SCOTTISH EXECUTIVE

HEALTH DEPARTMENT

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

SEPTEMBER 2005

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1. CHAPTER ONE – INTRODUCTION

1.1 This Memorandum gives guidance to those who are involved with the management and care of restricted patients; that is, patients who are subject to the special restrictions. Under the Mental Health (Care and Treatment)(Scotland) Act 2003, such patients cannot be granted suspension of detention from hospital, transferred between hospitals or returned to prison without the consent of Scottish Ministers. The explanations which this Memorandum gives and the procedures it describes should be closely noted and observed by all those involved in the care and management of restricted patients, both within hospitals and in the community. It is not, however, intended as a complete instruction document or an authoritative interpretation of the law.

1.2 Managers of restricted patients should also refer to other relevant literature (most notably the Mental Health (Care and Treatment) (Scotland) Act 2003, the Scottish Executive Health Department Code of Practice, the Mental Health Tribunal for Scotland Rules of Procedure, the Community Care guidance on care plans for people with mental illness, etc). The guidance assumes that use of the Care Programme Approach, (CPA) is standard practice for all patients who have required treatment in secure conditions and who now require continuing support to minimise the level of risk presented through their transfer to alternative care arrangements. The CPA care plan forms the template for discharge, through-care and aftercare arrangements and specifies individual and agency responsibilities. NHS Boards and their operating divisions, hospitals and local authority and other services must ensure satisfactory working procedures and communication between all relevant parties in relation to the patients concerned.

1.3 The 1999 policy statement on health, social work and related services for mentally disordered offenders in Scotland set out guidance for the organisation of safe care and accommodation, supported by joint working between all relevant agencies. The policy and principles are well understood by the Partnership Agencies. A care pathway document published in 2001 provided a planning and audit tool on which to base service re-design or measure progress towards overall objectives. The guidance promotes multi-agency and multi-disciplinary working to ensure services provide quality care and rehabilitation that responds to individual needs, under conditions of appropriate levels of security and with regard for public safety. Guidance published in 2000 on the management and reduction of risk in mental health care settings generally also highlights the factors to be taken into account when considering patient, staff and public safety and offers advice on a range of key issues and approaches including procedures to review critical incidents.

1.4 In addition, an amendment to the Management of Offenders Bill, scheduled to come into force in spring 2006, will establish joint arrangements between the police, local authorities and the Scottish Prison Service as responsible authorities to manage the risk from sex offenders and violent offenders and those offenders who continue to pose a risk to the community. Building on the arrangements in the Bill, an amendment was introduced at stage 2 of its progression through Parliament which provides also for the health service to become a responsible authority in the establishment of joint arrangements for the assessment and management of mentally disordered offenders who are also sex offenders and violent offenders. This will provides a robust statutory framework for ensuring that justice and health work in partnership in providing services to those deemed to pose a continuing risk to the public. Significantly, they will allow the Health Service to formalise the Care Programme Approach. The Forensic Network have agreed to take the development of revised care

programme guidance forward in a multi-disciplinary, multi-agency setting as part of their ongoing work.

1.5 The Memorandum sets outs the formal responsibilities of the Responsible Medical Officer (RMO), supervising psychiatrist and social worker in the care and management of restricted patients. **However, the Scottish Executive Health Department (SEHD), Psychiatric Adviser and SEHD officials are keen to encourage informal contacts with those caring for restricted patients in addition to these formal requirements. RMOs and others are, therefore, invited to telephone the Psychiatric Adviser or SEHD officials to discuss any particular issues relating to a patient on which they wish advice or guidance. Contact numbers are provided in Annex A1, page 73**

1.6 Restricted patients have been a part of the mental health system in Scotland for many years and hospitals caring for such patients will already have established procedures for their care and management. There are generally around 300 restricted patients in the system at any one time. Around half this number are detained in the State Hospital with the remainder detained in local psychiatric hospitals or living in the community on conditional discharge. However, despite the long history of the system, the SEHD urges all those concerned to pay close attention to the up-to-date guidance in this Memorandum, and advises NHS Boards and hospitals to review their internal procedures in relation to restricted patients to comply with the guidance set out in this paper.

1.7 The Mental Health (Scotland) Act 1984 gave the then Secretary of State particular powers in relation to restricted patients. Since the introduction of the Scotland Act 1998 these powers are the responsibility of Scottish Ministers. Some of these powers - including decisions relating to conditional or absolute discharge and lifting of restriction orders – have transferred, under the provisions of the 2003 Act, to the new Mental Health Tribunal for Scotland ("the Mental Health Tribunal").

1.8 This Memorandum indicates, therefore, that some decisions on restricted patients are taken by Scottish Ministers. Previously, the First Minister personally took decisions on restricted patients on behalf of Scottish Ministers although decisions may be taken by any Scottish Minister, if necessary. While legally all decisions on restricted patients are taken by Scottish Ministers there are procedures, whereby, Scottish Ministers may delegate this authority to appropriate officials.

1.9 Consultation is currently underway with Scottish Ministers about their roles in the decision making process and representation at Mental Health Tribunals. In the meantime the First Minister will continue to take decisions as previously with the exception of those decisions taken by the Mental Health Tribunal. This section will be updated in due course.

1.10 The First Minister generally delegates to officials all other decisions relating to the management of restricted patients. This may be subject to revision.

1.11 The SEHD Psychiatric Adviser provides advice to Scottish Ministers and officials on the course of action to pursue in relation to any decision on a restricted patient.

Role of the Mental Welfare Commission for Scotland

1.12 The Mental Welfare Commission for Scotland ("the Mental Welfare Commission") is an independent body working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. The Commission will give advice and guidance to patients and to service providers. They will arrange to visit people detained in hospital, including people subject to restriction orders. Whilst the Mental Welfare Commission cannot order the release of a restricted patient they can recommend to Scottish Ministers that a patient's case be referred to the Mental Health Tribunal for consideration. The new Act continues and extends the role of the Mental Welfare Commission. It gives the Commission a duty to monitor the operation of the Act and to promote best practice in its use. This includes promotion of the principles of the Act. The Commission have already indicated that there are some topics they will be looking closely at including care plans, compulsory treatment in the community and overridden advance statements. Further information is contained in the Mental Welfare Commission's booklets "Who we are and what we do" and "Monitoring your care and treatment".

Enquiries

1.13 Any enquiries on this Memorandum should be addressed to the Scottish Executive Health Department, Mental Health Division, Room 2N.08, St Andrew's House, Edinburgh, e-mail restrictedpatient@scotland.gsi.gov.uk.

2. CHAPTER TWO - ADMISSION TO HOSPITAL

How restricted patients are admitted to hospital

2.1 A patient becomes subject to special restrictions as a result of one of the following orders made under the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act"), as amended by the Mental Health (Care and Treatment)(Scotland) Act 2003 ("the 2003 Act"), or the 2003 Act itself. The orders are divided into pre and post-disposal for ease of reference: -

Pre-disposal

- An assessment order under section 52D of the 1995 Act - a pre-disposal order made by the court authorising hospital detention for up to 28 days so that the patient's mental condition may be assessed. Compulsory treatment may also be given in certain circumstances (see section 242(5) (b). The order may be renewed once only for 7 days.

- A treatment order under section 52M of the 1995 Act - a pre-disposal order made by the court authorising hospital detention for treatment of a person's mental disorder. The order ceases at the end of the period for which the person is on remand or is committed.

- An interim compulsion order under section 53 or 57(2)(bb) of the 1995 Act - a pre-disposal order made by the court authorising hospital detention for 12 weeks (but can be renewed regularly for up to one year) so that the court can gather further evidence on whether the forensic criteria apply.

Post-disposal

- An order under section 57(2) (a) and (b) of the 1995 Act. This may follow a finding of insanity in bar of trial or acquittal on the grounds of insanity. Where there is a finding of insanity in bar of trial, an examination of facts will determine **beyond reasonable doubt** whether the offence(s) in question took place.

- A restriction order made by the court under section 59 of the 1995 Act at the time of disposal and is added to a compulsion order under section 57A of that Act. It means that the measures specified in the compulsion order will be without limit of time.

- A hospital direction order made by the court under section 59A of the 1995 Act following a conviction on indictment under the 1995 Act. In addition to receiving a prison sentence, a hospital direction is made. It allows the person to be detained in hospital for treatment of their mental disorder and then transferred back to prison to complete their sentence once detention in hospital is no longer required.

- A transfer for treatment direction - an order made by Scottish Ministers under section 136 of the 2003 Act which allows the transfer of a prisoner to hospital for treatment of a mental disorder.

- Removal to Scotland from another part of the United Kingdom in any case where the patient has been subject to similar restrictions under the equivalent statutory provisions.

2.2 The following orders were available under the Criminal Procedure (Scotland) Act 1975 and the 1995 Act prior to the introduction of the 2003 Act. These will automatically transfer over to the corresponding provisions under the 1995 Act, as amended by the 2003 Act, at the point of its introduction:

- A restriction order under section 178 or 379 of the Criminal Procedure (Scotland) Act 1975 (the 1975 Act) made in addition to a hospital order under section 175 or 376 of that Act.

- An order under section 174 of the 1975 Act, following a finding of insanity in bar of trial or acquittal on grounds of insanity. In accordance with section 174(4) such an order has the effect of a hospital order together with a restriction order.

- An order made by the High Court on appeal, under section 254(4)(b) of the 1975 Act (which like a section 174 order and, by reason of section 254(5) of the 1975 Act, has the effect of a hospital order together with a restriction order).

- A restriction order under section 59 of the Criminal Procedure (Scotland) Act 1995 made in addition to a hospital order under section 58 of that Act. The Court may make a restriction order under section 59 if, having had regard to various considerations, it considers this necessary for the protection of the public from serious harm.

- An order under section 57(2)(a) and (b) of the 1995 Act. This may follow a finding of insanity in bar of trial or acquittal on the grounds of insanity. Where there is a finding of insanity in bar of trial, an examination of facts will determine **beyond reasonable doubt** whether the offence(s) in question took place.

- An order made by the High Court on appeal, under section 118(5)(b) of the 1995 Act (which like a section 57(2)(a) and (b) order has the effect of a hospital order together with a restriction order).

- A Hospital Direction order under section 59A of the 1995 Act following a conviction on indictment under the 1995 Act. In addition to receiving a prison sentence, a hospital direction with restriction direction is made. Section 62A(5) of the 1984 Act sets out the restriction applicable to a Hospital Direction.

