among these principles in this connection will be that stated at section 1(4) of the 2003 Act which provides for any person discharging a function under that Act to discharge that function in a manner which “involves the minimum restriction on the freedom of the patient that is necessary in the circumstances”.

- 37 It would be expected that the patient and his/her named person would be as fully involved with the planning process preceding the decision to grant a suspension certificate as is practicable, bearing in mind that the patient’s expectations should not be raised prior to the Scottish Ministers’ consent having been obtained. Subject to the patient’s consent, detailed prior consultation will also need to take place with any appropriate relatives or friends of the patient (particularly where the patient is to reside with them once no longer detained in hospital) and with relevant community service providers. It would not be best practice to grant a suspension certificate where the patient does not consent to relatives or friends being consulted where they are to be involved in his/her care once no longer in hospital.
- 38 While the patient is subject to a suspension certificate the RMO remains responsible for his/her care and treatment. The RMO must therefore ensure that appropriate arrangements are made for the patient’s care and treatment while not in hospital.

## Notification

- 39 Where the RMO proposes to grant a certificate for a period of more than 28 days; or less than 28 days but for a period which, when added to any previous period granted during the last 12 months, takes the total over 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 (section 224(8)). It would be expected that this would allow for the arrangement of any necessary services.
- 40 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).

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## **The circumstances in which a certificate may be revoked**

- 41 A certificate granted with respect to an assessment order 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.
- 42 Similarly a certificate granted with respect to an order or direction listed in paragraph 21(ii) to (vi) above 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. Revocation of the certificate authorises the immediate conveyance of the patient back to hospital.

### *Notification by the RMO*

- 43 Where the RMO revokes a certificate which was granted with respect to an assessment order he/she must, as soon as practicable after doing so, inform the patient, any person in whose charge he/she may have been in terms of section 221(6)(a) and the Scottish Ministers (section 222(3)).
- 44 Where the RMO revokes a certificate which was granted with respect to an order or direction listed in paragraph 21(ii) to (vi) above 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 period of suspension was for more than 28 days), any person in whose charge the patient may have been in terms of section 224(7)(a), the MHO and the Scottish Ministers (section 225(3)).

### *Notification by the Scottish Ministers*

- 45 Where the Scottish Ministers revoke a certificate which was granted with respect to an assessment order they must, as soon as practicable after doing so, inform the patient, the patient's RMO and any person in whose charge the patient may have been in terms of section 221(6)(a) and the RMO (section 223(3)).

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- 46 Where the Scottish Ministers revoke a certificate which was granted with respect to an order or direction listed in paragraph 21(ii) to (vi) above 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 period of suspension was for more than 28 days), any person in whose charge the patient may have been in terms of section 224(7)(a) the RMO and the MHO (section 226(3)).
- 47 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 Mental Welfare Commission within 14 days of that certificate being revoked.

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## Absconding

### Introduction

- 48 **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005** (“the regulations”) set out the procedures to be followed when persons who are subject to one of the following orders or directions abscond:
- (a) assessment order (section 52D);
  - (b) treatment order (section 52M);
  - (c) temporary compulsion order (section 54(1)(c));
  - (d) interim compulsion order (section 53);
  - (e) compulsion order (section 57A);
  - (f) compulsion order and a restriction order (sections 57A and 59);
  - (g) hospital direction (section 59A);
  - (h) transfer for treatment direction (section 136 of the 2003 Act).

### What constitutes “absconding”?

- 49 In general terms, the circumstances in which a person who is subject to one of the orders or directions listed in paragraph 48 above is deemed to have absconded are where the person:
- absconds from any place where he/she is being kept pending removal to hospital under the order or direction;
  - absconds while being removed to hospital under the order or direction;
  - absconds from the hospital in which he/she is being detained under the order or direction;
  - is subject to a suspension of detention certificate under sections 127(1) as applied by section 179(1), 221(2) or 224(2) of the 2003 Act:
    - which requires the person to be kept in the charge of someone authorised by the RMO and he/she absconds from that charge;
    - which requires the person to reside continuously or for a specified time at a specified place and he/she fails to comply with that condition;
    - and the person absconds following the expiry of a specified period, or after the occurrence of a specified event, or on the revocation of the certificate.
  - is subject to a compulsion order and breaches a requirement in terms of section 57A(8)(e) which requires the person to reside at a specified place;
  - absconds while being transferred from one hospital to another, including where the person is being transferred out of Scotland;

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- has been conditionally discharged and absconds following being recalled to hospital by the Scottish Ministers under section 202;
- absconds while being transported to a prison, institution or other place following the hospital direction or transfer for treatment direction to which the person is subject having been revoked by the Scottish Ministers;
- absconds from custody.

## What should happen once a patient has absconded?

- 50 Where a patient has absconded he/she is liable to be taken into custody and dealt with in accordance with the regulations. For further information refer to the regulations and to paragraphs 54 to 59 below.
- 51 It would be expected that the decision as to whether the patient has absconded and is liable to be taken into custody is recorded in his/her medical notes with respect to issues such as who took the decision; who was consulted before the decision was taken; and on what evidence the decision was taken. It would usually be best practice for the patient's multi-disciplinary team to be the forum in which such a decision would be taken but time may not allow for this in the case of a patient who is subject to an assessment order, a treatment order, an interim compulsion order, a compulsion order and a restriction order ("CORO"), a hospital or a transfer for treatment direction given that he/she has "restricted" status and so action should be taken immediately.
- 52 This transparency around the decision-making process will be particularly important where the patient was subject to a compulsion order ("CO") which authorises compulsory measures in the community when he/she was deemed to have been liable to be taken into custody. In such cases, the patient should be afforded as full an opportunity as possible to explain why, for example, he/she failed to comply with a requirement to reside at a specified place in terms of section 57A(8)(e) of the 1995 Act before the decision is taken that he/she is liable to be taken into custody. It will also be important in such circumstances to have regard to the principles and other matters set out in sections 1 to 3 of the 2003 Act, and in particular the principle stated at section 1(4) with respect to discharging functions under that Act in a manner "that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances".

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53 It may appear that there is an overlap between the regulations and the provisions in sections 112 and 113 of the 2003 Act (as applied by section 177) which relate to a patient's non-compliance with a CO which authorises compulsory powers in the community. This is mirrored in the civil procedures with respect to a compulsory treatment order. *For further information about which provisions should be used in which circumstances, see Chapter 6 of Volume 2 of this Code of Practice.*

## Action to be taken following the absconding

### *Duties on the RMO*

54 The regulations place a duty on the RMO to notify certain parties when he/she becomes aware that an absconding has taken place. It is important therefore that where it appears that this may be the case the RMO is informed immediately of the situation. The parties which the RMO must notify are:

- the Scottish Ministers;
- the court which imposed the order to which the person is subject;
- the Mental Welfare Commission;
- the prosecutor (where the person is subject to an assessment order or a treatment order which were imposed prior to conviction, or a temporary compulsion order).

The Scottish Ministers should be informed immediately upon the RMO becoming aware that an absconding has taken place, as should the local constabulary in the area in which the absconding took place. The RMO should also inform the designated MHO.

### *Taking into custody and returning of a patient who has absconded*

55 Once the patient has absconded the following actions may be taken:

- the absconding patient may be taken into custody;
- the absconding patient may be returned or taken to the hospital in which he/she was detained or due to be detained. If this is not appropriate or practicable, he/she may alternatively be taken to any other place which is considered appropriate by the RMO;
- the absconding patient may be returned or taken to any other place which he/she absconded from or where he/she failed to reside. If this is not appropriate or practicable, the patient may alternatively be taken to any other place which the RMO considers appropriate.

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- 56 The persons who are allowed to carry out the actions described in paragraph 55 above are:
- a mental health officer;
  - a police constable;
  - a member of staff of any hospital;
  - any other person who has been authorised to carry out any of the actions in paragraph 55 by the RMO.
- 57 With respect to the final bullet point in paragraph 56, it would always be expected that this power would only be authorised with respect to an appropriately trained and qualified individual.
- 58 In the situation where the patient is subject to a suspension certificate granted under sections 127(1) as applied by section 179(1), 221(2) or 224(2) of the 2003 Act, and the certificate contains a condition that he/she must be kept in the charge of an authorised person, that authorised person may carry out certain actions separately from those persons listed in paragraph 56 above. These actions are:
- take the patient into custody;
  - resume charge of the patient. If this is not appropriate or practicable, he/she may take the patient to any place considered appropriate by the patient's RMO.
- 59 The regulations allow the use of reasonable force where the actions described in paragraphs 55 and 58 are being carried out. However it would be expected that reasonable force would be used as a last resort where all other appropriate approaches not involving force have been exhausted. It is important that practitioners have regard to the principle set out at section 1(4) of the 2003 Act with respect to discharging functions under that Act in a manner which "involves the minimum restriction on the freedom of the patient that is necessary in the circumstances".

## **Effect of the period of unauthorised absence on certain orders**

- 60 Where the patient is subject to an assessment order or an interim compulsion order, both of which are of a limited duration, the duration of the order is suspended during the period of the unauthorised absence until the day on which the patient is again taken into custody.

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- 61 The effect of a period of unauthorised absence on a CO varies depending on the length of the period and when in relation to the expiry date of the compulsion order the patient is taken into custody:
- if the period of unauthorised absence continues for more than 3 months, the CO to which the patient was subject ceases to have effect;
  - if the period of unauthorised absence continues for more than 28 consecutive days but ceases at least 14 days before the expiry date of the CO, the CO ceases to have effect 14 days after the patient's period of unauthorised absence ends;
  - if the period of unauthorised absence ends either on the day on which the CO was due to expire or within 14 days prior to that day, the CO continues for 14 days from the point at which the patient's period of unauthorised absence ended;
  - if the period of unauthorised absence continues for less than 3 months but ceases after the day on which the CO was due to expire, the CO is treated as having continuing effect even after its expiry date and continues to have effect for a period of 14 days from the point where the patient's unauthorised absence ended.
- 62 Where the patient is subject to a hospital direction or a transfer for treatment direction the period of unauthorised absence does not count as time served with respect to his/her sentence.

## Review of the order or direction

- 63 The regulations provide for the review of the order or direction by the RMO once the patient has been taken into custody. It would be expected that the MHO and the other members of the multi-disciplinary team where relevant and appropriate would contribute to this review.

### *Review of an assessment order, a treatment order, a temporary compulsion order or an interim compulsion order*

- 64 Where the patient is subject to an assessment order, a treatment order, a temporary compulsion order or an interim compulsion order the RMO must as soon as reasonably practicable after becoming aware that he/she has been taken into custody, review the order. It would be expected that it may not be reasonably practicable to carry out such a review if as a result of the patient's further progression to the next stage of the criminal justice process time does not allow for this.



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- 65 Where the RMO has carried out a review and as a result considers that the measures in the order require to be varied he/she must apply to the court for this variation. For example, he/she may consider that the patient requires to be detained in a hospital which provides a higher level of security than the one from where he/she absconded.

## *Review of a compulsion order*

- 66 In general terms, where the patient is subject to a compulsion order the RMO must carry out a review of the order in terms of section 139(3) of the 2003 Act within 14 days of the order continuing in effect following the patient having been taken into custody. If following the review the RMO considers that the compulsion order requires to be varied he must apply to the Tribunal in the usual way. *For further information about these application procedures refer to Part 2, Chapter 1 of this Volume of the Code of Practice.*
- 67 If the patient is subject to a compulsion order which authorises detention in hospital and the RMO considers that as a result of his/her absconding the patient requires to be transferred to another hospital this should be arranged in accordance with section 124 of the 2003 Act as applied by section 178.
- 68 It should be noted that where the patient is subject to a compulsion order which authorises compulsory measures in the community, section 113 of the 2003 Act as applied by section 177(1) allows the RMO in certain circumstances to detain the patient in hospital for a period of 72 hours so that a medical examination may be carried out. Section 114 of the 2003 Act as applied by section 177(2) further allows him/her in certain circumstances to grant a certificate authorising the continued detention of the person in hospital for 28 days. *For further information about these provisions see Chapter 6 of Volume 2 of the Code of Practice.*

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## *Review of a CORO, a hospital direction or a transfer for treatment direction*

69 In general terms, where the patient is subject to a CORO, a hospital direction or a transfer for treatment direction the RMO must, within 14 days of the patient having been taken into custody, carry out a review of the orders or direction in terms of sections 182(3) (with respect to a CORO) or 206(3) (with respect to a hospital direction or a transfer for treatment direction) of the 2003 Act. If following the review the RMO considers that the patient should be transferred to a hospital which provides a higher level of security than the one from where he/she absconded then this should be arranged in accordance with section 218 of the 2003 Act.

## **Suspension of detention – revocation of certificate**

70 Where the patient has absconded or has been taken into custody after having absconded while being subject to a suspension of detention certificate granted under section 127(1) as applied by section 179(1), or sections 221(2) or 224(2) of the 2003 Act, the RMO may revoke that certificate. It would be expected that this would be considered where the certificate authorises further periods of leave.