2.3 The following orders made under the Mental Health (Scotland) Act 1984, prior to the introduction of the 2003 Act, will automatically transfer over to the corresponding provisions under the 2003 Act at the point of its introduction:

- Sections 71 and 72 - a transfer direction and restriction direction made by Scottish Ministers in respect of a person serving a sentence of imprisonment; and

- Removal to Scotland from another part of the United Kingdom in any case where the patient has been subject to similar restrictions under equivalent statutory provisions.

However, an order under section 70 - a transfer order in respect of an untried prisoner which has the effect of a hospital order and a restriction order – will continue to run to the end of that particular stage of the criminal justice process. However, any subsequent order made would be under the 2003 Act.

Order for Lifelong Restriction

2.4 Part 1 of the Criminal Justice (Scotland) Act 2003 provides for the establishment of the Risk Management Authority and, from 1 January 2006, for a new High Court disposal for high risk violent and sexual offenders, the Order for Lifelong Restriction (OLR). The OLR is designed to ensure that offenders are not released into the community until they have served an adequate period in custody to meet the requirements of punishment and thereafter do not present an unacceptable risk to public safety.

2.5 Where an offender with a mental disorder is convicted of a serious violent and sexual offence such that he meets both the criteria for the Court to impose an OLR and the criteria for a Compulsion Order, the High Court will have the choice between:

- a Compulsion Order and Restriction Order; or
- an Order for Lifelong Restriction and a Hospital Direction.

The deciding factor between these two would be whether the offender's risk is "directly or in significant part linked to a mental disorder likely to benefit from treatment" – if it is, then the mental health disposal would be more appropriate than the OLR.

Effect of Special Restrictions

2.6 A patient who is subject to special restrictions cannot be transferred or granted suspension of detention for specified occasions unless Scottish Ministers have given consent. Discharge of such a patient from hospital (whether conditional or absolute) or the lifting of a restriction order can only be authorised by the Mental Health Tribunal for Scotland ("the Mental Health Tribunal").

2.7 There are also times when the responsibilities of Scottish Ministers automatically come to an end on a particular date. These are:

- when a patient is subject to an assessment order or treatment order under section 52D and 52M or an interim compulsion order under sections 53 or 57(2)(bb) of the 1995 Act, as amended by the 2003 Act, once the case is finally disposed of by the Courts or proceedings dropped (unless a compulsion order and a restriction order are made);

- when a determinate or extended sentence prisoner who is also subject to a transfer for treatment direction or hospital direction is released on licence at their earliest date of liberation (EDL) or is granted early release on the recommendation of the Parole Board for Scotland;

- when an indeterminate sentence prisoner, who is subject to a transfer for treatment direction or hospital direction is released on life licence.

Patients detained under sections 52D, 52M, 53 and 57(2)(bb)

2.8 A person detained in custody whilst awaiting trial or sentence may be transferred to a hospital by order of the Court under sections 52D, 52M, 53 and 57(2)(bb) of the 2003 Act and thus become a restricted patient. Once that person's case is disposed of by the Court, or if proceedings are dropped, the temporary restricted patient status lapses, subject to the right of the Courts to make a compulsion order with or without a restriction order under the 1995 Act, as amended by the 2003 Act. The hospital authorities should include the SEHD in their notification system when any such patients are admitted to hospital and when their cases are disposed of by the Court (or proceedings are dropped). **The SEHD have put in place a protocol with Scottish Court Service (SCS) and will be notified by the courts of all new pre-disposal orders and any subsequent changes to their status**.

2.9 Where a section 52D, 52M, 53 or 57(2)(bb) patient has clearly recovered from their mental disorder in advance of their anticipated court appearance, it will be appropriate for the RMO to submit a report to the court who will decide whether or not it is appropriate to return the patient to custody or release them. Scottish Ministers have no statutory role in this process.

2.10 Under the 2003 Act, there is no longer any automatic provision for the continued detention in hospital of a patient subject to an order under sections 52D, 52M, 53 or 57(2)(bb) where the transfer order ceases to have effect because the proceedings have been dropped or the person has been acquitted. In such circumstances, civil detention procedures should, where necessary, be effected under sections 36, 44 or 63 of the 2003 Act.

Transfers from out with Scotland

2.11 Restricted patients may be accepted on transfer from countries with which there are reciprocal legislative arrangements i.e. England, Wales and Northern Ireland, as well as from other countries. The transfer might be on compassionate (such as family reasons) or on treatment grounds. Patients from Northern Ireland, who require care in conditions of special security which are not available presently in Northern Ireland, may be transferred to the State Hospital if the hospital agrees to accept these patients while they require such care. For all patients, the Scottish Executive Health Department (SEHD) must check that the patient is detainable under the legislation currently applying before arrangements can be made for the transfer.

2.12 Full details of the procedures to follow in respect of transfers are to be found in Chapter 8.

3. CHAPTER THREE – ROLES AND RESPONSIBILITIES OF SCOTTISH MINISTERS AND SCOTTISH EXECUTIVE PERSONNEL

Role of Scottish Ministers

3.1 The Mental Health (Scotland) Act 1984 gave the then Secretary of State particular duties in relation to restricted patients. Since the introduction of the Scotland Act 1998 these duties are the responsibility of Scottish Ministers and are normally carried out by the First Minister.

3.2 With the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003, the 1984 Act will be repealed and the responsibilities of Scottish Ministers will be significantly altered. However, the authority of Scottish Ministers will still be required at key points in the care of restricted patients:

- transfer between hospitals or to another hospital unit within a hospital (section 218);
- transfer between hospital and prison (section 210);
- cross border transfers (section 290);
- suspension of detention out with the hospital grounds (sections 221 and 224);
- variation of conditions of discharge (section 200(2)); and
- recall from conditional discharge (section 202).

3.3 In addition, Scottish Ministers will be responsible for making references or applications to the Mental Health Tribunal following:

- a recommendation from the Responsible Medical Officer (RMO) (sections 185 & 210);
- notice from the Mental Welfare Commission (sections 186 & 209);
- a period of not more than 2 years after the date of the patient's previous reference/application or the day on which the Compulsion Order/Restriction Order, hospital or transfer for treatment direction is made (sections 189 & 213); and
- as a result of their duty to keep Compulsion Order/Restriction Orders under review (section 188).

3.4 **All requests for consideration of any of the above should be directed to the Psychiatric Adviser, who will ensure that the appropriate action is taken.** On receiving a request from an RMO, Scottish Ministers will consider and give authority or refer the case to the Mental Health Tribunal for consideration as appropriate. **Scottish Ministers' primary aim is to provide for the protection of and security of the public**. The decision of Scottish Ministers will be relayed to the RMO by SEHD officials. Where they do not authorise any request the reason for this will be given.

3.5 It is important that RMOs allow sufficient time for such decisions to be considered. Every effort will be made to process requests timeously. RMOs can assist in this by ensuring that all relevant information is provided to the SEHD to enable Scottish Ministers or the Mental Health Tribunal to make the decision. It is very important that RMOs do not assume that a favourable decision will be given to any request and, in particular, do not raise a patient's expectations unrealistically.

Role of Officials in the Scottish Executive Health Department

3.6 The Scottish Executive Health Department (SEHD) undertakes the casework on restricted patients on behalf of Scottish Ministers. The SEHD role, like that of Scottish Ministers, is to ensure the protection of the public from serious harm in the management of restricted patients, as well as ensuring that the patients benefit from appropriate care and treatment. Risk assessment and management lie at the heart of the restricted patient casework carried out by officials in SEHD. The fuller the background information, the speedier the response officials are able to provide to recommendations for suspension of detention and transfer. Scottish Ministers need to be satisfied that any risk to the public has been properly identified and evaluated and that sound measures have been taken to guard against it. Further details on risk assessment are contained in Chapter 4, Chapter 5 and Annex B2.

3.7 Further information about the role of the Mental Health Tribunal and procedures for applications and referrals are contained in Chapter 9 and Annexes D & E.

3.8 Officials in the SEHD concerned with restricted patients are: -

- The SEHD Psychiatric Adviser, a psychiatrist who is responsible for liaison with the RMO and for advising Scottish Ministers and their administrative officials on clinical aspects in relation to restricted patients; and

- Officials in Mental Health Division of the SEHD who are responsible for administrative matters generally in relation to case work on restricted patients, and the preparation and submission of specific recommendations about a patient for consideration by Scottish Ministers or the Mental Health Tribunal.

Role of Psychiatric Adviser

3.9 The role of the Psychiatric Adviser is to provide advice to Scottish Ministers on restricted patients. The Psychiatric Adviser will visit and report on each restricted patient at appropriate intervals. These visits are likely to be around one year after admission and thereafter at intervals of between 6 months and 2 years depending on the patient and their rate of progress. In addition, the Psychiatric Adviser will normally visit the patient when the multidisciplinary team are considering transfer, discharge or lifting of a restriction order. This will ensure that advice and opinion provided to Scottish Ministers by the Psychiatric Adviser is based on up to date and first hand information. An RMO may ask the Psychiatric Adviser to visit their patient if they feel that they wish to discuss certain aspects of their care or rehabilitation.

3.10 When visiting a patient, the Psychiatric Adviser will normally discuss the patient and their progress with their RMO and members of the multidisciplinary team as well as, on occasion, reviewing relevant case notes. **When arranging a date to assess the patient it is important that this is organised on a date on which the RMO is available. Only in exceptional circumstances will the Psychiatric Adviser visit a patient when the RMO is not present**. **The RMO must be present when a change in the plan of care is being considered, i.e. transfer to a lesser degree of security or conditional or absolute discharge.** The Psychiatric Adviser will form a view on the patient's progress and care and prepare a report for the SEHD. A copy of this report will be sent to the RMO for information

(or the supervising psychiatrist and social work supervisor if the patient is on conditional discharge) and to the Mental Welfare Commission.

3.11 It should be noted that the role of the Psychiatric Adviser is to **advise** Scottish Ministers on restricted patients. Until the view of Scottish Ministers has been formally sought on any issue relating to a patient, the Psychiatric Adviser is not able to give a formal opinion on a patient's detainability, suitability for transfer, or other similar matters.

3.12 The Psychiatric Adviser is available to discuss any matters relating to Scottish Ministers' role in the management of restricted patients with an RMO if required. At certain points it may be helpful for the RMO to consider and evaluate with the Psychiatric Adviser the future options for the patient's care. The Psychiatric Adviser will not be able to give authority on behalf of Scottish Ministers or the Mental Health Tribunal to pursue any particular option but will be able to assist the RMO in considering the merits of each option, discuss how these might be taken forward and identify any difficulties or benefits there might be in pursuing a particular option. The Psychiatric Adviser will have a good sense of which cases are likely to give Scottish Ministers particular cause for concern and will be able to discuss with the RMO how such concerns might be effectively addressed.

3.13 In addition, it is often helpful if the Psychiatric Adviser, and/or members of the SE Health and Justice Departments, are invited to attend case meetings at significant points in a patient's care, for instance, at the initial consideration of transfer from the State Hospital, conditional discharge or planning for release on life licence of a life sentence prisoner. The procedures and information required in seeking approval can be explained and it may be possible to identify at this stage any particular concerns which Scottish Ministers would wish addressed. The shape of the plan for the next stages of the patient's care and rehabilitation can also be discussed.

3.14 All requests for suspension of detention, transfer, conditional or absolute discharge or lifting of a restriction order should continue to be directed to the Psychiatric Adviser who will consider and respond on behalf of Scottish Ministers where this is appropriate, e.g. suspension of detention. Where a request must be approved personally by Scottish Ministers or referred to the Mental Health Tribunal, the Psychiatric Adviser will ensure that the appropriate administrative procedures are initiated.

<u>Officials in the Mental Health Division of SEHD</u>

3.15 Officials in Mental Health Division of the SEHD are responsible for progressing the casework on restricted patients on behalf of Scottish Ministers. In order to do this, comprehensive records are maintained on each restricted patient to enable a full view of the patient's case to be taken at any time.

3.16 Officials are responsible for all the administrative work relating to restricted patients and are able to answer queries relating to procedures from professionals concerned with the care of such patients. They can indicate progress with any case and, in particular, provide information to the RMO on progress of any requests to Scottish Ministers for authority relating to a restricted patient. Officials can explain and expand on the guidance contained in this Memorandum and on mental health or criminal procedure legislation as it affects restricted patients. Where a recommendation for transfer is being considered, officials will keep the RMO informed of progress. Where an application or referral has been made to the

Mental Health Tribunal, the Tribunal Administration will ensure that all interested parties are kept informed of progress. Where legal advice is required and it is appropriate for this to be provided by the Scottish Executive, officials will obtain this from the Office of the Solicitor to the Scottish Executive (OSSE). However it should be noted that the final interpretation of the law is for the courts. The Central Legal Office (CLO) also provides legal advice to the NHS.

Officials in the Parole and Life Sentence Review Division of the Scottish Executive Justice Department and Officials of the Scottish Prison Service

3.17 These officials are responsible for the management of casework on prisoners and for presenting cases to the Parole Board for Scotland ("Parole Board"). Where a restricted patient is a life sentence prisoner, the Parole and Life Sentence Review Division (PLSRD) must be kept informed of the patient's progress in the mental health system. Officials of the SEHD will do this in liaison with the RMO. As reports on patients prepared by the RMO and Social Work Department may form part of the review dossier for referral to the Parole Board sitting as a Life Prisoner Tribunal, their permission will be sought before any such reports are sent to PLSRD. SEHD officials will keep the RMO informed of any relevant issues. Where a patient is a determinate or extended sentence prisoner with a parole qualifying date (PQD), PLSRD will contact the RMO and social worker in advance of the patient's PQD or other date on which a review for suitability of early release on licence is due. These reports should be sent to PLSRD and copied to the Psychiatric Adviser. The RMO will be notified whether or not the prisoner is successful in this application. Patients who are not released on their parole qualifying date will continue to be detained until their earliest date of liberation (EDL). See Annex I for contact details

Solicitors in the Office of the Solicitor to the Scottish Executive (OSSE) who advise Scottish Ministers and their Officials

3.18 The role of the Office of the Solicitor to the Scottish Executive (OSSE) is to provide legal advice to Scottish Ministers and officials including advice on all aspects relating to restricted patient cases. Such advice is not normally made public.

3.19 **Scottish Executive solicitors cannot give legal advice to RMOs, social workers or other mental health professionals. RMOs and other members of the care team should seek their own legal advice from Central Legal Office (CLO) or the appropriate local authority legal department.**

3.20 Solicitors will provide advice to officials on relevant legislation, on Scottish Ministers' statutory responsibilities and, where it is appropriate to do so, will represent Scottish Ministers at Mental Health Tribunal hearings and defend any appeals by restricted patients on behalf of Scottish Ministers.

4. CHAPTER FOUR - GUIDANCE WHILE IN HOSPITAL

4.1 This chapter deals with the role of the Responsible Medical Officer, the importance of detailed reporting, risk management and provides guidance on a range of other issues which may affect restricted patients while they are detained in hospital.

Role of the Responsible Medical Officer

4.2 The Responsible Medical Officer (RMO) has the primary responsibility for the patient's care and treatment. The RMO is responsible for planning this with due regard to public safety and ensuring that it is implemented within the confines of his responsibility for that patient and the legislative framework. The RMO must work in close co-operation with all others within the hospital involved with the care of the patient and with the Scottish Executive Health Department (SEHD).

4.3 SEHD would usually expect an RMO to be a Consultant Psychiatrist or Consultant Forensic Psychiatrist. However, we appreciate that in some circumstances, i.e. annual leave, it may be necessary for a Specialist Registrar (SpR) to act as RMO in the Consultant's absence. **In such cases, the Consultant or Medical Director must inform SEHD in writing prior to any period where an SpR will act as RMO.**

4.4 Paragraph 2.6 of this Memorandum sets out the effect of special restrictions on a patient to whom these apply and outlines the responsibilities of Scottish Ministers and the Mental Health Tribunal, under the 2003 Act, in relation to that patient's care. It is the responsibility of the RMO to recommend to the Psychiatric Adviser any action to be considered by Scottish Ministers or the Mental Health Tribunal.

4.5 The RMO must ensure, in consultation with other relevant parties within the hospital, that any incidents or other unusual issues relating to the patient are reported to the SEHD immediately, and that the notifications and routine reports mentioned in the following paragraphs are submitted timeously. More detail on this is contained in Chapter 6.

RMO reports on restricted patients

4.6 Under sections 182(2) and 183(2) of the 2003 Act for compulsion order/restriction order patients, and section 206(2) and 207(2) for those patients subject to a transfer for treatment direction or hospital direction, the RMO must, in the 2 month period ending with the anniversary of the date on which the order was made, examine and report on the patient to Scottish Ministers. The report must contain the information outlined in section 183(3) or sections 206(3) and 207(3) of the 2003 Act, in addition to any particulars which Scottish Ministers may require (see Annex B1, Page 77 for guidance). **These reports should be accompanied by completed form CORO1 or HD1 (see Annex J, page 111, for details)**. While the RMO should involve other medical staff in his care team in preparation of any reports, the RMO must take responsibility for all reports to the SEHD on a restricted patient. **Reports not prepared by the RMO must be countersigned by the RMO to indicate agreement with the opinion given.**

Admission report

4.7 Scottish Ministers require a report to be provided on each patient admitted to hospital (whether from court or on transfer from prison or another hospital) within 3 months of admission and annually thereafter (from the date of admission as a restricted patient). A copy of the Part 9 Care Plan should accompany this report and any subsequent annual report. For restricted patients admitted to the State Hospital, an admission history is routinely provided after the patient has been in hospital for 6 weeks. This may form part of the patient's 3-monthly report following admission, provided that there is a brief update on the patient's current mental state.

State Hospital intermediate and annual review reports

4.8 While there is no statutory requirement for such reports to be provided to Scottish Ministers, it is considered good practice for an RMO to copy these reports, as they relate to restricted patients, to the Psychiatric Adviser.

Annual reports

4.9 Scottish Ministers require that RMOs should prepare and submit a report on each restricted patient annually **on the anniversary of the date they received their hospital disposal or were admitted to hospital under a transfer for treatment direction**. The SEHD will issue a letter asking the RMO for an annual report on the appointed date. The report must be signed by the patient's RMO. In preparing reports, the RMO is expected to take into account the views of the multidisciplinary team caring for the patient, and in particular the views of the mental health officer. **The annual report should be accompanied by form CORO1 for those patients on a compulsion order and restriction order or form HD1 for those patients subject to a hospital direction or transfer for treatment direction.**

Content of reports

4.10 Each report (admission, 3 month, annual), in addition to providing background information on the patient at this stage, must provide the RMO's opinion of the patient's current mental state and detainability under the mental health legislation at the time of making the report. (Psychiatrists will be familiar with these tests as they are the admission criteria set out in section 182(3)(b) of the 2003 Act.) **Each report must also contain the patient's CHI number.** For further details of the information to include in the report please see the guidance offered in paragraph 4.6.

Guidance on reporting on patient's mental state and detainability

4.11 Section 182(3)(b) and (4) and section 183 of the 2003 Act outline the factors an RMO must take into account when assessing the continuing liability to detention of any patient subject to a compulsion order and restriction order.

4.12 The RMO must provide their present diagnosis for the patient including whether they consider that the patient suffers from a mental disorder. In the 2003 Act, mental disorder is defined as:

- mental illness;
- personality disorder; or
- learning disability

4.13 When preparing a report to Scottish Ministers, the RMO must meet the requirements of section 182(3) of the 2003 Act. Those requirements are to carry out a medical examination of the patient or to arrange for an approved medical practitioner to carry out an examination, and to consult with the mental health officer. When carrying out the examination, the RMO has to consider whether the conditions mentioned in section 182(4) of the 2003 Act continue to apply. These conditions are:

(a) that the patient has a mental disorder;

(b) that medical treatment which would be likely to –
(i) prevent the mental disorder worsening; or
(ii) alleviate any of the symptoms or effects of the disorder,
is available for the patient; and

(c) that if the patient were not provided with such medical treatment there would be a significant risk –
(i) to the health, safety and welfare of the patient; or
(ii) to the safety of any other person.

4.14 The RMO must then go on to consider –

(i) whether, as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment;

(ii) whether it continues to be necessary for the patient to be subject to the compulsion order; and

(iii) whether it continues to be necessary for the patient to be subject to the restriction order.

4.15 When considering "serious harm" it is relevant to consider the environment into which the patient might be transferred. This will involve an assessment of the likelihood of the patient re-offending and the likely nature of any such re-offending. This should be informed, where appropriate, by a full multidisciplinary assessment of potential risks. The RMO should take into account all relevant circumstances, including the patient's past history. Different considerations may apply depending on whether he is being released into the community or back to prison.