71 For further information about these provisions refer to **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**.

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## Medical treatment (which includes medication, psychological and social interventions)

- 72 Procedures related to the giving of medical treatment to patients subject to certain orders under the 1995 Act are set out in Part 16 of the 2003 Act. The following sets out the applicability of Part 16 of that Act to the various provisions for mentally disordered persons involved in criminal justice proceedings.
- 73 In general terms only orders that require two medical recommendations, one of which is by an approved medical practitioner, allow treatment under Part 16 of the 2003 Act; but any order allowing detention in hospital permits emergency treatment under section 243 of that Act. It would be expected that any primary treatment to be given under Part 16 of the 2003 Act other than medication would be a matter for discussion with the relevant multi-disciplinary team members.

### *Assessment order (section 52D)*

Medical treatment under Part 16 of the 2003 Act 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). This determination should be recorded in the patient's medical records.

### *Treatment order (section 52M)*

Medical treatment may be given in accordance with Part 16 of the 2003 Act.

### *Committal to hospital under section 200*

The giving of medical treatment under Part 16 of the 2003 Act is not authorised. Section 243 of the 2003 Act (urgent medical treatment) does apply. If non-urgent compulsory medical treatment is necessary best practice would suggest that the same procedure as outlined above for assessment orders should be followed.

### *Interim compulsion order (section 53)*

Medical treatment may be given in accordance with Part 16 of the 2003 Act.

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## *Compulsion order (section 57A)*

Medical treatment may be given in accordance with Part 16 of the 2003 Act where this measure is specified in the compulsion order in terms of section 57A(8).

## *Restriction order (section 59)*

Medical treatment may be given in accordance with Part 16 of the 2003 Act under the compulsion order attached to the restriction order where this measure is specified in the order in terms of section 57A(8).

## *Hospital direction (section 59A)*

Medical treatment may be given in accordance with Part 16 of the 2003 Act.

## *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 of the 2003 Act does not apply. Medical treatment may only be given with the patient's consent.

## *Supervision and treatment order (section 57(2)(d) and Schedule 4)*

Part 16 of the 2003 Act does not apply. Medical treatment may only be given with the patient's consent.

## *Urgent detention of acquitted person (section 60C)*

Part 16 of the 2003 Act does not apply. Medical treatment may only be given with the patient's consent.

## *Transfer for treatment direction (section 136 of the 2003 Act)*

Medical treatment may be given in accordance with Part 16 of the 2003 Act.

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## Appeals

- 74 A person who is made subject to:
- an interim compulsion order (section 53);
  - a compulsion order (section 57A);
  - 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 against its initial imposition in the same manner as an appeal against sentence.

- 75 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 54(1) (temporary compulsion order).

- 76 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/her 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 in paragraph 74 above.

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## Medical evidence

- 77 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)).
- 78 In some cases the legal process may require urgent opinion from medical practitioners and MHOs. However, as a rule this process should be characterised by multi-disciplinary working between the medical practitioners, the MHO and as many other relevant parties in the application process as are relevant and appropriate. Other members of the multi-disciplinary team may be able to provide additional assessment information and those who may be providing care and treatment to the patient (such as psychologists, CPNs, relatives/carers/significant other) should be consulted before the decision to initiate an application or submit a recommendation is made.

### **Do the medical practitioners need to be approved under section 22 of the 2003 Act?**

- 79 At least one of the two medical practitioners giving evidence to be taken into account for finding or making the following must be approved:
- treatment order (section 52M);
  - interim compulsion order (section 53);
  - insanity in bar of trial (section 54(1));
  - temporary compulsion order (section 54(1)(c));
  - compulsion order (section 57A);
  - guardianship order (section 58(1A));
  - hospital direction (section 59A);
  - an order authorizing detention of an acquitted person for medical examination (section 60C).
- 80 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)

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81 For the making of the following orders medical evidence is only required from one medical practitioner who does not require to be approved:

- assessment order (section 52D);
- committal to hospital following conviction for inquiry into mental condition (section 200).

82 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?**

83 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 should consult him/her or his/her representative to:

- seek his/her agreement to accepting the patient under his/her care; and
- ascertain that arrangements have been made for the patient to be received under the relevant order.

84 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:

- treatment order (section 52M);
- interim compulsion order (section 53);
- temporary compulsion order (section 54(1)(c));
- compulsion order (section 57A);
- hospital direction (section 59A).

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- 85 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.
- 86 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)).

## **Collaboration with other professionals**

- 87 It would be expected that the views and opinions of other relevant parties who currently provide or are likely to provide care and treatment to the patient in the future should be sought whenever possible while respecting issues of patient confidentiality. A multi-disciplinary assessment should be carried out with specialist assessments being sought where relevant and appropriate to assist in the decision making process. For example:
- a medical practitioner may seek input specifically from a suitably qualified psychologist in relation to a complex assessment of capacity or in cases where the person has a significant learning disability, or personality disorder;
  - a medical practitioner should seek input from the appropriately qualified party (psychologist or other) who will be likely to be providing a complex psychological intervention. This is required because only they will be able to assess the person's suitability for their particular intervention and be able to plan for it. This is particularly important in cases where it is anticipated that a psychological intervention may be implemented without a patient's consent e.g. a behaviour modification programme.
  - a medical practitioner should seek input from other appropriately qualified professionals, such as speech and language therapists or occupational therapists, where they would be able to usefully contribute from their own areas of expertise during the assessment process.



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## **Oral or written evidence?**

88 For the making of all the relevant orders 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.

89 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 person 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 person.

## **How should a second report be commissioned where this is necessary?**

90 Under some circumstances 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?**

91 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.

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## **Is it acceptable for the two reports to be prepared by medical practitioners working in the same unit or hospital?**

92 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, it would be expected, if practicable, 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 practicable 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?**

93 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.

94 The medical practitioner should arrange to interview the person, whether this is in hospital, prison or the community. The medical practitioner should explain to the person:

- who has instructed the report;
- the nature of the interview;
- the purpose of the interview;
- the limits of confidentiality.

95 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.

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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?**

- 96 If the person refuses to be examined the medical practitioner should 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.
- 97 If the person appears to have a mental disorder such as to make him/her incapable of refusing to allow an assessment to be undertaken and reported, then the medical practitioner should 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.
- 98 When reporting such an assessment the medical practitioner should state in his/her report that the person refused to be examined but appeared to have incapacity in relation to this decision.
- 99 If the person does not refuse to be assessed, but nevertheless appears to have a mental disorder such as to make him/her incapable of consenting to the assessment to be undertaken and reported, the medical practitioner should undertake the necessary assessment and state in his/her report that the person was incapable of consenting to the assessment.

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## What may be covered in the report?

100 Reports should 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 mention the status of the medical practitioner.

101 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 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 or an assessment order) 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

102 *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.

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## *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 in the presence of mental disorder:
  - 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 should this take place, does the person need a period of in-patient assessment and what level of security would be required?
  - why, which issues remain to be clarified?
- does the person require treatment for a mental disorder or condition?
  - what treatment does he/she need and where should this be given?
- state any matters that are currently uncertain and the reasons they remain uncertain

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## *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.

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## The Social Circumstances Report

103 In accordance with section 231 of the 2003 Act the MHO designated in terms of section 229 of that Act must provide the RMO and the Mental Welfare Commission with a report on the social circumstances of a person who is made subject to one of 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).

104 The MHO must prepare the Social Circumstances Report (“SCR”) and send a copy to the patient’s RMO and the Mental Welfare Commission within 21 days of the order, or as the case may be, direction being made. (There is no form prescribed for this report but a pro-forma, SCR1, may be found on the Scottish Executive website at [www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw).) The exception to this is where the MHO considers that the report would serve little or no purpose. This might be because 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.

105 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 Mental Welfare Commission in accordance with section 231(2) of the 2003 Act. For further information about SCRs refer to **The Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 (SSI No. 310)** and Chapter 11 of Volume 1 of the Code of Practice.

106 With respect to mentally disordered offenders in particular, when preparing the SCR, some additional specific issues that the MHO should consider in relation to the following orders are:

### *Assessment Order (section 52D)*

- identify if a treatment order may be required.

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## *Treatment Order (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 compulsory powers required

## *Interim Compulsion Order (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 Order (section 57A)*

- the requirements of this SCR should mirror those for a CTO.

107 In circumstances where an MHO report has been prepared under section 57C (where a compulsion order is under consideration by the court) or 59B (where a hospital direction is under consideration by the court), best practice would suggest that 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 compulsory powers.

## **How does the Social Circumstances Report interact with the Social Enquiry Report?**

108 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 in certain circumstances, the consideration of possible mental health disposals in the case.

109 The Social Enquiry Report ("SER") is prepared for the court to inform sentencing (see paragraphs 111 to 112 below). Where SCRs are being prepared pre-trial it can be rare for an SER to be requested.



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110 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. It would be expected that consideration would be given to the development of protocols to support appropriate information sharing in such cases, including mutual access to the respective reports subject to any necessary consent requirements.

# chapter six

## Social Enquiry Report

111 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 has been able to obtain about the offender’s circumstances; and it shall also take into account any information before it concerning his 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(2A)(a)).
- 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) and (2));
- requires a report about the offender and his circumstance, and his suitability to perform work under the order before making a Community Service Order (section 238(2)(c));
- requires the court to obtain a report about the offender and his circumstances before making a Supervised Release Order (section 209(2));
- requires the court to obtain a report about the offender and his circumstances before passing an Extended Sentence (section 210A(4));
- requires the court (except District Courts), 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).

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112 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. The compilation of this report would normally involve obtaining the views and opinions of other relevant parties who currently provide or are likely to provide care and treatment to the person in the future; these should be sought wherever possible while respecting issues of patient confidentiality. Specialist assessments should also be sought where these are of particular relevance to the decision making process.

# part 2

parts 9 to 13 of  
the mental health  
(care and treatment)  
(scotland) act 2003



# chapter 1

## compulsion orders

# chapter one

## Introduction

This chapter examines the procedures surrounding a compulsion order (“CO”) as laid out in Part 9 of the Mental Health (Care and Treatment) (Scotland) Act 2003. These procedures are very similar to those for a compulsory treatment order (“CTO”) in relation to patients subject to civil proceedings under Part 7 of that Act. Rather than duplicating the information contained in Chapters 4, 5, 6, and 9 of Volume 2 of the Code of Practice which cover these procedures with respect to a CTO, this chapter simply points out where the procedures are different. Therefore the aforementioned chapters in Volume 2 should be followed taking into account the differences outlined in this chapter.

The chapter begins by setting out an overview of 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 where they differ from those for a CTO.

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 Volume 2 of the Code of Practice which covers Part 7 of the Act.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise. It should be noted throughout this chapter that the term “CO” refers to a compulsion order and the term “CTO” refers to a compulsory treatment order.

## Overview

- 01 A CO may be imposed by a court under section 57A of the Criminal Procedure (Scotland) Act (“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 Volume of the Code of Practice.*

# chapter one

## The compulsion order in operation

02 The processes that should be followed in the immediate aftermath of CO having been imposed are very similar to those for a CTO in relation to patients subject to civil proceedings under Part 7 of the Act. Therefore Volume 2, Chapter 4 of the Code of Practice which covers the operation of a CTO should be followed, taking into account the differences in procedure which are outlined in paragraphs 4 to 6.

## The imposition of the order

03 A CTO is granted by the Tribunal under section 64(4)(a) 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 imposed by a criminal court under section 57A(2) of the 1995 Act following recommendations by two medical practitioners and an MHO report prepared in accordance with section 57C of the 1995 Act.

## The care plan

- 04 As soon as practicable after a CTO has been imposed, the patient's RMO is under a duty to prepare a care plan in accordance with section 76(1). Following the imposition of a CO the patient's RMO must prepare a Part 9 care plan in accordance with section 137(2). 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.
- 05 In general terms the care plan prepared after a CTO has been imposed sets out the forms of care and treatment for 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 Part 9 care plan contains the same core information as the care plan for a CTO but also includes other information to take account of the status of the patient as a mentally disordered offender. For further information refer to paragraphs 18 to 29 below.



# chapter one

## Recorded matters

- 06 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 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 Part 9 care plan. For further information about the Part 9 care plan refer to paragraphs 18 to 29 below

## Review criteria

- 07 The criteria considered in the imposition of, or the review of a CO, are identical to those for the granting of a CTO, except that for a CO the criterion set down in section 64(5)(d) does not apply. Quoting from section 64(5), 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

- 08 There is therefore no requirement to assess the ability of a patient to make decisions about the provision of his/her medical treatment when reviewing a CO. (It should be noted that the patient’s ‘decision-making’ ability with respect to medical treatments covered by Part 16 of the Act will be relevant when considering specific medical treatments but not for the renewal of the CO itself).
- 09 The procedures which should be followed in the review, variation and extension of a CO are almost identical to those for a CTO. *For information and guidance on the procedures relating to a CTO refer to Chapter 5 of Volume 2 of the Code of Practice taking into account the differences outlined in paragraphs 10 to 15 and 30 to 37 below.*

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## First mandatory review

- 10 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) to extend the order without any recourse to the Tribunal. However at the first mandatory review of a CO under section 139, 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. 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.
- 11 However, as for a CTO, all further extensions (where no variation is proposed) must be made by the RMO making a determination, without recourse to the Tribunal (section 152(2)).