4.16 If the patient is a transferred prisoner the RMO should also consider whether the patient should be returned to prison establishment. Scottish Ministers are not required to transfer back to prison anyone who is suffering from a mental disorder, where the effect of

such is that it is necessary to protect the public from serious harm that the patient remain in hospital.

4.17 Provision of these reports is the main route through which the SEHD obtains current information on a restricted patient. It is therefore important that the RMO ensures that all relevant information on the patient is provided. This should include any information which might provide further background detail on a patient which was not previously available or has become clearer or more detailed with time. The RMO may at any time provide information to SEHD on a patient and must in any case provide reports on any serious incidents which affect a patient at the time of their occurrence. (See Chapter 6).

4.18 If, in the interval between annual reports, the RMO considers that the patient's mental condition has changed in such a way that Scottish Ministers should be informed, they should take the initiative in making any additional report or recommendation which they consider appropriate. In assessing proposals regarding restricted patients, the SEHD looks for evidence of both appropriate risk assessment and effective risk management. See paragraphs 4.20 to 4.22, Chapter 5 and Annex B2, page 79 for further information on risk assessment. This will enable Scottish Ministers to consider what action, if any, needs to be taken in the light of the RMO's current view on the patient.

4.19 Any other unusual factor, for example, if the hospital receives information about any form of application to the Mental Health Tribunal, appeal to the Courts or further charges brought against the patient, should be notified at once to the SEHD.

Risk Assessment

4.20 The annual reports to Scottish Ministers represent the basic information which the RMO is required by the legislation to provide to Ministers on a restricted patient. However, in order to manage the patient's case and to give approval for suspension of detention, transfers, etc, it is very helpful if the SEHD is able to build up fuller details of the patient and to be kept updated on their progress in hospital.

4.21 Scottish Ministers' principal aims are to provide for the protection and security of the public and to secure individuals' rights and freedoms under the law. Ministers are therefore responsible for ensuring that risk to the public is taken into account fully in all decisions which involve a restricted patient. In order to do this, considerable detail is required about the patient, including both present circumstances and history. Officials in SEHD welcome risk assessments prepared using standardised clinical risk assessment tools such as HCR-20 or RAMAS but recognise that these tools are not always available. In such circumstances SEHD are happy to accept the information listed at **Annex B2, Page 78**, as part of a systemic approach to risk assessment**.** It should be recognised that the risk that a patient may present can vary over time and with the patient's condition. The SEHD will reassess the risk that a patient might present at appropriate points and, in particular, before giving approval for any suspension of detention or transfer. It would, therefore, be appropriate for the RMO to provide full, multidisciplinary risk assessment information to the SEHD at significant points in a patient's care.

4.22 When the RMO provides additional information, this ensures that the SEHD is fully aware of all relevant issues and allows the development of a full picture of the patient. This in turn assists the management of the case. In particular, it can help ensure that when

requests, such as for suspension of detention, are made by the RMO, the SEHD has readily available most, if not all, of the necessary information required to enable it to make a decision. If the Department needs to seek additional information from the RMO before making a decision, this inevitably leads to delay in approving the request and might, on occasion, mean that the outing has to be postponed until the necessary information has been obtained and assessed.

4.23 While it is for the RMO to consider how to provide this information, in the past the SEHD has found the following reports useful in maintaining current records on the patient and informing decisions:

- periodic nursing reviews;
- periodic security reviews (for State Hospital patients);
- other reports by professionals the patient comes into contact with in the hospital, such as occupational therapy;
- psychology reports;
- care plan objectives and suspension of detention programmes
- social work reports on patient and family and other contacts*; and
- victim factors.

(* It should be noted that where a patient is visiting the home of a relative or friend for the first time, a social work report will be required prior to the visit being authorised.)

Drug and alcohol misuse while in hospital

4.24 In the case of many restricted patients, their mental illness may be adversely affected by drug and alcohol misuse and in some cases may have led, albeit indirectly, to their admission to hospital. Misuse of alcohol and/or drugs either while in hospital or while on suspension of detention can have a detrimental effect on a patient's rehabilitation and can increase the risks to staff and other patients within the hospital. The RMO should ensure that all incidents of this type are reported to the Psychiatric Adviser along with details of the action taken. Circular NHS HDL (2002) 41 provides guidance on safe care approaches for staff, patients and visitors and on the management of those with a drug misuse or alcohol problem in mental health care settings.

Marriage

4.25 Scottish Ministers have no specific power to agree to or withhold permission for restricted patients to marry. In terms of the Marriage (Scotland) Act 1977 the Registrar is required to consider any objections to a marriage under section 5 of the 1977 Act and if satisfied that the objections are valid, the marriage cannot proceed. One of the grounds forming a legal impediment to a marriage is set out at section 5(4)(d) and states that "one or both of the parties is or are incapable of understanding the nature of a marriage ceremony or of consenting to marriage".

4.26 While ultimately it is for the Registrar to satisfy himself on this point, there is an onus on Scottish Ministers if they have any doubts that this condition is satisfied to communicate these to the Registrar in writing as required in the Act. It is, therefore, important that we are informed of any impending marriage plans to allow the Psychiatric Adviser and the RMO to provide their view on whether consent and understanding is likely to be clearly there. The

fact that the patients are detainable in terms of the 2003 Act does not necessarily mean they are incapable of understanding the nature of marriage or of giving appropriate consent.

4.27 In the case of a marriage ceremony within a hospital, it will be for the managers of that hospital to consider whether this is appropriate. In the case of a marriage ceremony out with the hospital, Scottish Ministers' consent will be required for suspension of detention for inpatients.

Withholding correspondence

4.28 Section 281 of the 2003 Act sets out the statutory powers of hospital managers in withholding mail. Mail may be withheld:

> (a) if the addressee has requested that communications addressed to him by the patient should be withheld; or
> (b) if the managers of the hospital consider that the correspondence is likely –
> (i) to cause distress to the person in question or any other person who is not on the staff of the hospital; or
> (ii) to cause danger to any person.

Any request for the purposes of paragraph (a) of this subsection requires to be made by a notice in writing to the managers of the hospital, the RMO or Scottish Ministers. This provision applies to all patients detained in hospital. Sections 281 to 283 of the 2003 Act set out further information about when the power to withhold mail does not apply, when managers of the hospital may open and inspect any postal package, the functions of the managers of the hospital and the duty to notify the Mental Welfare Commission.

Requests from the media to interview restricted patients

4.29 The decision on whether it is appropriate for a restricted patient to be interviewed by the media rests with the RMO and the managers of the hospital. The RMO will have to consider whether it is clinically appropriate for the patient to take part in the programme and address the questions of the patient's competency and appropriateness of the interview. RMOs should clearly record their reasons for their conclusions and a copy of this should be sent to the SEHD.

5. CHAPTER FIVE - SUSPENSION OF DETENTION

5.1 Under the Mental Health (Care and Treatment) (Scotland) Act 2003, Responsible Medical Officers (RMOs) need Scottish Ministers' consent before granting suspension of detention from hospital to detained restricted patients. **The primary role of the Scottish Executive in the management of restricted patients is to protect the public from serious harm.**

5.2 This chapter sets out to RMOs in medium secure units and other psychiatric hospitals, the framework for making a request to the Scottish Executive Health Department (SEHD) for suspension of detention for restricted patients which, from 5 October 2005, includes all remand and pre-disposal cases (with the exception of S200). The State Hospital will continue with their current system but adopting the principles contained in this guidance. The guidance **introduces new arrangements for rehabilitation leave and standard forms of reporting.**

5.3 The changes centre on:

- The new procedures set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) relating to suspension of detention;

- A requirement to report back to the Scottish Executive not later than 3 months after consent to suspension of detention using a standard form (Annex B4, Page 85) and thereafter using the standard form as part of the annual statutory report.

- A new standard form to be used by RMOs or Scottish Ministers when a suspension of detention certificate has been issued by the patient's RMO or revoked by the RMO or Scottish Ministers (SUS3, see paragraphs 5.19 and 5.30 and Annex J, Page 111 for details).

5.4 This guidance sets out the Scottish Executive's requirement for information needed in support of individual applications and the key points about risk assessment which must be taken into account.

Legislation

5.5 Section 224 of the 2003 Act sets out procedures for the suspension of detention, previously called "leave of absence", for patients who are on a compulsion order with a restriction order, a hospital direction, a transfer for treatment direction or any of the pre-disposal orders (with the exception of S200). Where a patient is subject to any of these orders, the RMO may grant a suspension of detention certificate for up to 3 months* (apart from for an assessment order which only lasts 28 days) provided that:

- **they have obtained the consent of the Scottish Ministers; and**
- **it does not take the total period of suspension granted over 9 months in any 12 month period.**

*Approval for suspension of detention for up to 3 months would only be granted in exceptional circumstances, and any requests should be discussed with the Psychiatric Adviser

before being submitted to Scottish Ministers. The expectation is that the current good practice of gradually building up suspension of detention to 4 overnights and 5 days will continue with the prospect of the leave being further extended in exceptional circumstances.

Reasons for suspension of detention of patients

5.6 Scottish Ministers recognise that well thought-out suspension of detention, which serves a definable purpose and is carefully and sensitively executed, has an important part to play in the treatment and rehabilitation of restricted patients by assessing risk and assisting their progress towards eventual discharge into the community. It also provides valuable information to help RMOs and Scottish Ministers in determining when, and under what conditions, moves within the hospital system can safely be made, and to all parties, including the Mental Health Tribunal, when considering discharge into the community. It is important that suspension of detention programmes should be designed and conducted in such a way as to sustain public confidence in the arrangements as a whole, and to respect the feelings and possible fears of victims and others who may have been affected by the offences.

5.7 In general, the SEHD will consider suspension of detention requests for the following purposes:

- rehabilitation including pre-transfer visits to another hospital;
- quality of life;
- compassionate visits;
- scheduled treatment in hospital;
- emergency treatment in hospital;
- attendance at Court in relation to criminal proceedings; and
- attendance at Court in relation to civil proceedings – but see paragraph 5.25 below.

Applications for suspension of detention

5.8 **Annex B3** (Page 80) sets out the format for making a request for the Scottish Ministers' consent to suspension of detention for the purpose of rehabilitation or quality of life. **The RMO should address the suspension of detention request to the SEHD Psychiatric Adviser using this proforma.** Other, "one off" requests should be made by letter or fax or, in the case of the State Hospital, on their approved outing form. Once suspension of detention has been approved by Scottish Ministers, the RMO must complete a certificate granting the patient permission for each individual suspension of detention. This should be done using form **SUS3**, see paragraph 5.19 and Annex J, Page 111 for details.