## Documents to accompany applications made by the RMO to the Tribunal

- 12 The documents which must be submitted to the Tribunal by the RMO where he/she is making an application with respect to a CTO are set out in **The Mental Health (Compulsory treatment orders – documents and reports to be submitted to the Tribunal) (Scotland) Regulations 2005 (SSI No.366)**. The equivalent regulations made with respect to CO applications are set out in **The Mental Health (Compulsion orders – documents and reports to be submitted to the Tribunal) (Scotland) Regulations 2005 (SSI No.365)**. The provisions of both sets of regulations are on the whole the same but there are a few specific differences as detailed in paragraphs 34 and 36 below. Where any application is being made to the Tribunal with respect to a CO, the RMO and the MHO should refer to these regulations if unfamiliar with the processes involved.
- 13 It should be noted that the regulations referred to in paragraph 12 above also allow for the Tribunal to request further information from the RMO and the MHO in the form of reports where the Tribunal is not satisfied that it has sufficient information to make a decision with respect to:
- an application by the RMO to extend the CO following first review (section 149);

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- an application by the RMO to extend and vary the CO (section 158);
- an application by the RMO to vary the CO (section 161);
- an application by the patient or the named person for the revocation of the RMO's determination to extend the CO under section 152 (section 163);
- an application by the patient or named person for the revocation or variation of the CO (section 164);
- a review by the Tribunal of a determination to extend the CO under section 152 (section 165).

For information on the content of the reports reference should be made to the regulations.

## **RMO's application to extend and vary a CO**

- 14 It should be noted that **The Mental Health (Care and Treatment) (Scotland) Act 2003 Modification Order 2004 (SSI No.533)** amended section 158 of the Act which sets out the information that must be included in the RMO's application to the Tribunal where he/she is making an application for a CO to be extended and varied. The effect of the amendment is that where the MHO disagrees with the application being made the RMO must include the MHO's reasons for doing so in his/her application.

## **Duty on the MHO with respect to an application to vary a CO**

- 15 It should be noted that **The Mental Health (Care and Treatment) (Scotland) Act 2003 Modification Order 2004 (SSI No.533)** also amended sections 159 and 161 of the Act which set out the statutory procedures for the RMO where he/she is making an application to the Tribunal for a CO to be varied. In general terms the amendments place a duty on the MHO which is almost identical to that under section 155 where an application to extend and vary the CO is being proposed, and a duty on the RMO with respect to the content of the application to the Tribunal which is almost identical to that under section 158 where an application to extend and vary the CO is being made. These new duties are also mirrored in civil proceedings with respect to CTOs. For further information refer to the regulations.

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## Absconding

- 16 The statutory procedures with respect to absconding by a patient subject to a CTO are set out in sections 301 to 307 of the Act. However the statutory procedures in relation to absconding by mentally disordered offenders are set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**. These mirror the procedures set out for CTOs in sections 301 to 307 of the Act. *For further information about the procedures relating to a CO refer to the regulations and to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## Forms

- 17 There are no prescribed forms for applications to the Tribunal, determinations, suspension of detention certificates etc. in relation to COs but pro-formas may be found on the Scottish Executive website [www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw). Refer to Part 2, Chapter 11 of this Volume of the Code of Practice for a detailed list.

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## The Part 9 Care Plan

### Before a CO is imposed

18 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 Act), it would be expected that a patient's future Part 9 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 Part 9 care plan, such as the consideration of, and recommendations for, compulsory measures to be applied, form part of the medical reports under section 57A(2)(a) of the 1995 Act and the MHO report prepared for the court in accordance with section 57C of the 1995 Act. *For further information on the procedure prior to the imposition of a CO refer to Part 1, Chapter 5 of this Volume of the Code of Practice.*

### After a CO is imposed

- 19 The patient's RMO must, in accordance with section 137, prepare a Part 9 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.
- 20 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 other members 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 and the RMO should be in a position to prepare it under section 137 soon after the CO has been imposed.
- 21 If this is not the case, there should be a multi-disciplinary review as soon as practicable after the imposition of the CO, involving the RMO, the MHO and the other members of the multi-disciplinary team so that the details of the Part 9 care plan may be agreed and set out.

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## 22 **The Mental Health (Content and amendment of Part 9 care plans)**

**(Scotland) Regulations 2005 (SSI No.312)** provide for the following additional information to that mentioned in paragraph 19 above to be recorded in the Part 9 care plan:

- (a) the full details of the CO and the day on which the order was made;
- (b) the objectives of the medical treatment which it is proposed to give, and which is being given to the patient;
- (c) details of any community care services or other relevant services and the objectives of those services which it is proposed to give, and which are being given to the patient;
- (d) details of any other treatment, care or service (other than that described in section 137(3)(a) or in paragraph (c) above) and the objectives of that treatment, care or service which it is proposed to give; and which is being given, to the patient;
- (e) the name and other appropriate contact details of the patient's responsible medical officer;
- (f) the name and other appropriate contact details of the patient's mental health officer;
- (g) details of the two month period during which the statutory reviews under sections 139(2) or 140(2) are required to take place
- (h) the actual dates on which the statutory reviews took place;
- (i) the date of the patient's conviction
- (j) the offence of which the patient was convicted;
- (k) if the patient is subject to:
  - (i) the notification requirements in Part 2 of the Sexual Offences Act 2003;
  - (ii) a sexual offences prevention order (section 105 of the Sexual Offences Act 2003),

and if so, the notification period referred to in (i) or the period specified in the sexual offences prevention order.

23 The full details of the CO as referred to in paragraph 22(a) above would include the measures authorised by the order.

24 With respect to the matters referred to in paragraphs 22(g) and (h) above this simply means that when the Part 9 care plan is first prepared under section 139 the RMO must detail in it the 2 month period during which the first statutory review must be carried out. When the first review has been carried out and the RMO is updating it as described in paragraph 26 below he/she must include the date on which the review took place

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and then detail the 2 month period during which the next statutory review must be carried out and so on.

- 25 Although most mentally disordered offenders are not subject to the provisions of the Sexual Offenders Act 2003, in the minority of cases where a patient who is subject to a CO is also subject to the notification requirements in Part 2 of the Sexual Offences Act 2003 or to a sexual offences prevention order (“SOPO”) under section 105 of that Act, this information must be recorded in the Part 9 care plan given that there may be resultant issues that will require to be addressed upon the release or transfer of the patient. For example, if the patient is subject to a SOPO he/she may be prohibited from visiting a particular geographical area.
- 26 The regulations also specify the circumstances in which the RMO must amend the Part 9 care plan. In general terms these are where:
- the Tribunal has made an order with respect to the CO;
  - the RMO has:
    - made a determination extending the CO under section 152(2);
    - granted a certificate under:
      - (i) section 127(1)(b) (as applied by section 179(1)) which suspends the measure of detention in the CO;
      - (ii) under section 128(1)(b) (as applied by section 179(2)) which suspends other measures in the CO;
 which specifies a period exceeding 28 days during which the patient’s CO shall not authorise the measure or measures specified in the certificate;
  - revoked under section 129(2) (as applied by section 179(3)), a certificate granted under any of the powers referred to in the bullet point above; or
  - carried out any further mandatory reviews of the CO under section 140(2);
  - the patient ceases to be subject to a notification requirement under Part 2 of the Sexual Offences Act 2003 (if applicable);
  - the patient is subject to a SOPO which is varied, renewed or discharged (if applicable).

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- 27 The procedures associated with the preparation of the Part 9 care plan are identical to those for the preparation of a care plan of a patient who is subject to a CTO. However, unlike the care plan for a CTO, a Part 9 care plan is also likely to include treatments for offending behaviour.
- 28 Where a Part 9 care plan is proposing psychological interventions, a psychologist or other person making that psychological intervention should have been consulted and involved in the assessment process. Such involvement is particularly important where the psychological interventions being implemented are without the patient's consent e.g. behaviour modification programmes.
- 29 Any psychological treatment that a failure to have or participate in would be likely to result in an ongoing need for secure care should be identified in the Part 9 care plan. An example of such treatment might be a substance abuse programme. It may be that a patient cannot be 'compelled' to participate in this like many other psychological treatments, but a failure to participate would be likely to have consequences in terms of limiting his/her clinical progress towards the least restrictive environment possible, influencing the patient's assessed level of risk and increasing his/her need for ongoing secure care.



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## First Mandatory Review

### Renewal of a CO

- 30 The procedures to be followed by the RMO and MHO at the first mandatory review of a CO (section 139) are identical to those for a CTO (section 77), as detailed in *Chapter 5 of Volume 2 of the Code of Practice*. 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 with respect to a CTO under section 86), the RMO must make an application to the Tribunal seeking an extension of the CO under section 149.
- 31 The RMO may 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 designated 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 whom the MHO has consulted under section 139(5) 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)).
- 32 Best practice would suggest that the RMO should make this application as soon as practicable after the need to make the application arises and after full consultation with the MHO and the other members of the multi-disciplinary team where relevant and appropriate.
- 33 An application made under section 149 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.

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- 34 In terms of **The Mental Health (Compulsion orders – documents and reports to be submitted to the Tribunal) (Scotland) Regulations 2005 (SSI No.365)**, the documents which the RMO must submit with the application are:
- a copy of the patient's Part 9 care plan as first prepared under section 137(2)(a);
  - a copy of the Part 9 care plan as amended following the first review;
  - a copy of any written evidence submitted to the court by the medical practitioners under section 57A(2)(a) of the 1995 Act; and
  - a copy of any report prepared for the court by the mental health officer in accordance with section 57C(2)(b) of the 1995 Act.
- 35 When considering the application the Tribunal may request reports from the RMO and the MHO under section 173 if it is not satisfied that it has sufficient information to make a decision with respect to the application. For further information on the content of these reports refer to the regulations mentioned in paragraph 34.

## Renewal and variation of a CO

- 36 If following the first review 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 30 above. Aside from the documents which must be submitted with the application this procedure mirrors that for the extension and variation of a CTO so the information contained in *Chapter 4 of Volume 2 of the Code of Practice* applies. The documents which the RMO must submit with an application under section 158 in these circumstances are the same as those mentioned in paragraph 34 above.
- 37 As with an application to extend the CO under section 149, if when considering the application the Tribunal is not satisfied that it has sufficient information to make a decision it may request reports from the RMO and the MHO in terms of the regulations made under section 173, **The Mental Health (Compulsion orders – documents to be submitted to the Tribunal) (Scotland) Regulations 2005 (SSI No.365)**. For further information on the content of these reports refer to these regulations.

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## **The CO and CTO analogous procedures**

- 38 Apart from the matters outlined in this chapter, procedures relating to the CO mirror those relating to the CTO. *For information on these procedures refer to Chapters 4, 5, 6 and 9 of Volume 2 of the Code of Practice, bearing in mind the differences outlined in this chapter.*
- 39 The table opposite sets out the analogous sections and the corresponding information in Volume 2 of the Code of Practice.

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Procedure	CO section no	CTO section no	Code of Practice Part 7		Comments
			Chap	Para	
	<b>2003 Act</b>	<b>2003 Act</b>			
Part 9 care plan	137	76	3 4	64-73 14-20 25-26	The proposed care plan (section 62) and the care plan (section 76) for a CTO is relevant to the Part 9 care plan bearing in mind the differences noted in paragraphs 4-5 and 18-29 of this chapter
Local authority's duty to designate an MHO	229	229	4	21-23	
MHO's duties subsequent to a CO being imposed	138 231	59 231	4	24	
First review of CO	139	77	5	7-11	Different review criteria for a CO as noted in paragraphs 7-8 of this chapter
Further reviews of CO	140	78	5	7-15	As for first review
RMO's duty to revoke CO: mandatory reviews	141	79	5	18-19	
Revocation of CO: RMO's duty to keep under review	142	80	5	18-19	
MWC's power to revoke CO	143	81	5	22-24	
Revocation of CO: notification	144	82	5	20-21	
Mandatory reviews: further steps to be taken where CO not revoked	145	83	5	25-29	
First review: RMO's duty where extension proposed	146	84	5	31-35	No recorded matters in a CO
Proposed extension on first review: MHO's duties	147	85	5	31-35	

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Procedure	CO	CTO	Code of Practice Part 7		Comments
	section no	section no	Chap	Para	
	<b>2003 Act</b>	<b>2003 Act</b>			
First review RMO's duty to apply for extension of CO	148	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	
Further review: RMO's duty where extension proposed	150	84	5	31-35	No recorded matters in a CO
Proposed extension of order on further review: MHO duties	151	85	5	31-35	
Further reviews: RMO's duty to extend CO	152	86	5	31-35	
Determination extending CO: notification	153	87	5	36-43	
RMO's duty where extension and variation proposed	154	88	5	49-53	
MHO's duties: extension and variation of CO	155	89	5	54-56	No recorded matters in a CO
RMO's duty to apply for extension and variation of CO	156	90	5	59-65	No recorded matters in a CO
Application for extension and variation of CO: notification	157	91	5	57-58	
Application to Tribunal for extension and variation of CO	158	92	5	59-65	No recorded matters in a CO. Amendment to section 158 as noted in paragraph 14 of this chapter
RMO's duties: variation of CO	159	93	5	70-73	No recorded matters in a CO. Amendment to section 159 as noted in paragraph 15 of this chapter
Application for variation of CO: notification	160	94	5	74-75	
Application to Tribunal by RMO	161	95	5	76	Amendment to section 161 as noted in paragraph 15 of this chapter

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Procedure	CO section no	CTO section no	Code of Practice Part 7		Comments
			Chap	Para	
	<b>2003 Act</b>	<b>2003 Act</b>			
Commission's power to make reference to Tribunal	162	98	5	98-100	
Application to Tribunal by patient etc. for revocation of determination extending CO	163	99	5	104-108	
Application to Tribunal by patient etc. for revocation or variation of CO	164	100	5	104-108	No recorded matters in a CO
Tribunal's duty to review determination under section 152	165	101	5	44-48	
Powers of Tribunal on review under section 165	166	102	5	47-48	No recorded matters in a CO
Powers of Tribunal on application under section 149, 158, 161, 163 or 164	167	103	5	66-67	No recorded matters in a CO
Interim extension etc. of order: application under section 149	168	105	5	68	No recorded matters in a CO
Interim variation of order following application, reference or review under Chapter	169	106	5	68	No recorded matters in a CO
Limit on power of Tribunal to make interim order	170	107	5	68	
Powers of Tribunal on reference under section 162	171	104	5	96-97 102-103	No recorded matters in a CO
Tribunal's order varying CO	172	108	5	85	No recorded matters in a CO
Applications to Tribunal: ancillary powers	173	109	5	–	
Effect of interim orders: calculation of time periods in Chapter	173	109	5	84	
Meaning of "modify"	175	111	5	–	No recorded matters in a CO

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Procedure	CO section no	CTO section no	Code of Practice Part 7		Comments
			Chap	Para	
	<b>2003 Act</b>	<b>2003 Act</b>			
Medical treatment: failure to attend	176	112	6	30-33	Rather than repeating procedures from Part 7 in Part 9 of the Act these sections set out that the relevant procedures for CTOs apply in an identical way to COs
Non-compliance generally with CO	177(1)	113	6	1-14	
Detention pending review or application for variation and certificate granted	177(2) and 177(3)	114, 116, 117, 119, 120, 121, 122	6	15-29	
Transfers	178	124-126	9	1-18	
Suspension of measures	179	127-129	4	27-61	
Interpretation of Part	180	N/A			

# chapter 2

the compulsion order and  
restriction order in operation



# chapter two

## Introduction

This chapter begins by setting down the statutory criteria that is considered by a court under section 59(1) of the Criminal Procedure (Scotland) Act 1995 (“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 Mental Health (Scotland) Act 1984 (“the 1984 Act”).

The chapter goes on to describe the processes which should be followed in the immediate aftermath of a compulsion order and restriction order (“CORO”) being imposed, including the preparation of a care plan by the RMO and the provision of information to the patient in terms of section 260. It also describes what would be expected of the designated MHO.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise.

## Overview

- 01 Part 10 of the Act governs the effect of a compulsion order when combined with a restriction order and sets out the procedures for the 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.

# chapter two

02 *For guidance on the imposition of a restriction order refer to Part 1, Chapter 4 of this Volume of the Code of Practice.*

## **What effect does a restriction order have on a compulsion order?**

- 03 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 require to be renewed;
  - neither the RMO nor the MWC has the power to revoke the orders;
  - suspension of 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?**

- 04 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 (either conditional or absolute).
- 05 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 under section 193(7); absolute discharge under sections 193(3) and 193(4)).
- 06 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 may also make their own applications to the Tribunal under section 191.
- 07 The patient and the patient's named person may make applications directly to the Tribunal (section 192(2)).

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- 08 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.
- 09 As previously stated, the Scottish Ministers therefore retain their role in authorising the suspension 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.

## **Suspension of detention (sections 224 to 226)**

- 10 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 CORO specifying detention of the patient. *For further information on these procedures refer to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## **Transfer (sections 218 to 221)**

- 11 Part 12 of the Act sets out the statutory procedures for the transfer within Scotland of a patient who is subject to a CORO. *For further information on these procedures refer to Part 2, Chapter 9 of this Volume of the Code of Practice.*

## **Absconding**

- 12 The statutory procedures in relation to absconding by mentally disordered offenders are set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**. *For further information refer to these regulations and to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## chapter two

### Responsibilities subsequent to a Compulsion Order and a Restriction Order being imposed

- 13 The compulsion order made in conjunction with a restriction order may include such directions as the court thinks fit in accordance with section 57A(14)(b) of the 1995 Act, for the removal of the patient to, and the detention of the patient in, a place of safety pending his/her admission to the specified hospital. In terms of section 307 of the 1995 Act this place of safety may be the detention area at the court, a police station, a prison, a young offenders' institution or a hospital. However best practice would suggest that, in keeping with the principles set down in section 1 of the Act, the most appropriate place of safety in these circumstances would be a hospital. It would be expected that only in exceptional circumstances would the alternatives listed in section 307 of the 1995 Act be used as a place of safety. The patient should be conveyed from the place of safety to the specified hospital as soon as practicably possible by a person listed in section 57B(2) of the 1995 Act.
- 14 Following the imposition of a CORO, the patient must be conveyed 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 carried out by the Prisoner Escort and Court Custody Service. Consideration should be given to providing a nurse escort to accompany patients who are very unwell. Although not a statutory provision under the Act, best practice would suggest that as soon as practicable after admission the hospital managers should ensure that the Scottish Ministers and the Mental Welfare Commission are informed of the patient having been admitted.
- 15 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 Chapter 6 of Volume 1 of this Code of Practice.*

# chapter two

- 16 An RMO and an MHO must be allocated for the patient's case under sections 230 and 229 respectively and a multi-disciplinary assessment should 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 and/or an interim compulsion order.

# chapter two

## RMO responsibilities – the care plan

- 17 Similar to cases where a compulsion order (“CO”) has been imposed without a restriction order, the RMO should prepare a care plan setting out the medical treatment that is currently being given to the patient (which includes medication, psychological and social interventions) and the medical treatment which it is proposed will be given to him/her. Although not a statutory duty it would be expected that the RMO would also record in the care plan similar information to that which is required in a Part 9 care plan for a patient who is subject to a CO without a restriction order as set down in **The Mental Health (Content and amendment of Part 9 care plans) (Scotland) Regulations (SSI No. 312)**. *For further information on the content of a Part 9 care plan refer to these regulations and to Part 2, Chapter 1 of this Volume of the Code of Practice.*
- 18 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 Scottish Ministers, the MHO and the other members of the multi-disciplinary team where relevant and appropriate. The RMO should record on the care plan the details of those parties who have received a copy.
- 19 Although not a statutory duty under the Act best practice would suggest that the RMO would, in consultation with the MHO and other members of the multi-disciplinary team where relevant and appropriate, update the care plan following a statutory review of the order under section 182(2) or where there has been a change to the status of the patient such as his/her being conditionally discharged.
- 20 Although most mentally disordered offenders are not subject to the provisions of the Sexual Offences Act 2003, in the minority of cases where a patient who is subject to a CORO is also subject to the notification requirements under Part 2 of that Act, the care plan should be updated when the notification period expires. If the patient is subject to a sexual offences prevention order under section 105 of the same Act the plan should be updated where that order is varied, renewed or discharged.
- 21 It would be expected that the RMO would send a copy of the updated plan to the parties mentioned in paragraph 18 at the time of the statutory review of the CORO under section 182(2).

## chapter two

- 22 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 should 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 this process and the administrative procedures involved he/she should contact the Health Department of the Scottish Executive for further information.

# chapter two

## MHO responsibilities

- 23 When a CORO is imposed the relevant local authority must allocate a designated MHO for the patient in accordance with section 229. As with cases where a CO has been imposed without a restriction order, it would be expected that the MHO 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 Social Circumstances Report (“SCR”) prepared by the MHO in terms of section 231; best practice would suggest that the MHO should send a copy of the SCR to the Scottish Ministers. *For information on the duties of the MHO see Chapter 4 of Volume 2 of this Code of Practice.*
- 24 As soon as practicable after the CORO 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 181).





# chapter 3

reviewing a compulsion order  
and a restriction order

# chapter three

## Introduction

This chapter begins by examining the formal processes to be followed where a compulsion order and a restriction order (“CORO”) are 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 best practice points for the designated MHO in relation to the review. The possible outcomes of the review are:

- the CORO remains unchanged;
- the restriction order is revoked and the patient remains subject to the compulsion order, the measures in which may be varied
- the patient is conditionally discharged with the Tribunal imposing such conditions as it thinks fit;
- the compulsion order is revoked and the patient absolutely discharged.

The chapter goes on to describe the duty placed on the RMO and the Scottish Ministers to keep the continuing need for the CORO under review 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.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise.

## Overview of the review process

### Review criteria

01 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”);

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- 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”).

02 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 criteria in paragraph 1 are met. The onus is therefore not on the patient to demonstrate that he/she does not meet the criteria.

03 *For information on the assessment of risk refer to Part 1, Chapter 5 of this Volume of the Code of Practice.*

04 Where it is the RMO (rather than 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.

# chapter three

## Mandatory review by the RMO (sections 182 to 184)

### Overview

- 05 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), consider the review criteria, consult the MHO and then prepare and submit a report to the Scottish Ministers.
- 06 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 a great sense of multi-agency and multi-disciplinary co-operation and consultation. In that connection, it would be best practice for a full case conference to be held when a mandatory review is being carried out. It would also be best 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.
- 07 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 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 12 to 18).
- 08 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.

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## Medical examination

- 09 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;
  - consult the named person and relatives/carers/significant other;
  - 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; and
  - consider any relevant third party information.

## Recommendations which may result from the review of a CORO

- 10 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));

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- 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));
  - if the mental disorder criterion and the serious risk to others criterion are met, whether any of the other criteria are met or not, *the patient should remain subject to a compulsion order with a restriction order*.
- 11 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)).

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## RMO's report to the Scottish Ministers (section 183(2))

- 12 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 such 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).
  
- 13 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 but a pro-forma, CORO1, may be found on the Scottish Executive website at : [www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw). Non-statutory guidance on the report may also 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;
  - occupational therapy;
  - changes in mental state since the last annual report;
  - MHO opinion;
  - social work assessment;
  - child protection issues;
  - issues in relation to sex offending registration;
  - the patient's relations with staff and other patients;
  - the patient's participation in activities while in hospital;
  - freedoms available e.g. leave in grounds, suspension of detention etc. and how they are used;
  - the patient's relations with family and friends;
  - plans for the patient's future care;
  - victim and public safety issues.



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- 14 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 should 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.
- 15 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;
  - how risk issues will be managed;
  - 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 to 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.
- 16 Where the patient has a **mental illness** it would be expected that the report would address the following:
- the relationship between dangerous behaviour and the patient's 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;

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- early signs indicating relapse in the patient's illness and signs which indicate that there may be an immediate risk;
  - how risk issues will be managed.
- 17 Where the patient has a **learning disability** it would be expected that the report would address the following:
- the relationship between dangerous behaviour and the patient's learning disability;
  - whether the patient has benefited from treatment including psychological treatment and education;
  - whether the patient's inappropriate behaviour is currently stable and whether this has been tested in various circumstances;
  - whether the patient is able to understand the consequences of his/her actions;
  - whether his/her conduct poses a risk to the public and the nature and level of any risk;
  - how risk issues will be managed.
- 18 Where the patient has a **personality disorder** it would be expected that the report would address the following:
- the relationship between dangerous behaviour and the patient's personality disorder;
  - 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; how this manifests itself, and how much is context specific;
  - areas of functioning that continue to be a problem, how they manifest themselves in the past and present, and how they may be managed in the future.

## Consultation between the RMO, the MHO and the multi-disciplinary team

- 19 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 should 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.

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- 20 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.
- 21 It would be expected that the designated MHO would maintain a sufficiently close involvement with the patient, any carer(s), and other members of the multi-disciplinary team, to ensure that he/she 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 should keep the MHO informed of any key developments in the care and/or treatment of the patient.

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## Best practice points for the MHO

- 22 When forming his/her opinion in relation to the annual review of a patient subject to a CORO (section 182(3)(c)) the MHO should:
- interview the patient;
  - consult the named person and relatives/carer/significant other;
  - 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.
- 23 When interviewing the patient and consulting the named person and others as outlined in paragraph 22, 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 recommendations which may subsequently be made to the Tribunal. The MHO should ensure that the patient is aware of the availability of advocacy services and support him/her in making arrangements to have access to these services if required. *For further information see Chapter 6 of Volume 1 of this Code of Practice.*
- 24 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 patient continue to suffer from a mental disorder? What is the psychiatric opinion and evidence in relation to this matter?
  - does the patient 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 patient present a risk of serious harm to others?
  - which compulsory measures are necessary to safeguard the patient's care and treatment requirements, and ensure the safety of others?

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- 25 When considering the issues listed in paragraph 24 above 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.
- 26 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 which led up to the patient 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 compulsory powers;
  - the patient's history of drug or alcohol misuse, and any implications this may have in relation to the person's behaviour;
  - victim issues, including the patient's attitude towards his/her offending; evidence of victim empathy; possible risks from previous victims or associates;
  - the patient's historical and current attitude towards complying with services and treatment.
- 27 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**

- 28 When forming his/her opinion on whether the restriction order should be revoked the MHO should 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.

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- 29 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 the other members of the multi-disciplinary team where relevant and appropriate.
- 30 The MHO should 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, the patient's carer (if appropriate) and other care and service providers.
- 31 If the Tribunal subsequently revokes the restriction order under section 193(5) the patient's future care and treatment would be managed under the same arrangements that apply to a patient subject to a compulsion order under Part 9 of the Act.

## **Conditional discharge**

- 32 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.
- 33 When forming his/her opinion on whether the patient should be conditionally discharged the MHO should 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 criterion are met, but the serious risk to others criterion is not met.