5.9 When applying for permission to grant a suspension of detention certificate, the RMO should draw on best practice in order to report to the Scottish Ministers details about risk assessment and risk management and provide a satisfactory plan. **Annex B2 provides a useful checklist of some of the risk factors which should be considered.** In addition, RMOs will also need to consider all other risk factors which apply individually to the patient. Suspension of detention for rehabilitation or quality of life reasons should relate to an overall care and treatment programme and set personal objectives for the patient. The request to the Psychiatric Adviser should explain the part this will play in the overall plan.

5.10 Each request for suspension of detention is considered on its merits by the SEHD having regard to all relevant factors. When making a request the RMO should provide details of the following:

- an assessment of any risk of harm to the public arising from the proposal, and the nature and adequacy of safeguards against any specific identified risk;
- the patient's current mental state;
- the purpose of the suspension of detention; whether for rehabilitation, quality of life etc, the arrangements for escorting the patient, where necessary;
- destination, duration and frequency of event(s);
- aims of the proposal and what part the individual events will play in the overall care and treatment plan, including any personal objectives for the patient;
- the contribution which the suspension of detention is expected to make to future assessments of the patient's likely behaviour, and to plans for managing the patient's future rehabilitation;
- any conditions considered necessary by the RMO, such as safeguards against any specific identified risk of harm to the patient or the public arising from the proposal, such as the patient being kept in the charge of an authorised person or the risk of absconding;
- any reasonable public concerns which the suspension of detention would be likely to arouse, and any measures proposed in response to such concerns; and
- proposed measures in response to any concerns which have been expressed or are likely to be expressed by victims of the offences committed by the patient, or by anyone who, on account of their relationship with the patient, may have reasonable cause to be concerned about the patient's presence in the community;
- whether any children will be present at the location to be visited and, if so, any special arrangements required to protect them;
- any social work or other reports prepared in relation to the planned suspension of detention (particularly where it is a first visit to the home of family or friends); and
- the monitoring and reporting arrangements, whether by escorting staff, the patient's own report or both.

5.11 Where a patient is being escorted to court by the police/Reliance, permission is still required from the SEHD.

5.12 Permission for suspension of detention **from the State Hospital** is sought by submitting an appropriately completed "Patient Outing Application Form" to the Psychiatric Adviser. Each application should inform whether the use of handcuffs has been considered necessary and, if so, the reasons for this and the arrangements for their use.

Information to support requests

5.13 It is helpful if the SEHD has an opportunity to identify any potential concerns and resolve these with the RMO in good time before any suspension of detention. Where the suspension of detention is the first the patient has received for some time, is an unusual request or for a special occasion, it is helpful if the RMO informs the SEHD when the initial discussion on the suspension of detention takes place between the multidisciplinary team. Where consideration is being given to a patient being allowed compassionate or rehabilitation suspension of detention for the first time to the home of family members or friends, the SEHD will need to be reassured that all relevant matters have been identified and taken into account in planning the suspension of detention. **A social work report on the location to be visited will be required to inform consideration of the request for a first home visit.**

Series of events

5.14 Where it is intended that the patient makes a series of similar events over a known time span (such as a series of hospital appointments, pre-transfer visits, rehabilitation programme including, for instance, attendance at college), a single detailed request may be submitted for the planned suspension of detention. The RMO should make clear the escort arrangements, if appropriate, and whether there are plans to vary the arrangements over time. Agreement would generally be granted to such arrangements, although each suspension of detention would be subject to the patient's mental state being stable on the day. It would be the RMO's responsibility to ensure this and to notify the SEHD of any changes. If the proposal is for a phased programme of rehabilitation which would develop according to the patient's reactions, mental state and behaviour, the proposal should be set out in full.

Requests for unescorted suspension of detention

5.15 For patients whose rehabilitation is well advanced, it is helpful to the RMO and the SEHD to provide a full plan of all the proposed programme. Any planned increases in these freedoms over time should be detailed with the timing and reasons for these. Where appropriate, the SEHD will give approval for the series of events for a patient. Any changes in the circumstances involving a patient should be made known to the SEHD immediately.

Requests for unescorted suspension of detention for patients on remand or pre-disposal orders (with the exception of S200)

5.16 An accused person who is detained in hospital while awaiting trial should be subject, at least initially, to a high level of supervision. The patient should not be allowed to leave the ward or place of supervised occupation without an escort. In some cases this level of supervision will require to be maintained throughout the remanded person's stay in hospital. In other cases, where, for example, the previous history of the accused is well known, or where his mental condition improves, the psychiatrist may think it appropriate to allow some relaxation in supervision. All escorted and unescorted leave is now subject to the suspension of detention procedures under the 2003 Act and SEHD will require to be consulted, using the appropriate forms, in all cases. SEHD will consult with the Procurator Fiscal in all requests for suspension of detention (except urgent clinical or court requests) to ensure that Scottish Ministers have all the relevant information to hand in considering such requests.

Timing of Requests

5.17 As a general rule, the longer or more unusual the freedoms sought, then the more advance notice the SEHD requires to consider the request. The RMO should not make final arrangements for the suspension of detention to take place until Scottish Ministers' consent has been received. Care should also be taken not to raise the patient's expectations.

5.18 Consideration of requests takes some time. **It is important that, where possible, the SEHD is given at least three weeks notice of a request for suspension of detention.** It is appreciated that it is very upsetting for a patient (and where involved, the patient's family) when a suspension of detention planned by the multidisciplinary team is not approved by the SEHD due to lack of time for full consideration of the request. However, Scottish Ministers' responsibilities require that proper consideration is given to each suspension of detention request, that any risk to the public has been properly identified and evaluated, and that sound measures have been taken to guard against it. Late requests, and those where insufficient information on which to base a decision has been provided, must, therefore, be refused.

Suspension of detention certificates

5.19 After receiving the approval of Scottish Ministers, the patient's RMO may grant a certificate specifying the period during which the relevant order does not authorise the patient's detention in hospital, and any conditions attached to the suspension of detention (**form SUS3**). When the RMO proposes to grant a certificate specifying:

- a period of more than 28 days; or
- a period which, when taken together with the period specified in any other certificate granted during the last 12 months, would exceed 28 days

the RMO must, before granting the certificate, give notice of the proposal to:

- the patient;
- the patient's named person;
- the patient's general practitioner and the Mental Health Officer; and
- when granting a certificate for more than 28 days the RMO must also, before the expiry of the period of 14 days beginning with the day on which the certificate is granted, give notice of the granting of the certificate to the Mental Welfare Commission for Scotland.

Risk assessment preceding approved suspension of detention and reporting on suspension of detention

5.20 It will be important that each occasion of suspension of detention is preceded by a careful risk assessment by the RMO or someone nominated by him/her who knows the patient well. If there are any doubts that the suspension of detention should take place, it should be stopped. A change in risk could have arisen from, for example, a change or cessation of medication; self-harming; the involvement of the patient in an incident in the hospital; abuse of substances; or the added stress of bad news from outside or from another stressful occasion. The RMO should also inform the SEHD should any change occur which affects the basis on which the Scottish Ministers' consent has been given for a suspension of detention. **Escorted and unescorted suspension of detention which has been approved at**

the RMOs discretion should be reported back to the SEHD no later than 3 months after receiving the consent of the Scottish Ministers. The standard form for the reporting on suspension of detention is at **Annex B4, Page 85**. Thereafter use of the standard form should form part of the annual statutory report.

Suspension of detention for compassionate reasons

5.21 Suspension of detention for compassionate reasons will be given serious consideration by the SEHD. It should be noted that such a request is more likely to be considered acceptable if efforts have been made to ensure a low profile, particularly, for example, where the media are already aware of the patient's background. Extending this example, visits to a sick relative in hospital are more likely to be acceptable if efforts are made to arrange this out with normal visiting hours. In cases where the risk is considered to be relatively high, efforts to secure a separate room for the visit would also be appropriate.

5.22 Where a patient's relative has died and the patient requests permission to attend the funeral, consideration should be given to the impact this might have on other family members, the victim and their family, and the general public in the area. In some cases an alternative may be for the patient to visit the funeral parlour or family home the evening prior to the funeral to view the deceased in the company of close family members.

Suspension of detention for cases of emergency

5.23 Telephone requests by the patient's RMO or the duty RMO may be made in compassionate or emergency circumstances which necessitate urgent suspension of detention (for example, to a hospital for treatment of a serious physical ailment). In these cases, the RMO or duty RMO must contact the Psychiatric Adviser or a SEHD official to obtain the necessary approval. **The Psychiatric Adviser and officials may be contacted at any time including out of office hours – see Annex A1 (Page 73) for contact details.** Where permission is not obtained in advance of urgent leave (such as an emergency visit to hospital), a telephone report must be made to the SEHD by the RMO as soon as possible thereafter, followed by a formal report including details of why prior contact was not possible.

Court/Tribunal appearances

5.24 Where a patient is being charged in a criminal court then they are entitled to be at court for their trial. A request for suspension of detention as detailed at paragraphs 5.8 to 5.18 should be submitted to the Psychiatric Adviser and will normally be approved, subject to consultation with the Procurator Fiscal in cases where patients are subject to remand or pre-disposal orders. If the RMO considers that the patient is not sufficiently well enough to attend court, the RMO should inform the court of this.

5.25 Where the patient is involved in a civil court case, different considerations apply. Where the case involves a civil matter, such as reparation, there is no entitlement for the patient to be present in court. Where the patient wishes to attend and the RMO considers this appropriate, an application for suspension of detention would need to be made.

5.26 Where the case involves an appeal to the Mental Health Tribunal, the patient would be allowed to attend subject to: the health provisions outlined in rule 55(1) of the Rules of

Procedure; or where excluded from all, or part, of the hearing by virtue of rules 68(1) or 69(1) of the Rules of Procedure. Where the hearing is taking place out with the hospital, a request must be made for suspension of detention.

Suspension of detention for life sentence prisoners

5.27 Scottish Ministers personally approve all requests for suspension of detention for life sentence prisoners. It is, therefore, helpful to draw up a programme of freedoms for a period of time for which approval can be sought in advance - one-off requests for life sentence prisoners are not helpful. Prior to submitting a request, it is often helpful for the clinical team at the hospital, the Psychiatric Adviser and SE Health and Justice Department officials to meet when rehabilitation has progressed to unescorted suspension of detention. This ensures that all the relevant parties are informed at the appropriate stage about a provisional timescale in relation to possible release on life licence.

Suspension of detention for sex offenders

5.28 Section 96 of the Sexual Offences Act 2003 provides a power to make regulations requiring those who are responsible for an offender while they are in detention to notify other relevant authorities of their release or transfer to another institution. The new regulations will come into force towards the end of 2005 or beginning of 2006 and will bring into force a number of changes affecting the registration requirements of those who are required to register under the 2003 Act. The main changes affecting mentally disordered offenders is the requirement on hospital managers to inform the police when a patient is transferred to another hospital, discharged from hospital and in cases where the patient is to be released from detention for a period of 3 days or more. Guidance on the operation of the regulations will be issued as soon as practicable following the regulations coming into force.

Patients on conditional discharge

5.29 Requests for suspension of detention for patients on conditional discharge within the United Kingdom are not normally required. However, where a patient wishes to go abroad, the SEHD must be consulted in advance as there are legislative implications for a patient on conditional discharge in another jurisdiction. It is worth noting, however, that requests for permission to go abroad are not normally considered until a patient has been on conditional discharge for at least one year. Further information on the supervision of conditionally discharged patients is contained in Annexes F (Page 91) and G. (Page 100).

Revocation of a certificate authorising suspension of detention by the RMO

5.30 A suspension of detention certificate can be revoked by the patient's RMO (under section 225 of the 2003 Act) if the RMO is satisfied that it is necessary to do so in the interests of the patient or for the protection of any other person. **Revocation of a suspension of detention certificate (using form SUS3) authorises the immediate conveyance of the patient back to hospital by the staff of the hospital and/or the police**. As soon as is practicable after the revocation of the certificate the RMO must notify:

- the patient;
- the patient's named person;

- the patient's general practitioner (where the certificate specified a period of more than 28 days);
- the Mental Welfare Commission (within 14 days of the revocation of the certificate);
- where a person is being kept in charge of a person authorised in writing by the RMO, that person;
- the mental health officer, and
- the Scottish Ministers (**copy of form SUS3**).

5.31 The RMO must also make the SEHD aware if any suspension of detention is terminated or if an incident has taken place during the suspension of detention. When an event has been cancelled the reasons for this should be made known and whether it is planned that the event will take place at a later date.

Revocation of a certificate authorising suspension of detention by Scottish Ministers

5.32 A suspension of detention certificate can also be revoked by Scottish Ministers (under section 226 of the 2003 Act) if they are satisfied that it is necessary to do so in the interests of the patient or for the protection of another person. **Revocation of a suspension of detention certificate by Scottish Ministers (using form SUS3) authorises the immediate conveyance of the patient back to hospital by the staff of the hospital and/or the police**. As soon as is practicable after the revocation of the certificate the Scottish Ministers must notify:

- the patient;
- the patient's named person;
- the patient's RMO;
- the patient's general practitioner (where the certificate specified a period of more than 28 days);
- the Mental Welfare Commission (within 14 days of the revocation of the certificate);
- the mental health officer, and
- where a person is being kept in charge of a person authorised in writing by the RMO that person.

Absconding while on suspension of detention

5.33 A patient will be treated as having absconded (and so is liable to be taken into custody) if he absconds from the charge of an authorised person in terms of section 224(7)(a) whilst out on a period of suspension of detention. **In these circumstances, the suspension of detention certificate will not require to be revoked for the accompanying nurse to have the power to return the patient to hospital.** Any abscond must be reported to SEHD officials immediately; see Chapter 6 for further guidance.

Suspension of detention following transfer

5.34 A consent to escorted or unescorted suspension of detention does not move with the patient if they are subsequently transferred. A new application for suspension of detention should be submitted by the RMO together with a new risk assessment reflecting the changed circumstances.

6. CHAPTER SIX - NOTIFICATION OF INCIDENTS

Notification of incidents

6.1 While the RMO has primary responsibility for the patient's care and treatment, Scottish Ministers have specific responsibilities in relation to restricted patients and officials must, therefore, be advised of all serious incidents involving restricted patients. Scottish Executive Health Department (SEHD) officials are responsible for responding to any media interest in incidents relating to restricted patients and must be able to brief Ministers, if necessary. It is also essential that officials are informed about any serious incident involving a restricted patient to ensure that Scottish Ministers have a full and up to date record of each restricted patient. **It is the RMO's responsibility to report all such incidents to the Scottish Executive and the Mental Welfare Commission. A checklist of information required when reporting an incident is attached at Annex A2, Page 74.**

Definition of serious incident

6.2 A serious incident involving a patient can be defined as one which:

- results in serious injury or death to the patient or to another person involved in the incident;
- requires a formal critical incident review by the hospital management (whether internal or external) as result of a disturbance or other event occurring;
- results in serious damage to the unit;

or involves:

- concerted indiscipline by a number of patients involving violence;
- the use of seclusion;
- the taking of a person hostage;
- making a protest in a public place, for example, following unauthorised access to a rooftop;
- escapes from the hospital building;
- absconds while on suspension of detention (escorted or unescorted) out with the hospital building.

6.3 A serious injury can be defined as any which results in:

- injury to the patient or another person requiring treatment in hospital; or
- any of the following injuries whether or not hospitalisation is required:
  - fractures;
  - concussion;
  - internal injuries;
  - crushing;
  - severe cuts or lacerations;
  - severe bruising, scalds or burns; or
  - severe shock requiring medical treatment.

The aim where any restricted patient absconds or escapes is to ensure that the patient is found and returned to the hospital as soon as possible with no violence being perpetrated. Where an incident occurs within the hospital, it should be resolved with minimum force necessary, to prevent injury to the patient and others wherever possible.

6.4 It must be recognised that there will be occasions when an incident has the potential to result in media interest. In the event of a serious incident involving a restricted patient, arrangements for providing the media (including the radio and television companies) with information about the incident must be handled sensitively.

6.5 The Scottish Executive Press Office will co-ordinate all media liaison about incidents involving restricted patients. However, arrangements can be made for a Trust's Public Relations staff to be authorised to carry out this function in liaison with the Scottish Executive **(**see paragraph 6.17).

Who to notify in event of an incident

6.6 The hospital authorities must advise the police immediately of an escape, serious assault, abscond or other significant incident involving a restricted patient. Immediately thereafter, the hospital should make a telephone report to the SEHD as set out in the Notification of Incidents Circular issued by The Scottish Executive Health Department (**see Annex A1, Page 73**). **The circular provides out of hours' telephone and pager numbers for SEHD officials which should be used to contact officials between the hours of 5pm and 8.30am and on weekends and on public holidays**. Where, exceptionally, no contact can be made with an official, a message may be left with the Security Guards at the Scottish Executive, Victoria Quay (by dialling the main Scottish Executive phone number – 0131 556 8400). Security will relay the message to an official as soon as possible. Please note that **on no account** should patient details be left as part of such a message.

6.7 The SEHD official will contact the Press Office (Health Desk during office hours, Duty Press Officer out of hours) who will, where appropriate, contact the Crown Office and a decision will then be made on what information, if any, should be given to the media. Where permission is required for the release of a photograph of the patient, SEHD officials will liaise with the Crown Office.

Escape

6.8 An escape will have taken place when a restricted patient breaches a physical barrier, for example, breaks out of a locked ward. In such cases, the police and the SEHD should be notified immediately.

6.9 When advised of an escape, the SEHD official will require the information set out in the checklist at Annex A2 (Page 74). If any of the following apply:

- the assessment is that the patient is "high risk"; or
- that the patient's recent conduct indicates that there may be some risk to the public,

the Press Office (as referred to in paragraph 6.7) will be contacted to arrange the issue of a short statement to the media. Unless the restricted patient is considered as "high risk", the statement will give the patient's name and age, the hospital concerned and a brief physical description. Other information may be included as appropriate. The media will not automatically be notified of the crime for which the restricted patient has been sentenced. Scottish Criminal Records Office are the holders of this information and it is a breach of the

Data Protection Act to disclose this information. Crown Office will be consulted on any occasion when a photograph is to be used.

6.10 In the case of an untried prisoner on transfer to hospital who escapes, no details will be volunteered. However, if media enquiries are made, no details of any previous convictions will be given and particular care must be taken to ensure that no information is given out which might be argued to be prejudicial to any future proceedings. It is also unlikely that the escapee would be described as dangerous. This would only be done on the basis of advice from the Crown Office.

Abscond

6.11 An abscond will have taken place when a restricted patient is absent without authority from a ward, work placement, open supervision (i.e. supervision which does not require the use of physical restraints nor continued oversight), or exceeds his or her authorised suspension of detention, or makes away from an escort. The police and the SEHD should be notified immediately.

6.12 When advised of an abscond, the SEHD official will establish the answers to the questions at paragraph 6.9 above. If they are all negative, no immediate press statement is necessary. Once 24 hours have elapsed and the patient has not returned, a short Press Release may be issued. The Press Office will be informed of the absconding to hold against any enquiries but will not volunteer information to the media in these cases. Where their recent conduct indicates that they may present some danger to the public, the procedure for an escape (at paragraphs 6.8 to 6.10) will be followed.

Transferred Prisoners

6.13 Prisoners do not become the responsibility of the Health Service until they are received into hospital, and a warrant/receipt handed over to those transferring the patient by the hospital managers after reception. Similarly they cease to be the lead responsibility of the Health Service while under escort from hospital to court or prison. Such escort will normally be provided by Reliance Prisoner Custody Officers, as part of Reliance Custody Services, who have responsibility for the prisoner while attending court. Good practice suggests that hospital staff should accompany the patient. Enquiries concerning any prisoner who absconds from escort going to or from hospital before or after trial, or from police custody or a police cell, should be referred to the police force in the area in which the incident has taken place.

The Police Role

6.14 Hospital authorities should note that, in addition to the statement put out by the Scottish Executive Press Office, it is always open to the police to issue to the media any supplementary material which may assist in the recapture of a patient who has absconded or escaped. Each case is considered on its own merits. The hospital authorities should co-operate in the supply of any material requested by police and advise the SEHD of the information provided: they in turn will advise the Press Office.

6.15 In cases where a press release has been issued by the police, it will be the responsibility of the police to inform the media in all instances where an escapee or

absconder is recaptured. Press Office will be responsible for issuing a short statement in those cases when a press release has been issued on behalf of Scottish Ministers and the patient has been returned to hospital.

The Press Office Role

6.16 The Press Office will inform the SEHD, the local hospital authorities, the Crown Office and the appropriate police headquarters of the issue of the statement. At this point, the matter becomes the responsibility of the investigating police force to whom the Press Office will refer all enquiries relating to the abscond or escape.