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- 34 The MHO should 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.
- 35 In the interests of best 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, the patient should be kept informed about realistic timescales and possible outcomes of the annual review.
- 36 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, joint assessment and care planning for a proposed conditional discharge should 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 protocols that are in place which apply to planning for the discharge of a patient from hospital.

## **Absolute discharge**

- 37 When forming his/her opinion on whether the patient should be absolutely discharged the MHO should 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.

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- 38 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 patient properly provided with information about how to seek assistance or access to services in future?
  - the views of the named person, 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.
- 39 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).



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## Other reviews of a CORO

### **RMO's duty to keep a CORO under review (section 184)**

- 40 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).
- 41 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 multi-disciplinary team meetings, 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 should be noted alongside any other matters routinely noted at such meetings.
- 42 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 members of the multi-disciplinary 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.

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- 43 While the Act places the responsibility for a “from time to time” review on the RMO and the Scottish Ministers (see paragraph 45), 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.
- 44 If after the review described in paragraph 40 the RMO is of the opinion that there should be a change to the status of the patient, he/she must in terms of section 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)**

- 45 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)).

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## The circumstances which may prompt a reference or an application to the Tribunal

### Reference initiated by the RMO

46 Where the RMO has submitted a report to the Scottish Ministers which includes a recommendation for a change to the status of a patient subject to a CORO (sections 183(2) or 184), the Scottish Ministers 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 Scottish Ministers 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.

### Reference initiated by the MWC (section 186)

47 The MWC may notify the Scottish Ministers in writing under section 186 that it requires 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 the MWC's reasons for requiring the reference to be made must be stated (section 187(4)).

### Automatic reference made by the Scottish Ministers after two years (section 189)

48 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;

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- a reference by the Scottish Ministers under section 187(2) following notice from the MWC;
- an application by the Scottish Ministers under section 191;
- an application under section 192(2) by the patient or the patient's named person.

49 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.

50 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.

## **Application by patient or named person (section 192)**

51 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

52 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 made an order under section 193 or having made a decision under that section to make no order. The named person must notify the patient if he/she makes an application (section 192(6)).

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- 53 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, and 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 upon receipt of a reference or application**

- 54 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 of the Act.
  - 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).

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- 55 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) and 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**

- 56 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 of the Act as if the patient had been placed on the compulsion order on the day on which the Tribunal revoked the restriction order (section 198(2)). The renewal and review procedures as set down in Part 9 of the Act would also apply and continue with the timescales for the reviews being based on that day.
- 57 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.

# chapter three

## Appeal against a decision of the Tribunal

58 The procedures for an appeal 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 as set down in **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Period for Appeal) Regulations 2005** where 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.

59 *For further information about the procedures for an appeal against a decision of the Tribunal see Chapter 13 of Volume 1 of this Code of Practice and the regulations referred to in paragraph 58 above.*

# chapter 4

discharge of a patient  
subject to a  
compulsion order and  
restriction order



# chapter four

## Introduction

This chapter outlines the processes surrounding the conditional discharge and absolute discharge of a patient subject to a compulsion order and a restriction order (“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 includes best practice points allied to these provisions.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise.

## Conditional Discharge

### Overview

- 01 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.
- 02 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;

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- 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).
- 03 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).
- 04 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

- 05 Conditional discharge may be ordered by the Tribunal under section 193(7) and such conditions as seem fit to the Tribunal may be imposed. Examples of such conditions may include:
- residence at a stated address;
  - supervision by a social worker;
  - psychiatric supervision;
  - attendance at specific places (e.g. clinic, hospital, day-hospital, day-centre, work placement);
  - 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 Part 16 of the Act);
  - compliance with other treatments (e.g. engagement in a 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).

# chapter four

It should be noted that this is not an exhaustive list of conditions that may be imposed.

## Variation of conditions by the Scottish Ministers

- 06 Section 200 allows the Scottish Ministers to vary the conditions imposed by the Tribunal 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 intervention 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 these variations (section 200(3)).

## Appeal against variation

- 07 Within 28 days of being notified by the Scottish Ministers of the proposed variation to the conditions imposed by the Tribunal on the conditional discharge of the patient, the patient and his/her named person, may appeal to the Tribunal against the variation under 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

- 08 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 that there is an increased risk to others, or that the patient has breached any of the conditions imposed the Scottish Ministers should be notified of this, usually by the patient's RMO. Best practice would suggest that where the MHO becomes aware of such concerns he/she should immediately notify the RMO.
- 09 Before notifying the Scottish Ministers, the RMO should 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 Scottish Ministers to make.

# chapter four

- 10 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, best 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.
- 11 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**

- 12 Within 28 days of the patient returning to hospital, the patient and his/her named person may appeal against the recall from conditional discharge to the Tribunal under 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 a patient while on conditional discharge**

- 13 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.
- 14 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 Tribunal review within a 2 year period and applications to the Tribunal by patients or named persons, all

# chapter four

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.

- 15 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**

- 16 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.
- 17 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 protocols for Health Boards and local authority services together to support immediate care and treatment planning and the provision of necessary services.
- 18 The patient, the patient's named person, any guardian of the patient, any welfare attorney of the patient and the Scottish Ministers have the right under section 322(2) 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.

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## Further offending

- 19 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 Ministers may choose to decide to let the law take its course. In that event, it would be expected that the court would 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 of action 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.
- 20 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 best practice would suggest that the RMO, the MHO and the other members 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.
- 21 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 or the patient may be recalled to hospital under section 202 on release from prison.

# chapter four

## Absolute Discharge

### Overview

- 22 A patient who is subject to a CORO is absolutely discharged when the Tribunal revokes the compulsion order to which he/she is subject (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 is 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.
- 23 Best practice would suggest that there should be close consultation between the RMO, the MHO and the other members of the multi-disciplinary team before a recommendation is made to the Scottish Ministers for the absolute discharge of a patient. Suitable aftercare arrangements for the patient should be agreed and put in place in advance of the recommendation being made even though these would not be subject to compulsion.
- 24 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, 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



# chapter five

## 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”). Section 136 has been amended to also include any person detained under the Immigration Act 1971 or under section 62 of the Nationality, Immigration and Asylum Act 2002. (For further information about this amendment refer to **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005**).

This procedure was previously set down in section 71 of the Mental Health (Scotland) Act 1984 (“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 imposed with the direction.

This chapter sets out the formal procedures involved in the making of a TTD.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise.

## Overview

- 01 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 CTO which authorises detention in hospital except that, as with other procedures for mentally disordered offenders, the ‘impaired decision making ability’ criterion under section 64(5)(d) of the Act does not apply. So the criteria to be considered and which are set down in section 136(4) are:

# chapter five

- 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

02 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)).

# chapter five

## Measures Authorised by a TTD (Section 136(6))

- 03 The measures which may be authorised in a TTD are:
- within 7 days of the making of the direction the removal of the prisoner to the specified hospital by any of the following: 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 136(6)(a); 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 (which include medication, psychological and social interventions).
- 04 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).
- 05 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)). Best practice would suggest that, in keeping with the principles set down in section 1 of the Act, the most appropriate place of safety in these circumstances would be a hospital.
- 06 Information on the procedures after a prisoner has been admitted to hospital under a TTD are covered in the next chapter.

# chapter five

## Medical Recommendations

- 07 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 for mental disorder then an assessment by an approved medical practitioner should be arranged.
- 08 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. Best practice would suggest that one of the reports should be by a medical practitioner 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. If this is the case, the AMP should check with the admitting hospital that a bed can be made available. Best practice would also suggest that the two medical practitioners 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.
- 09 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).
- 10 The criteria set out in section 136(4) (as detailed in paragraph 1) must be considered and the medical practitioners must, in accordance with section 132(7), be in agreement about the presence of the same type of at least one of the three categories of mental disorder (as defined in section 328(1)).
- 11 The hospital to which it is proposed to admit the prisoner must be suitable for the purpose of giving medical treatment to him/her in accordance with Part 16 of the Act (which includes medication,

## chapter five

psychological and social interventions); it should be specified in the reports and a bed must be available within 7 days of the TTD being imposed (section 136(3)). (This 7 day period commences with the day on which the order is made. For example, if the order were imposed on Tuesday a bed in the specified hospital would require to be available to the person by the following Monday if not before).

- 12 The level of security of the unit to which the prisoner is to be transferred should be the least restrictive setting taking into account the risk the prisoner poses and his/her clinical needs. It would be expected that where there is a difference of opinion regarding the prisoner's security categorisation, either between the Scottish Prison Service and the medical practitioners, or between the medical practitioners themselves, there would be a discussion with a view to reaching a mutually acceptable solution.
- 13 Section 136(5) allows for the prisoner to be admitted to a state hospital where it appears to the Scottish Ministers that he/she requires to be detained in hospital under conditions of special security that can only be provided by a state hospital. When considering whether conditions of special security are required it would be expected that reference would be made to section 102(1) of the National Health Service (Scotland) Act 1978. 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.
- 14 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, the prisoner should be transferred under a TTD; the fact that a prisoner consents to treatment in hospital does not mean that a TTD may not be imposed.
- 15 The assessing medical practitioners should 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.

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## Best practice – MHO opinion

- 16 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.
- 17 It would be expected that the first point of contact for a medical practitioner seeking an MHO opinion in this situation would be the local authority for the area in which the patient was resident prior to being made subject to the TTD. Where the situation is urgent the provision of this opinion should not create unnecessary delay.
- 18 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 compulsory powers;
  - the risks involved if the prisoner were not made subject to compulsory powers.
- 19 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. Which 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 notification requirements or a sexual offences prevention order in terms of the Sexual Offences Act 2003.



# chapter 6

the hospital direction  
and the transfer for  
treatment direction  
in operation



# chapter six

## 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 Criminal Procedure (Scotland) Act 1995 (“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 volume of the Code of Practice. For information and guidance on the imposition of a transfer for treatment direction refer to the previous chapter in this volume.

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.

The chapter outlines the processes which should be followed in the immediate aftermath of a direction being made.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise.

## Overview

- 01 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. Under no circumstances should compulsory treatment for mental

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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

- 02 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. *(For further information refer to Part 1, Chapters 2 and 4 of this Volume of the Code of Practice.)* Previously section 70 of the 1984 Act provided for the transfer of unsentenced prisoners to hospital for treatment.
- 03 Most prisons and young offenders' institutions have visiting 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 refers him/herself 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 and/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 of the 1995 Act respectively).

## Sentenced prisoners

- 04 Section 136 makes provision for a Transfer for Treatment Direction ("TTD") which allows for the transfer of sentenced prisoners with mental disorder to hospital. **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005** amended section 136 to also include any person detained under the Immigration Act 1971 or under section 62 of the Nationality, Immigration and Asylum Act 2002.
- 05 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

## chapter six

that the person be detained initially in hospital for medical treatment of his/her mental disorder in accordance with Part 16 of the Act (which includes medication, psychological and social interventions). For further information about the imposition of this direction refer to the previous chapter.

- 06 Where a patient is subject to either direction mentioned in paragraphs 4 or 5 a prison sentence runs concurrently with his/her period of detention in hospital. When the patient no longer requires medical treatment for mental disorder in hospital in terms of the Act 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).
- 07 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 ceases to have effect.
- 08 Patients subject to these directions have “restricted” status and so decisions about suspension of detention and transfer to another hospital must be authorised by the Scottish Ministers. In addition it should be noted that only the Scottish Ministers may revoke a direction as mentioned in paragraph 6 above although the Tribunal may, under certain circumstances, direct the Scottish Ministers 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).

# chapter six

## **Suspension of detention (sections 224 to 226)**

09 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 direction specifying detention of the patient. *For further information on these procedures refer to Part 1, Chapter 6 of this Volume of the Code of Practice.*

## **Transfer (sections 218 to 221)**

10 Part 12 of the Act sets out the statutory procedures for the transfer within Scotland of a patient who is subject to a direction. *For further information on these procedures refer to Part 2, Chapter 9 of this Volume of the Code of Practice.*

## **Absconding**

11 The statutory procedures in relation to absconding by mentally disordered offenders are set out in **The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**. *For further information refer to these regulations and to Part 1, Chapter 6 of this Volume of the Code of Practice.*

# chapter six

## Responsibilities subsequent to a direction being imposed

- 12 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”).
- 13 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 an HD has been imposed by the court, it would be expected that the transport of the patient to the hospital would be the responsibility of the court.
- 14 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 see Chapter 6 of Volume 1 of this Code of Practice.*
- 15 An RMO and an MHO must be allocated to the patient under sections 230 and 229 respectively and a multi-disciplinary assessment should 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 and/or an interim compulsion order.