The Role of Hospital Information Officers

6.17 NHS Board PR Officers, or private companies handling media enquiries for hospital authorities, should not deal directly with the media in any incident involving a restricted patient: all enquiries should be referred to the SEHD. The SEHD can, however, authorise arrangements for hospital staff to fulfil the media liaison role assigned to the Press Office in this guidance. The SEHD will provide written approval and guidance for such an arrangement, where necessary.

Reports to the Scottish Executive Health Department

6.18 Once the incident has been resolved, the RMO should make a formal report to the SEHD. Where the incident involved the patient being absent without permission, full details of what occurred while the patient was absent should be provided, including any misdemeanours or suspected misdemeanours.

Critical Incident Review

6.19 Following an incident involving a restricted patient, Scottish Ministers may seek a Critical Incident Review (CIR). Alternatively, the NHS Board, hospital managers or lead clinician involved in the case, may consider it appropriate to initiate a CIR. In such circumstances, the RMO should advise SEHD officials of the likelihood of a CIR when submitting their report on the incident (see paragraph 6.18 above).

6.20 Critical incidents are defined in the Mental Health & Well Being Support Group – Risk Management Report [NHS HDL (2000) 16], as follows:

(a) Death of a resident, in-patient or out-patient which is sudden or unexpected or where suicide is the most likely cause.

(b) Homicide allegedly committed by the in-patient or out-patient.

(c) "Incidents" including those which might have resulted in suicide or homicide, episodes where there is evidence of serious intent of self-harm, violence to others or which led to injury or disability.

(d) An event where an important policy, procedure, or practice was not followed by staff leading to a detriment or potential detriment of care – so called "near misses".

6.21 A CIR, as described in the Risk Management Report, is intended to be seen as part of the NHS Board's wider risk management processes to link all levels of the organisation – ward, clinical managers and Board managers – into a system which takes the opportunity to learn from incidents and enact any changes in practice necessary to forestall a similar incident in future. It should not be seen as a disciplinary process. Further guidance on procedures for CIRs can be found in Annex D of the Risk Management Report, circulated under cover of NHS HDL (2000) 16.

7. CHAPTER SEVEN – TRANSFERRED PRISONERS

Background

7.1 Section 136 of the Mental Health (Care & Treatment) (Scotland) Act 2003 sets out provisions for persons serving a prison sentence to be transferred to hospital for treatment - a "transfer for treatment direction". This direction has the effect of a compulsion order and restriction order. Where a person is a restricted patient as a result of such a transfer, these special restrictions will apply for so long as the person would have been held in custody had they not been transferred, unless they are returned to prison at an earlier stage. If a patient is to be detained beyond the expiry of their sentence, further steps (as set out in Schedule 3 of the 2003 Act should be taken).

7.2 A patient in this category cannot be transferred or have suspension of detention without the permission of Scottish Ministers. There is also during that period, no possibility of absolute or conditional discharge from hospital under the 2003 Act. If it ceases to be appropriate for such a patient to be detained in hospital, they will usually be returned to prison by direction of Scottish Ministers. Where Ministers decide not to act on a recommendation to revoke the transfer direction, they must refer the case for consideration by the Mental Health Tribunal. Should the Tribunal conclude that the direction indeed be revoked, it will direct Ministers to revoke it and return the patient to prison. Where a patient who is a transferred prisoner appeals successfully against transfer to hospital, the Mental Health Tribunal will direct their return to prison to complete the remaining part of their sentence.

7.3 A direction for the return of a transferee to prison is given by warrant on the recommendation of the RMO and the Scottish Executive Health Department's (SEHD) Psychiatric Adviser. In no circumstances can the RMO return the person to prison without the Scottish Ministers' warrant. If the RMO concludes that it is unnecessary or inappropriate for the transferee to remain in hospital, they should inform the Psychiatric Adviser accordingly so that the appropriate steps may be taken.

Statutory provisions governing release

7.4 Provision relating to the release of such restricted patients is made in section 217 of the 2003 Act. Attached at Annex H (Page 109) is a Patient Guide to the current provisions.

Transferred prisoners serving determinate or extended sentences

7.5 A transfer for treatment direction given in respect of a determinate or extended sentence prisoner ceases to have effect on the date on which, but for the transfer, that person would have been released from prison. A prisoner sentenced on or after 1 October 1993 to less than 4 years is automatically released as soon as he has served one half of the sentence. A prisoner sentenced on or after that date, to 4 years or more, is eligible for parole after serving one half of the sentence and must be released on licence after serving two thirds of the sentence. The timing of the release of a prisoner subject to an extended sentence is governed by the custodial term of the sentence.

7.6 When a determinate or extended sentence prisoner is transferred to hospital, SEHD staff take careful note of the date on which he or she must be released and on which the

transfer for treatment direction will therefore cease to have effect (this is known as the earliest date of liberation or EDL). SEHD will issue a letter to the RMO, where possible, 6 weeks prior to the EDL to advise him or her of the effect on the transfer for treatment direction and the need to consider whether the patient requires to be detained in hospital beyond their EDL.

7.7 Prisoners serving sentences of 4 years or more, or, in the case of extended sentence prisoners with custodial terms of 4 years or more, qualify for consideration of early release on licence at the half-way point of sentence. Where a transferred prisoner is eligible for parole, a note should also be taken of the parole qualifying date (PQD). Once that date has been reached, Scottish Ministers may release the individual on licence if this is recommended by the Parole Board for Scotland ("Parole Board"). Approximately 6 months prior to the prisoner's PQD, officials in Parole and Life Sentence Review Division (PLSRD) will write to the RMO for an assessment on whether or not it is appropriate for the parole review to take place and for confirmation of whether or not the individual wishes the review to proceed. Only in the most exceptional circumstances, that is, where an RMO has reason to believe that consideration of early release by the Parole Board would bring about a serious deterioration in the patient's mental health, should the RMO recommend that a parole review should not proceed. In addition, close regard must be had to the individual's own views on the matter. In these cases, SEHD will again write to the RMO approximately 6 weeks prior to the PQD highlighting the possibility of the patient's release and the need to consider re-detention under the 2003 Act.

7.8 Where it is determined that the review should proceed, the parole co-ordinator at the prison where the individual was last detained will assemble the dossier of papers on the individual's circumstances including a comprehensive report on the patient's progress in the mental health system and reports from the hospital social work unit and a community based social worker. **RMOs will wish to bear in mind that the Parole Board is concerned primarily with the question of the risk that a person's early release would present to the public and, where possible, they should make a specific comment about this in any report that they prepare for the Parole Board.**

7.9 Once all the reports have been received, the parole co-ordinator will assemble these into a dossier which will be submitted to PLSRD. PLSRD will subsequently refer the case to the Parole Board to consider the transferred prisoner's suitability for early release on licence. In accordance with the Parole Board (Scotland) Rules 2001, a copy of the dossier which is sent to the Parole Board will also be sent to the transferred prisoner who will have the opportunity to submit representations to the Board and to be interviewed by a Parole Board member prior to the consideration of his case.

7.10 In other circumstances where the RMO is of the view that a transferred prisoner meets or is likely to meet the criteria for discharge during the period between the PQD and the EDL, he or she may recommend through the Psychiatric Adviser that release on licence direct from hospital should be considered. This will then be raised with PLSRD to consider whether or not the individual's case should be referred to the Parole Board to consider his suitability for early release.

7.11 Where a transferred prisoner is not returned to prison or otherwise discharged from hospital before the date on which the transfer for treatment direction ceases to have effect, under section 217(2) of the 2003 Act, the RMO is required, not earlier than 28 days before

that date, to obtain from another medical practitioner a report on the condition of the patient and then to assess the need for the patient's continued detention in hospital. If it appears that the patient should continue to be detained, the RMO is required to send to the managers of the hospital and the Mental Welfare Commission for Scotland a report to that effect along with the other medical practitioner's report. If these steps are not taken within 28 days before the date on which the transfer for treatment direction ceases to have effect, the patient must be discharged on that date. (The patient may, of course, remain as a voluntary patient where they are in a local psychiatric hospital.)

7.12 The steps for the continued detention of a transferred prisoner are prescribed in Schedule 3 of the 2003 Act. Schedule 3 makes provision for a compulsory treatment order (CTO) application to be made to the Mental Health Tribunal in relation to a patient who is subject to a transfer for treatment direction (or hospital direction) provided that the direction has less than 28 days left to run. The 6 month period during which the measures are authorised by the compulsory treatment order does not begin until the day on which the direction expires. In such cases, the patient has a right to apply to the Mental Health Tribunal for an order revoking or varying the compulsory treatment order but not until 3 months after the date on which the order commenced.

7.13 All determinate sentence prisoners sentenced to 4 years or more after 1 October 1993 and all extended sentence prisoners require to be released on licence at their earliest date of liberation. For determinate sentence prisoners sentenced to 4 years and extended sentence prisoners with a custodial term of 4 years or more, the licence exists until the prisoner's sentence expiry date (SED). For extended sentence prisoners with a custodial term of less that 4 years, the licence exists until the end of the extension period. In cases where a transferred prisoner is in hospital prior to their EDL, the licence authorising the release will be sent to the individual's RMO, with a copy to the named social work supervisor, with a request that the purpose and terms of the licence be explained to the individual. Ideally, both the RMO and the named social work supervisor should discuss the terms of the licence with the prisoner.

7.14 Information on parole eligibility or licence requirements of a transferred prisoner with a determinate or extended sentence can be obtained from PLSRD, Scottish Executive Justice Department, St Andrew's House, Regent Road, Edinburgh, EH1 3DG. **A list of contacts can be found at Annex I, Page 110.**

Transferees serving indeterminate sentences

7.15 Where a person has been sentenced to life imprisonment, detention for life or detention without limit of time, they will not have an "earliest date of liberation". Therefore, if they are transferred to hospital, the restrictions will apply indefinitely. If the person makes a full recovery from mental illness, 2 options exist: either –

- a return to prison (by warrant under section 210(2) of the 2003 Act); or
- release on life licence direct from hospital. (Such release would be under section 2(4) of the Prisoners and Criminal Proceedings (Scotland) Act 1993.)

In either event, the transfer for treatment direction or hospital direction will cease to have effect.

7.16 Under the relevant provisions of the Convention Rights (Compliance) (Scotland) Act 2001 effective from 8 October 2001, the arrangements relating to the release of transferred adult mandatory life prisoners were brought into line with other life prisoners. Under these provisions, a punishment part is set by a judge in open court and is the length of time that the judge considers a transferred prisoner should serve for retribution and deterrence. As soon as the punishment part has expired, he has the right in law to require Scottish Ministers to refer his case to the Parole Board. The case is reviewed by the Parole Board sitting as a Life Prisoner Tribunal: that is there are 3 members of the Parole Board who consider the case.