# chapter six

## RMO responsibilities – the care plan

- 16 Although not a statutory duty under the Act, the RMO should prepare a care plan setting out the medical treatment that is currently being given to the patient (which includes medication, psychological and social interventions) and the medical treatment which it is proposed will be given to him/her. Although not a statutory duty it would be expected that the RMO would also record in the care plan similar information to that which is required in a Part 9 care plan for a patient who is subject to a compulsion order as set down in **The Mental Health (Content and amendment of Part 9 care plans) (Scotland) Regulations (SSI No. 312)**. *For further information on the content of a Part 9 care plan refer to these regulations and to Part 2, Chapter 1 of this Volume of the Code of Practice.*
- 17 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 other members of multi-disciplinary team.
- 18 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 other members of the multi-disciplinary team where relevant and appropriate. The RMO should record on the care plan details of the parties who have received a copy.
- 19 Although not a statutory duty under the Act best practice would suggest that the RMO would, in consultation with the MHO and other members of the multi-disciplinary team where relevant and appropriate, update the care plan at least once a year following a statutory review of the direction under sections 206(2) if not more often.
- 20 Although most mentally disordered offenders are not subject to the provisions of the Sexual Offences Act 2003, in the minority of cases where a patient who is subject to a direction is also subject to a notification requirement under Part 2 of the Sexual Offences Act 2003 the plan should be updated when the relevant notification period expires. If the patient is subject to a sexual offences prevention order under section 105 of the same Act the plan should be updated where that order is varied, renewed or discharged.

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- 21 It would be expected that the RMO would send a copy of the updated plan to the parties mentioned in paragraph 18 at the time of the statutory annual review of the direction under section 206(2).
- 22 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 direction; and thereafter an annual report is requested. The care plan should 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 this process and the administrative procedures involved he/she should contact the Health Department of the Scottish Executive for further information.

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## MHO responsibilities

- 23 When a direction is imposed the relevant local authority must allocate a designated MHO for the patient in accordance with section 229. This MHO should 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 Social Circumstances Report (“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 see Chapter 4 of Volume 2 of this Code of Practice.*
- 24 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).
- 25 Where a patient has been admitted under a TTD, the MHO should 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.
- 26 Depending on the status of the patient while in prison, it is possible that a 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 patterns of offending, mental health concerns; drug and alcohol misuse, and other relevant information.



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- 27 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 Part 2, Chapters 2 and 3 of this Volume of the Code of Practice 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 CTO the designated MHO may make an application to the Tribunal in accordance with Schedule 3. *(For information about this procedure refer to Part 2, Chapter 8 of this Volume of the Code of Practice).*

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## Best practice points for information that should be noted upon the admission of a patient subject to a direction

### 28 *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 to which he/she is subject 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. (It would be expected that this information would be obtained by the Medical Records Manager following the patient's admission).

### 29 *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 licence 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 ceases to have effect.

30 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. (It would be expected that this information would be obtained by the Medical Records Manager following the patient's admission).

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## 31 *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.

32 In accordance with section 2(6) of the 1993 Act, after a life prisoner has served the punishment part, he/she may require the Scottish Ministers to refer his/her case to the Parole Board for review. It is the responsibility of the Parole Board sitting as the Life Prisoners Tribunal ("LPT") to consider in terms of section 2(5)(b) of the 1993 Act, the level of risk that 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.

33 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.

34 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.

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- 35 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 at which point the direction will cease to have effect. (It would be expected that this information would be obtained by the Medical Records Manager following the patient's admission). 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.
- 36 If the prisoner requires compulsory treatment for his/her mental disorder in terms of the Act while on life licence this may be accomplished under civil procedures (sections 36, 44 or 63 of the 2003 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 under section 66 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 hospital direction  
or a transfer for treatment  
direction

# chapter seven

## Introduction

This chapter begins by examining the formal processes to be followed where a hospital direction (“HD”) or a transfer for treatment direction (“TTD”) is being reviewed, as laid out in Part 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. 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 Scottish Ministers 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 and the section numbers refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) unless stated otherwise.

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## Overview of the review process

01 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).

### Review criteria

02 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").

03 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.

04 *For information on the assessment of risk refer to Part 1, Chapter 5 of this Volume of the Code of Practice.*



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- 05 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.

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## Mandatory review by the RMO (section 206)

- 06 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), consider the review criteria set down in section 206(3)(b), consult the MHO and then prepare and submit a report to the Scottish Ministers.
- 07 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 a great sense of multi-agency and multi-disciplinary co-operation and consultation. In that connection, it would be best practice for a full case conference to be held when a mandatory review is being carried out. It would also be best 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.
- 08 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 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)) in paragraphs 12 to 23).
- 09 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.

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## Medical examination

- 10 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;
  - consider the views of the patient's named person.
- 11 The RMO must consider the criteria described in paragraph 2 above 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 that the direction should be revoked (section 207(4) or (5)). 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));
  - if the mental disorder criterion and the serious risk to others criterion are met, whether any of the other criteria are met or not, *the patient should remain subject to the direction*.

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## RMO's report to the Scottish Ministers (section 207(2))

- 12 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.
- 13 As soon as practicable after carrying out the review the RMO must submit a report containing his/her findings to the Scottish Ministers 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. 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.
- 14 The format and content of the RMO's report is not set down in the Act (aside from the information detailed in section 207(3) but a pro-forma, HD1, may be found on the Scottish Executive website at [www.scotland.gov.uk/health/mentalhealth](http://www.scotland.gov.uk/health/mentalhealth)). Non-statutory guidance may also be obtained from the Scottish Executive Health Department. Best practice would therefore suggest that, where the RMO is unfamiliar with this 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.
- 15 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;
  - occupational therapy;
  - 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;
  - the patient's relations with staff and other patients;
  - the patient's participation in activities while in hospital;

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- freedoms available e.g. leave in grounds, suspension of detention etc and how they are used;
  - the patient's relations with family and friends;
  - plans for the patient's future care;
  - victim and public safety issues.
- 16 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 should 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.
- 17 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;
  - how risk issues will be managed;
  - 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 to 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.

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- 18 Where the patient has a **mental illness** the report would be expected to address the following:
- the relationship between dangerous behaviour and the patient's 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;
  - how risk issues will be managed.
- 19 Where the patient has a **learning disability** the report would be expected to address the following:
- the relationship between dangerous behaviour and the patient's learning disability;
  - whether the patient has benefited from treatment including psychological treatment and education;
  - whether the patient's inappropriate behaviour is currently stable and whether this has been tested in various circumstances;
  - whether the patient is able to understand the consequences of his/her actions;
  - whether the patient's behaviour poses a risk to the public and the nature and level of any risk;
  - how risk issues will be managed.
- 20 Where the patient has a **personality disorder** the report would be expected to address the following:
- the relationship between dangerous behaviour and the patient's personality disorder;
  - 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; how this manifests itself, and how much is context specific;
  - areas of functioning that continue to be a problem, how they manifested themselves in the past and present, and how they may be managed in the future.

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## **Consultation between the RMO and the MHO and the multi-disciplinary team**

- 21 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 should 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.
- 22 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.
- 23 It would be expected that the designated MHO would maintain a sufficiently close involvement with the patient, any carer(s), and other members of the multi-disciplinary team, to ensure that he/she 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 should keep the MHO informed of any key developments in the care and/or treatment of the patient.

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## Best practice points for the MHO

- 24 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 should also:
- 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.
- 25 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.
- 26 When interviewing the patient and consulting the named person and/or the primary carer as outlined in paragraph 24, 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 see Chapter 6 of Volume 1 of this Code of Practice.*



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## Other reviews of a direction

### **RMO's duty to keep a direction under review (section 208)**

- 27 The RMO must 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 the report to the Scottish Ministers under section 207(2).
- 28 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 multi-disciplinary team meetings, 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.
- 29 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.

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- 30 While the Act places the responsibility for a “from time to time” review on the RMO and the Scottish Ministers (see paragraphs 32 to 33 below), 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.
- 31 If after the review described in paragraph 28, 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)**

- 32 The Scottish Ministers must keep a direction under ongoing review, by considering ‘from time to time’ the matters set out in section 212(2).
- 33 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 must 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 (section 210(3)).

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## Power of the Scottish Ministers to revoke a direction

- 34 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).
- 35 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.
- 36 Where a reference is made to the Tribunal in terms of section 210(3), after hearing the patient's case the Tribunal may direct the Scottish Ministers to revoke the direction (section 215(3) or (4)).

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## Circumstances which may prompt a reference or an application to the Tribunal

### Reference initiated by the RMO

37 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 Mental Welfare Commission.

### MHO – best practice points where a reference has been initiated by the RMO

- 38 On receiving such a notification the MHO should 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 should 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.
- 39 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 for the Scottish Ministers.
- 40 Where, following the receipt of a report from the RMO recommending that the direction be revoked the Scottish Ministers do not revoke the direction, the MHO should be clear as to the basis for the differing opinions, and consider carefully the potential implications for the patient's health, welfare, safety, or the safety of others, associated with the revocation and the non-revocation of the direction.

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41 Many of the matters for consideration by the MHO in these circumstances, are similar to the considerations described in Part 2, Chapter 3 of this Volume of the Code of Practice in relation to a review of a CORO. However a significant difference with respect 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 (section 209)**

42 The MWC may notify the Scottish Ministers in writing 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 Part 2, Chapter 3 of this Volume of the Code of Practice.*

## **Automatic reference made by the Scottish Ministers after two years (section 213)**

43 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) following a recommendation from the patient's RMO;
- a reference by the Scottish Ministers under section 211(2) following notice from the MWC;
- an application under section 214(2) by the patient or the patient's named person.

44 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

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that the Tribunal would review the patient's case a minimum of every two years. Section 213(5) sets down the information that must 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 Mental Welfare Commission.

## **Application by patient or named person (section 214)**

- 45 The patient and the patient's named person may make an application to the Tribunal requesting that the Tribunal revoke the direction (section 214(2)).
- 46 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)).
- 47 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 TTD (section 214(5)).
- 48 Only one application each may be made by the patient and the named person in the 12 month period beginning with the imposition of a direction, and then in every 12 month period thereafter (section 214(6)). Where an application is made by the named person then he/she must inform the patient in terms of section 214(7).
- 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.

## **Powers of the Tribunal (section 215)**

- 50 Following a reference or an application being made under sections 210(3), 211(2), 213(2) or 214(2) the Tribunal may make:

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- no direction to the Scottish Ministers to revoke the direction (section 215(2));
- a direction to the Scottish Ministers to revoke the direction (section 215(3) or (4)).

51 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.

52 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) and 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).

## Appeal against the decision of the Tribunal

53 The procedures for an appeal to be made against a decision of the Tribunal are set down in Part 22 of the Act. The patient, the patient's named person, any guardian of the patient, any welfare attorney of the patient and the Scottish Ministers have the right under section 322(2) to appeal to the Court of Session against a decision of the Tribunal. In relation to a decision by the Tribunal to make a direction under section 215(3) or (4) (i.e. where the Tribunal directs the Scottish Ministers to revoke the direction), where the Scottish Ministers appeal against the decision 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 direction continue to have effect pending the outcome of the appeal. *For further information about appeals against a decision of the Tribunal see Chapter 13 of Volume 1 of the Code of Practice.*

# chapter 8

discharge of a patient  
subject to a hospital direction  
or a transfer for treatment  
direction



# chapter eight

## Introduction

Throughout the duration of a hospital direction or a transfer for treatment direction the Scottish Ministers may revoke the direction under sections 210(2) or 212(3) or (4) of the Act, without any recourse to the Tribunal, 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).

The chapter describes the different scenarios which may arise at the expiry of the patient's sentence in relation to his/her detention under the Act.

In this chapter a hospital direction and a transfer for treatment direction are both referred to as "directions". All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") unless stated otherwise.

### Revocation of a direction before the expiry of sentence

- 01 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. It would be expected that this would be instigated by the Scottish Ministers issuing a warrant.
- 02 It would be expected that it would be the responsibility of the hospital managers to arrange for the transportation of the person to prison.
- 03 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

- 04 If a patient is 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).

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- 05 If at that time the patient meets the criteria for a compulsory treatment order as set down in section 64(4), an application should be made 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)**

- 06 For those patients who are considered to still require to be detained in hospital for 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 set out the procedure for an application for a compulsory treatment order ("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.
- 07 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 other members of the multi-disciplinary team where relevant and appropriate, should review the patient's case and make a decision as to whether an application should be made to the Tribunal for a CTO. The application requires a mental health officer's report and a proposed care plan by an MHO, and mental health reports by two medical practitioners. Best practice would suggest that where an application is considered necessary it should be made by the patient's designated MHO. *For further information on the application process see Chapter 3 of Volume 2 of this Code of Practice*, bearing in mind the application provisions set down in section 71 of, and Schedule 3 to, the Act.
- 08 As a general rule it would be expected that emergency detention (section 36) or short-term detention certificates (section 44) would not be used at the end of a direction to detain a person in hospital. However in some circumstances this 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;

# chapter eight

- 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.

09 Under such circumstances Parts 5 and 6 of the Act, and the Code of Practice relating to these parts must be followed (Volume 2, Chapters 2 and 7). 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 a patient is being released on licence, the RMO and the MHO should when arranging aftercare services give careful consideration to any possible conditions which may be imposed by the licence.
- 11 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 an MHO for a CTO which authorises compulsory powers in the community (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 an MHO, and mental health reports by two medical practitioners. Best practice would suggest that this application should be made by the patient's designated MHO. *Chapter 3 of Volume 2 of the Code of Practice* should be referred to for information, bearing in mind the application provisions set down in section 71 of, and Schedule 3 to, the Act.
- 12 The Tribunal may make a CTO in these circumstances within the 28 day period before the expiry of the direction and 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

transfer of a patient  
subject to a compulsion  
order and a restriction  
order, a hospital  
direction or a transfer  
for treatment direction

# chapter nine

## Introduction

Part 12 of the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the procedures for the transfer between hospitals in Scotland of a patient who is subject to:

- a compulsion order and a restriction order (sections 57A and 59 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 the orders and directions listed above are referred to as a 'relevant order'.

This chapter describes the formal processes associated with the transfer of a patient within Scotland who is subject to a relevant order. For information about the procedures for the transfer of these patients outwith Scotland refer to Volume 1, Chapter 14 of this Code of Practice.

All section numbers in this chapter refer to the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") unless stated otherwise.

## Overview

- 01 Section 218 sets out procedures for the transfer of a patient who is detained in hospital under a relevant order. Examples of when it may be necessary to transfer a patient subject to a relevant order may include:
- where it is a part of the patient's rehabilitation through lower levels of security and nearer to the community to where he/she will ultimately return;
  - where it is considered that the patient requires a higher level of security than that to which he/she is currently subject;
  - 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.

## chapter nine

- 02 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 a suitably qualified psychologist where appropriate; the patient; the patient's named person and carers; the patient's advocate, and the Scottish Ministers.
- 03 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 should ensure that the MHO, the primary carer and the named person are notified as soon as possible.
- 04 In practical terms, the range of issues which should be considered when planning the transfer of a patient include:
- ensuring that the patient, and his/her relatives, carers, named person, independent advocate and representatives have been informed of an agreed departure time in advance of the transfer, and ensuring that the patient is fully supported in preparing for the journey;
  - providing an appropriate, swift and comfortable means of transport which is also suitable for the provision of medication, where necessary;
  - anticipating any difficulties in relation to the required level of security and possible absconding en route (in as far as this is possible), bearing in mind the importance of caring for the patient in the manner which involves the minimum restriction on the patient's freedom that is necessary in the circumstances;
  - ensuring that there is a clearly identified RMO in the receiving hospital.

# chapter nine

## Non-urgent transfer

### Overview

- 05 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).
- 06 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.
- 07 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 compulsory powers (as described in paragraphs 5 and 6 above). 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 which the patient might him/herself wish to provide.
- 08 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).

# chapter nine

## Transfer to another hospital as part of rehabilitation – best practice points

- 09 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 to where the patient will eventually be discharged (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).
- 10 Such transfers should be planned well in advance (see paragraphs 2 to 4 of this chapter). Where the RMO, in consultation with the MHO and the other members 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 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.
- 11 Careful consideration should be given to any possible funding and care management issues that may require 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 with respect to the appropriate timing of the transfer actually taking place (in accordance with section 218) in liaison with the Scottish Ministers.



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- 12 Usually the patient would visit the receiving hospital initially under the suspension of detention provisions set down in section 224 which would require the consent of the Scottish Ministers. (*For further information see Part 1, Chapter 6 of this Volume of the Code of Practice.*) 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).
- 13 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 the 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.

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## Transfer to a more secure hospital – best practice points

- 14 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 15 to 17 below.
- 15 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.
- 16 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 health.
- 17 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 13. 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

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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**

- 18 In most cases treatment in a general medical hospital for physical illness would be expected to be undertaken via the suspension of detention provisions set down in section 224. (*For further information see Part 1, Chapter 6 of this Volume of the Code of Practice.*) 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.
- 19 If it seems likely that the patient will require a prolonged period of treatment for physical illness (lasting longer than 3 months which is the maximum time that section 224(2) allows for one continuous period where the patient's detention has been suspended) the Scottish Ministers' consent should 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.
- 20 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).

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## Urgent transfer

### Overview

21 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 a non-urgent transfer, no notification to the patient is required if the patient consents to the transfer (section 218(7)), (see paragraph 7 relating to the assessment and the recording of consent). The requirements as to the consent of the Scottish Ministers 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 8).

### Transfer to a general medical hospital for treatment of physical illness

22 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. *(For further information see Part 1, Chapter 6 of this Volume of the Code of Practice.)*

### Transfer to a more secure hospital – best practice points

- 23 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:
- an urgent referral should be made to the proposed receiving hospital;
  - the Scottish Ministers should be notified and urgent consent sought for transfer if the receiving hospital accepts the referral.
- 24 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.

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- 25 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.
- 26 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.

# chapter nine

## Appeal against transfer

- 27 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 within Scotland.
- 28 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 pursuing 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**

- 29 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 he/she was transferred.
- 30 If an appeal has been made to the Tribunal before the proposed transfer has taken place, the transfer must not go ahead until the appeal has been concluded unless the Tribunal orders that it should in accordance with section 219(4)(b).

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## **Appeal against transfer to a state hospital**

- 31 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.
- 32 Where an appeal has been made to the Tribunal before the transfer has taken place, the transfer must 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 where this might be appropriate would be where the patient's mental state and behaviour is such that the RMO and the Scottish Ministers 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.
- 33 If the Tribunal is not 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 10

## glossary of commonly used terms



# chapter ten

**Advance statement:** this is a document drawn up in accordance with sections 275-6 of the Act. It is a written and witnessed document which is made when the patient is well and which sets out how s/he would prefer to be treated (or not treated) if s/he were to become ill in the future. The Tribunal and any medical practitioner treating the patient must have regard to the advance statement. A medical practitioner must also send to the Commission a written record of the reasons why the wishes set out in the advance statement have not been followed.

**Assessment Order (section 52 of the 1995 Act):** an order imposed by a criminal court prior to trial and/or after conviction before sentencing which authorises hospital detention for up to 28 days so that the patient's mental condition may be assessed. Medical treatment under Part 16 of the Act may be given to a patient in certain circumstances while subject to this order. It may be extended once only for a period of 7 days.

**Approved medical practitioner:** this 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. Only an approved medical practitioner can grant a short-term detention certificate; and at least one of the two mental health reports forming part of a compulsory treatment order application must be provided by an approved medical practitioner.

**Authorised person's warrant/a "section 292 warrant":** this warrant authorises a person to enter the premises of another person where the person entering the premises has already been given the authority under another provision of this Act to take the person to another place or into custody. This could happen, for example, in a situation where a patient has absconded and a person who has been authorised under section 303 of the Act to take that patient into custody or to return them to hospital requires entry to the premises where the patient has been found.

**Care plan:** this is a document prepared by the patient's responsible medical officer under section 76 of the Act after a compulsory treatment order has been made. It lays out the forms of medical treatment and the other services the patient will be receiving while subject to the compulsory treatment order. This document should not be confused with the "proposed care plan" which is prepared under section 62 of the Act as part of the application for a compulsory treatment order.

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**Compulsion Order (section 57A of the 1995 Act):** a final disposal imposed by a criminal court which authorises hospital detention or compulsory powers in the community for a period of 6 months, if not otherwise renewed. It may be renewed for six months and then annually thereafter. The procedures for the review of this order and for its renewal, variation and revocation are almost identical to those for a compulsory treatment order imposed under civil proceedings.

**Compulsory treatment order:** this is an order granted by the Tribunal under section 64(4) of the Act. It authorises any of the compulsory measures listed at section 66(1) for a period of six months, if not otherwise renewed. The compulsory treatment order can be renewed for six months, then for twelve months thereafter.

**Designated medical practitioner:** this is a medical practitioner appointed by the Mental Welfare Commission under section 233 of the Act. The function of a designated medical practitioner is to provide a second medical opinion with respect to certain medical treatments being given under Part 16 of the Act.

**Emergency detention certificate:** this is a certificate granted under section 36 of the Act. Where strict criteria have been met, it authorises the removal of a person to hospital within 72 hours and the detention of that person in hospital for a further 72 hours. An emergency detention certificate can be granted by any fully registered medical practitioner who has, where practicable, consulted and sought the consent of a mental health officer to the granting of the certificate.

**Extension certificate:** this is a certificate issued under section 47(1) of the Act. Where strict criteria have been met, it extends a period of short-term detention by three working days (not three calendar days) to allow for the preparation of an application for a compulsory treatment order.

**Hospital Direction (section 59A of the 1995 Act):** a final disposal imposed by a criminal court in addition to a sentence of imprisonment which allows the person to be detained in hospital initially for treatment for mental disorder and then transferred to prison to complete their sentence once detention in hospital is no longer required.

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**Independent Advocate:** a person who enables the patient to express their views about the decisions being made about their care and treatment by being a voice for the patient and encouraging them to speak out for themselves. An independent advocate is employed by an advocacy organisation which is not directly funded or run by the Health Board or Local Authority. All people with mental disorder have a right to independent advocacy, not only those subject to compulsory measures.

**Interim Compulsion Order:** an order imposed by a criminal court after conviction and before sentencing which authorises hospital detention for assessment and treatment for a period of 12 weeks to allow further evidence to be obtained with respect to the person's mental disorder and the risk that they pose as a result of this disorder. It may be renewed regularly for up to one year.

**Interim compulsory treatment order:** this is an order granted by the Tribunal under section 65(2) of the Act. It authorises any of the compulsory measures listed at section 66(1) of the Act for a period of up to 28 days at a time. An unlimited number of interim orders can be granted as long as the total detention period authorised by the interim orders does not exceed 56 consecutive days.

**Mental health officer's report:** this is a report prepared under section 61 of the Act. It is prepared by the mental health officer as part of the application for a compulsory treatment order. It must detail background information on the person who is the subject of the application.

**Mental health report:** this is a report required under section 57(4) of the Act and prepared by a medical practitioner. Two such reports must form part of the application for a compulsory treatment order. The practitioner must lay out in this report the reasons why s/he believes that a compulsory treatment order is appropriate.

**Multi-disciplinary team:** this 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), a mental health officer and other social workers, nursing staff/Community Psychiatric Nurses, psychologists, occupational therapists

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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.

**Named person:** this is someone nominated by a person in accordance with the provisions of Part 17 Chapter 1 of the Act to support them and protect their interests. The named person is entitled to receive certain information about the person and to act on behalf of the person in certain circumstances and at certain times set out in the Act.

**Nearest relative:** there are occasions in the Act where the nearest relative is given information about a person coming under the provisions of the Act, such as where a person is removed to a place of safety. Section 254 of the Act sets out a list of the people who will be considered in identifying a person's nearest relative.

**Nurse's holding power:** this is a power which can be exercised by nurses of a prescribed class by way of section 299 of the Act to hold a patient for up to 2 hours while awaiting a medical examination.

**Place of safety:** Section 300 defines a place of safety as a hospital, premises which are used to provide a care home services or any other suitable place (other than a police station) where the occupier is willing to temporarily receive a person with mental disorder. However, if no place of safety is available, a police officer may remove a person to a police station which should then be treated as a place of safety for the purposes of the person's detention.

**Part 9 care plan:** this is a document prepared by the patient's responsible medical officer under section 137 of the Act after a compulsion order has been imposed by a criminal court. It contains the same core information as the care plan of a patient who is subject to a CTO in that it sets out the forms of care and treatment for the mental disorder that the patient will receive while subject to the order but it also includes other information to take account of the status of the patient as a mentally disordered offender.

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**Proposed care plan:** this is a document drawn up under section 62 of the Act by the mental health officer who is making the application for a compulsory treatment order. It contains details of the medical treatment for mental disorder, the community care services; and any other forms of care and treatment which it is proposed to provide to the patient if the compulsory treatment order is made. The “proposed care plan” should not be confused with the “care plan” which is prepared under section 76 of the Act by the patient’s responsible medical officer subsequent to the making of a compulsory treatment order.

**Removal order/“a section 293 warrant”:** an order granted by a sheriff or a justice of the peace under section 293(1) of the Act. It authorises certain persons to enter the premises of an individual at risk in order to remove them to a place of safety. It also authorises a constable to open lockfast places and the detention of the person for 7 days.

**Restriction Order (section 59 of the 1995 Act):** an order imposed by a criminal court in conjunction with a compulsion order with the effect that the measures specified in the compulsion order are without limit of time and the patient may not be granted leave or transferred to another hospital without the consent of the Scottish Ministers.

**Section 35 warrants:** these are warrants issued by a sheriff or a justice of the peace on an application from an MHO. The purposes for which these warrants can be granted are to enter premises; to detain a person in order to carry out a medical examination; and to allow a medical practitioner access to a person’s medical records. There is no right of appeal against a warrant being granted or not being granted under section 35.

**Section 68 detention period:** this is a period of detention which lasts for five working days (not five calendar days). This detention period occurs automatically once an application for a compulsory treatment order has been submitted to the Tribunal. It begins on the expiry of a short-term detention certificate or an extension certificate, depending on which certificate the patient is subject to. The Tribunal must determine the compulsory treatment order application by the end of this section 68 detention period.

**Section 86 determination:** this is a determination made by the patient’s responsible medical officer under section 86 of the Act to extend the compulsory treatment order without any variation of the compulsory

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measures or recorded matters specified in the order. A compulsory treatment order can be extended for six months, then for twelve months at a time thereafter. However, the Tribunal must review an order if it has not done so at any point within the previous two years. The Tribunal must also review section 86 determination if the mental health officer disagrees with this determination or if there is a difference between the type(s) of mental disorder stated in the section 86 determination and those in the compulsory treatment order.

**Section 92 application:** this is an application which the patient's RMO must make to the Tribunal under section 92 of the Act where s/he wishes to extend a compulsory treatment order with a variation of the compulsory measures or recorded matters specified in a compulsory treatment order.

**Section 95 application:** this is an application which the patient's RMO must make to the Tribunal under section 95 of the Act where s/he wishes to vary the compulsory measures or recorded matters specified in a compulsory treatment order.

**Section 292 warrant:** see "authorised person's warrant".

**Section 293 warrant:** see "removal order".

**Short-term detention certificate:** this is a certificate issued under section 44(1) of the Act. Subject to strict criteria, it authorises the conveyance of a person to hospital within 3 days of the certificate being granted, and then the detention in hospital of that person for a period of up to 28 days. A short-term detention certificate can only be granted by an approved medical practitioner with the consent of a mental health officer.

**Social circumstances report:** this is a report prepared by a mental health officer under section 231 of the Act. It must be produced within 21 days of any of the following events taking place: the granting of a short-term detention certificate; the making of an interim compulsory treatment order; a compulsory treatment order; an assessment order; a treatment order; an interim compulsion order; a compulsion order; a hospital direction; or a transfer for treatment direction. However, an MHO does not need to complete an SCR where s/he is satisfied that an SCR would serve little or no practical purpose. However, a record must be produced stating why the SCR is not being prepared. This record must be sent to the Mental Welfare Commission and to the patient's RMO.

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**Suspension certificate:** this is a certificate granted under section 41, 53 127 or 128 of the Act. A suspension certificate granted under sections 41, 53 or 127 suspends the hospital detention requirement of an emergency detention certificate, a short-term detention certificate or a CTO respectively. A suspension certificate granted under section 128 can suspend any measure authorised in a CTO other than the hospital detention requirement. Under the Mental Health (Scotland) Act 1984, “suspension” was sometimes referred to as “leave of absence” or “being out on pass”.

A suspension certificate may also be granted with respect to a patient who is subject to criminal justice proceedings. The processes involved in granting and revoking such a certificate are set out in Part 13 of the Act with the exception of a certificate with respect to a patient who is subject to a compulsion order without a restriction order; these are set out in section 127 as applied by section 179(1). Similar to CTOs, a suspension certificate granted under section 128 as applied by section 179(2) may suspend any measure in a compulsion order other than the hospital detention requirement.

**Transfer for Treatment Direction:** an order made by the Scottish Ministers under section 136 of the Act which allows the transfer of a prisoner to hospital for treatment of a mental disorder.

**Treatment Order (section 52M of the 1995 Act):** an order imposed by a criminal court which authorises hospital detention for treatment for mental disorder. Section 52R of the 1995 Act sets out the circumstances in which this order ceases to have effect.

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## forms



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All forms are non-statutory except where indicated

Form	Act reference	
<b>Short-term and Emergency detention (Parts 5 and 6)</b>		
<b>DET 1</b>	Sections 36 & 37	Emergency detention certificate
<b>DET 2</b>	Sections 44 & 45	Short term detention certificate
<b>DET 3</b>	Section 45	MHO duties under section 45
<b>DET 4</b>	Sections 47 & 48	Extension of short-term detention certificate
<b>Compulsory Treatment Order (Part 7)</b>		
<b>CTO 1</b>	Sections 63, 64 & 66	CTO application pack
<b>CTO 1a</b>	Sections 63, 64 & 66	CTO admission form
<b>CTO 2</b>	Section 58	Mental health report
<b>CTO 3a</b>	Sections 77, 78 & 86	RMO's mandatory review of a CTO and section 86 determination to extend a CTO
<b>CTO 3b</b>	Sections 77, 78 & 86	Review by the Tribunal of a section 86 determination
<b>CTO 4</b>	Sections 78, 91, 92 & 103	RMO's mandatory review of a CTO and a section 92 application to extend and vary a CTO
<b>CTO 5</b>	Section 94	RMO's application to the Tribunal to vary a CTO
<b>CTO 6</b>	Section 65	The making of an interim CTO by the Tribunal
<b>CTO 7</b>	Section 112	RMO's record of a patient having been taken into custody following failure to attend for medical treatment where this is a compulsory measure in the CTO (this form may also be used for compulsion orders)
<b>CTO 8</b>	Sections 113, 117	RMO's record of the patient's non compliance generally with a CTO which authorises compulsory powers in the community (this form may also be used for compulsion orders)

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<b>CTO 9</b>	Sections 114 & 177	RMO's certificate authorising continued detention of the patient pending review or application for variation; or interim compulsory treatment order detention pending further review
<b>CTO 10</b>	Sections 96, 97	RMO's reference to the Tribunal with respect to the non-provision of a recorded matter and the Tribunal's determination with respect to such a reference
<b>CTO 11</b>	Section 98	Reference to the Tribunal by the MWC and the Tribunal's subsequent determination
<b>CTO 12</b>	Sections 105/106	Tribunal's determination where an interim extension and/or interim variation of the order is imposed
<b>CTO 13</b>	Section 99	Application to the Tribunal by the patient or named person to revoke the RMO's determination extending the order
<b>Admission following criminal justice proceedings</b>		
<b>ADM 1</b>	Criminal Procedure (Scotland) Act 1995	Notification of admission of a patient following the imposition of an assessment order, a treatment order, an interim compulsion order, a supervision and treatment order, a compulsion order, a compulsion order and a restriction order, a hospital direction, a transfer for treatment direction or a probation order with a requirement for treatment for mental condition

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		<b>Discharge of a patient subject to criminal proceedings</b>
<b>DISC 1</b>	Criminal Procedure (Scotland) Act 1995	Record of the discharge of a patient who is subject to: an assessment order, a treatment order, an interim compulsion order, a supervision and treatment order, a compulsion order, a compulsion order and a restriction order, a hospital direction, a transfer for treatment direction or a probation order with a requirement for treatment for mental condition.
		<b>Review of an interim compulsion order (Part 8)</b>
<b>CO 5</b>	53B(1) of CPSA 1995	RMO's report to the court where he/she considers that an interim compulsion order should be extended
		<b>Compulsion Order (Part 9)</b>
<b>CO 1</b>	Sections 149 and 167	RMO's application to the Tribunal to extend a CO following first review and the Tribunal's order following application
<b>CO 2a</b>	Sections 140, 152, 153 & 166	RMO's determination to extend a compulsion order following further review
<b>CO 2b</b>	Sections 140, 152, 153 & 166	Review by the Tribunal of the RMO's determination to extend a CO following further review
<b>CO 3</b>	Sections 157, 158 & 167	RMO's application to the Tribunal to extend and vary a CO and determination by the Tribunal following an application to extend and/or vary a CO
<b>CO 4</b>	Sections 160, 161 & 167	RMO's application to the Tribunal to vary a CO and the Tribunal's subsequent determination

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<b>CO 6</b>	Sections 168/169	Tribunal's determination where an interim extension and/or interim variation of a CO is imposed
<b>CO 7</b>	Sections 163, 164	Application by the patient or the named person to the Tribunal to revoke or vary a CO and the Tribunal's subsequent determination
<b>CO 8</b>	Sections 162/171	Reference to the Tribunal by MWC and the Tribunal's subsequent determination
<b>CTO 7</b>	Section 112 as applied by section 176	RMO's record of the patient having been taken into custody following failure to attend for medical treatment where this is a compulsory measure in the CO (or a CTO)
<b>CTO 8</b>	Sections 113 and 117 as applied by section 177	RMO's record of the patient's non compliance generally with a CO (or a CTO) which authorises compulsory powers in the community
<b>CO 9</b>	Section 114 as applied by section 177(2)	RMO's certificate authorising continued detention of the patient pending review or application for variation of a CO
<b>CO 10</b>	Sections 141, 142, 144	RMO's record of the revocation of a CO; a record of the notifications made with respect to the revocation and record of termination of a CO
<b>Compulsion Order and Restriction Order (Part 10)</b>		
<b>CORO 1</b>	Sections 183 & 185	RMO's review of a CORO
<b>CORO 2</b>	Sections 191, 193	Application by Scottish Ministers to Tribunal under section 191 or 193

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<b>CORO 3</b>	Sections 193, 201 and 204	Tribunal's record of an application by the patient or named person against: <ul style="list-style-type: none"> <li>– the variation by the Scottish Ministers of the conditions imposed by the Tribunal on the conditional discharge of the patient</li> <li>– being recalled to hospital by the Scottish Ministers and the Tribunal's subsequent determination of the application</li> </ul>
<b>Hospital direction/Transfer for treatment direction (Part 11)</b>		
<b>HD 1</b>	Section 206	RMO's review of a hospital direction or a transfer for treatment direction
<b>HD 2</b>	Sections 210, 211, 213 to 215	The Scottish Ministers' record of their decision whether or not to revoke the direction following a recommendation by the RMO; their reference to the Tribunal where they have not revoked a direction after having received such a recommendation and their record of revoking the direction upon the instructions of the Tribunal. The Tribunal's record of the patient or named person having made an application under section 214 and of its own direction to the Scottish Ministers to revoke the direction
<b>Suspension of detention (Parts 5, 6, 7, 9 and 13)</b>		
<b>SUS 1</b>	Sections 127, 128 & 129	RMO's certificate granting the suspension of compulsory measures relating to a CTO, or an interim CTO

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<b>SUS 2</b>	Sections 41, 42, 53 & 54	RMO's certificate granting the suspension of an emergency detention certificate, or a short-term detention certificate and any subsequent revocation or suspension (where appropriate)
<b>SUS 3</b>	Sections 221 to 226	RMO's certificate granting the suspension of the measure authorising detention in hospital in accordance with sections 221 or 224 and revocation by the RMO or the Scottish Ministers of such a certificate.
<b>SUS 4</b>	Sections 127, 128, 129, as applied by 179	RMO's certificate granting the suspension of compulsory measures relating to a CO and the revocation of such a certificate
<b>Revocation of certificates (Parts 5, 6 and 7)</b>		
<b>REV 1</b>	Section 40	Revocation of emergency detention, short-term detention certificate and extension certificate
<b>REV 2</b>	Sections 72 & 80	RMO's revocation of a CTO or an interim CTO
<b>REV 3</b>	Section 119	RMO's revocation of a certificate granted under section 114 or 115 (applies to CTOs and COs)
<b>REV 4</b>	Sections 50, 100 & 120	Determination by the Tribunal following application by patient or named person to revoke a short-term detention certificate or a extension certificate ; or to revoke a section 114 or 115 certificate (as applicable to CTOs or COs); or to revoke or vary a CTO
<b>Transfers (Parts 7, 9, 12 and 18)</b>		
<b>TX 1</b>	Section 290	Cross-border transfer of a patient subject to civil or criminal justice proceedings

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<b>TX 2</b>	Sections 124, 178 & 218	Notification by hospital managers of the transfer within Scotland of a patient subject to a CTO, a compulsion order, a compulsion order and a restriction order, a hospital direction or a transfer for treatment direction
<b>TX 3</b>	Sections 125, 126, 178, 219 & 220	Appeal by patient against transfer within Scotland
<b>TX 4</b>	Section 290	Tribunal determination following an appeal by the patient or named person against a cross-border transfer under section 290
<b>Social Circumstances Report (Part 15)</b>		
<b>SCR 1</b>	Section 231	Social circumstances report
<b>Medical treatment (Part 16)</b>		
<b>T 1 (statutory)</b>	Sections 235, 236 & 245	Safeguards for treatment by: certain surgical operations
<b>T 2 (statutory)</b>	Sections 238, 240 & 276	Certificate of consent to treatment
<b>T 3 (statutory)</b>	Sections 239, 241, 245 & 276	Certificate of second opinion for patients refusing consent of incapable of consenting, and record of section 276 requirements
<b>T 4</b>	Section 243	Urgent medical treatment
<b>T 5</b>	Section 248	Certificate safeguarding treatment to inform patients under 16
<b>Excessive security (Part 17)</b>		
<b>EXS 1</b>	Sections 264 & 265	Detention in conditions of excessive security
<b>EXS 2</b>	Sections 265, 266, 269 & 270	Order under sections 265, 266, 269 or 270 of the Act
<b>EXS 3</b>	Sections 267 & 271	Application to recall under sections 267 (264 – 266) and 271 (268 – 270) of an order made by the Tribunal
<b>EXS 4</b>	Section 291	Record of appeal under section 291 of the Act in relation to an unlawful detention

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		<b>Nurse's holding power (Part 19)</b>
<b>NUR 1</b>	Section 299	Nurse's power to detain pending medical examination
		<b>Removal to a place of safety (Part 19)</b>
<b>POS 1</b>	Section 298	Police constable's report: removal to a place of safety
		<b>Warrants relating to the duty to enquire under section 33 (Part 4)</b>
<b>MHO 1 (statutory)</b>	Section 35(1)	Application for warrant to enter premises
<b>MHO 2 (statutory)</b>	Section 35(4)	Application for warrant to enable medical examination
<b>MHO 3 (statutory)</b>	Section 35(7)	Application for warrant for medical practitioner to have access to medical records
		<b>Warrants and Orders relating to entry detention and removal powers (Part 19)</b>
<b>MHO 4 (statutory)</b>	Section 292 (Civil and Criminal)	Application by an authorised person to enter premises for the purpose of taking/retaking a patient
<b>MHO 5 (statutory)</b>	Section 293	Application to the sheriff for a removal order
<b>MHO 6 (statutory)</b>	Section 294	Application to a justice of the peace for a removal order
<b>MHO 7 (statutory)</b>	Section 295	Application for a recall or variation of a removal order

From September 2005, all Non Statutory forms and Statutory forms may be found on the Scottish Executive's website at

[www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw)



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