7.17 The purpose in sending the case to the Parole Board is to allow it to judge the level of risk the patient might present to the public. If that risk is considered by the Life Prisoner Tribunal to be acceptable, it will decide that he should be released on life licence (and simultaneous absolute discharge). If that is the decision, it will direct Scottish Ministers to release the transferred prisoner. Scottish Ministers are statutorily obliged, on receipt of a direction, to release the transferred prisoner as soon as practicable. The Parole Board will also decide on any special conditions to include in the life licence. If the Parole Board considers that the level of risk is unacceptable, it will advise the individual, explaining why it considers he requires to continue to be confined. The Parole Board may also make recommendations about the steps that could be taken to reduce the risk before the next hearing. The Parole Board will fix the date for the hearing no later than 2 years from the current disposal. The right of a life prisoner to require Scottish Ministers to refer his case to the Parole Board is not affected by transfer under the 2003 Act.

7.18 Where a transferred prisoner subject to such a sentence no longer meets the criteria for detention in hospital the patient should not be discharged and he should be returned to prison.

7.19 However, where the advice of the RMO is that the transferred prisoner cannot be returned to prison on medical grounds, the RMO may propose that the individual is prepared for release on life licence direct from hospital. The preparatory period for such release can be lengthy. Scottish Ministers will normally expect the person to progress through a local hospital and be gradually re-introduced to the community and tested through a programme of increasing unescorted freedoms.

7.20 Where a RMO intends to recommend that a transferred prisoner should be released in this way, this should be made clear to the Psychiatric Adviser at the earliest possible stage. The RMO should be as specific as possible about the likely timescale and preparations for release and whether these will include a proposal for transfer to another hospital, a move to a less restricted regime, or increasing outside freedoms. Suitable accommodation and supervision arrangements should also be in place in the community. Although such patients are unlikely to progress quickly through their rehabilitation, the RMO should make the SEHD aware of their views on the patient as early as possible and certainly at least 18 months before they make any formal recommendation for release on life licence and simultaneous absolute discharge. The SE Health and Justice Departments will need to consider the future plans for the patient and the timescale envisaged by the RMO. This process is likely to involve detailed correspondence and discussions between representatives of the SE and the RMO.

7.21 Once the RMO considers that the patient will be well enough for release on life licence and simultaneous absolute discharge in 6 to 12 months' time, they should make their views known to Scottish Ministers. Release on life licence and simultaneous absolute

discharge may only take place once the individual has served the punishment part of the life sentence, i.e. the period for retribution and deterrence, and on the direction of the Parole Board. The RMO must also be aware that release is not automatic and even if there is a good clinical case for return to the community, at the end of the day the Parole Board, from the wider perspective of public safety, may be unable to authorise release. The RMO should ensure that the patient's expectations about the timing of their discharge from hospital are not raised unrealistically.

Alteration of sentence

7.22 In the event of a transferred prisoner becoming the subject of a further court order or decision while in hospital, for example, as a result of a separate offence or appeal against sentence, the RMO must notify the Health and Justice Departments immediately as this may affect the transfer for treatment direction or hospital direction and the timing of a review of the case by the Parole Board. If the RMO is aware that the person has been to court but not of the outcome, they must find out, and inform the SE Health and Justice Departments (with a copy of the Court order or decision) and must keep in close contact with other interests within the hospital. The SE Health and Justice Departments do not receive notification direct from the courts.

Hospital directions

7.23 Hospital Directions allow the courts to impose a sentence of imprisonment on someone who is in immediate need of hospital treatment, and at the same time direct their admission to hospital for as long as they are in need of that treatment. If a patient on a hospital direction recovers sufficiently so as to no longer warrant detention in hospital, before the date they would be released from prison, they can be transferred to prison to serve the balance of their sentence. Where an RMO is considering a return to prison he should contact the Psychiatric Adviser to discuss the case and allow the opportunity for them to review the patient. The RMO should put their formal recommendation in writing to the Psychiatric Adviser. If, however, the patient does not recover before the "expiry date" of the hospital direction, and still requires treatment in hospital, the RMO must take the steps outlined in 7.11 – 7.12 above. For indeterminate sentenced prisoners on a Hospital Direction the steps outlined in 7.15 to 7.21 should be followed.

7.24 Further guidance on hospital directions was issued by SEHD in NHS HDL (2005) 4.

8. CHAPTER EIGHT - TRANSFERS BETWEEN HOSPITALS OR RETURN TO PRISON

To another hospital involving a reduction in the level of security

8.1 This type of transfer might be appropriate when a patient who has been in a hospital with special security (e.g. the State Hospital) is considered no longer to need these conditions. Usually this will result from an improvement in the patient's mental disorder and behaviour through treatment and rehabilitation. Alternatively the patient may have been transferred to more secure conditions because of a particular set of circumstances which no longer apply and it may, therefore, be appropriate to return the patient to conditions of lesser security.

8.2 The courts and Scottish Ministers have the power to specify hospital units. This is to differentiate between "medium" and "non-secure" psychiatric care under the same management. In these cases Scottish Ministers personal approval is required. Currently the only facility meeting this criteria is the Orchard Clinic, although plans are underway for other medium secure units in Glasgow and the west and north of Scotland.

8.3 Scottish Ministers must personally approve all transfers to conditions involving a drop in security i.e. from the State Hospital or from a unit which has medium secure status to a local hospital. They will not normally consider transfers to conditions of lesser security in advance of formal plans having been agreed between the patient's current and future RMOs unless a bed is available or is likely to become available in the near future. **With respect to patients who are subject to a compulsion order/restriction order, a transfer for treatment direction or a hospital direction, Scottish Ministers must approve all transfers whether to higher, lower or equivalent levels of security under section 218(3) of the 2003 Act.** The accepting RMO is expected to personally assess the patient before agreeing to become the RMO. Experience has shown that transfers often take some time to arrange and to prepare the patient for the transfer. In some cases, the patient's condition might deteriorate or change with the result that the original approval given might no longer be appropriate in the circumstances and have to be reviewed or reconfirmed. It should be noted that gaining approval for the transfer once the arrangements are in place and a bed is available can normally be achieved quickly and will not delay the transfer. It is important, however, that the multidisciplinary team planning the transfer keep in close contact with Scottish Executive Health Department (SEHD) officials to ensure that they have provided all the relevant information and that the process proceeds smoothly.

8.4 The RMO should discuss at an early stage with the Psychiatric Adviser the possibility of transfer for the patient. While the Psychiatric Adviser cannot agree transfer – as that decision rests with Scottish Ministers - they will be able to indicate what issues would need to be addressed before a case can be prepared for Scottish Ministers' consideration. The RMO should also inform the patient's local authority to ensure that forward care planning, if required, is alerted at an early stage. This is particularly important for 'out of area' transfers.

8.5 In considering such a move, Scottish Ministers will need to be reassured about the patient's progress and behaviour, why the patient is considered to no longer need the conditions of special security and what the plans are for the patient's future care. **The information required by the SEHD is contained in Annex C, Page 86.**

8.6 On receipt of the formal recommendation for transfer, the Psychiatric Adviser may visit the patient if they have not done so recently and discuss with the RMO plans for transfer. Once a receiving hospital and RMO have been identified, a full case conference involving both multidisciplinary teams (including relevant social work staff) should be arranged. In certain controversial or high profile cases, it may be helpful to invite SEHD officials – who can help identify possible areas of concern and discuss how these might be addressed.

8.7 Thereafter, SEHD officials will start to prepare a case for the Scottish Ministers' consideration. It is at this point that the SEHD may identify areas where further information is required and request this from the RMO. It is good practice for pre-transfer visits to take place as they help familiarise the patient with the accommodation and build up a therapeutic relationship with the multidisciplinary team at the receiving hospital. If pre-transfer visits do not take place, the reasons for this should be clearly set out in the letter recommending transfer. Requests for suspension of detention should be submitted in the usual way. Where a number of pre-transfer visits are considered appropriate, a block request may be submitted – see Chapter 5 and Annexes B3 and C for details.

8.8 Once all arrangements are agreed and after the patient has successfully completed any agreed pre-transfer visits, the SEHD will seek the agreement of Scottish Ministers to the transfer. In some circumstances, officials can seek an "in principle" decision on transfer from Ministers, subject to a bed becoming available at the receiving facility.

8.9 Once Scottish Ministers have responded to the recommendation for transfer, SEHD officials will notify the RMO of the outcome. If approval is given to the transfer, officials will liaise with the RMO to ascertain the date of transfer. A letter will thereafter issue to the Medical Directors and RMOs of both hospitals. The letter must remain with the patient's medical records as the formal record of the transfer. If approval is not given, officials will provide the reason for deferral and discuss with the RMO any further requirement for patient's care and rehabilitation. As in Chapter 9, paras 15 and 25 of the Forensic Code of Practice, it is good practice for the RMO to consult and notify the MHO in cases of transfers.

8.10 The SEHD will notify the Mental Welfare Commission of the patient's transfer.

Transfer to the State Hospital from conditions of lower security

8.11 In certain circumstances it may be necessary for the multidisciplinary team in a local or medium secure unit to consider transferring a patient to the special security of the State Hospital i.e. on account of his dangerous, violent or criminal propensities. When considering such a transfer, reference should be made to section 102(1) of the National Health Service (Scotland) Act 1978 which reflects the same statutory test which was set out in S29(4) of the 1984 Act and this may be used as the 'test' at an appeal hearing. Where a patient is accepted for transfer to the State Hospital permission must be sought from Scottish Ministers. However, SEHD officials appreciate that, by its nature, a transfer to the State Hospital may need to be effected urgently, and are willing to accept telephone and fax contact from the RMO where an immediate permission is required. The patient and their named person should be notified of the transfer 7 days, where possible, in advance. Where urgent transfer is required or where it is felt that to inform the patient prior to transfer may lead to a further deterioration in their behaviour, this notification may be made "after the fact".

Transfer to hospital with same level of security

8.12 These transfers will take place for any number of reasons such as a hospital closing, further developments in a patient's care or rehabilitation or to move the patient closer to family and friends. In any case where the primary reason for transfer is to allow the patient to be closer to family and friends, a supporting social work report must be provided.

8.13 Transfers to a hospital with the same level of security also require Scottish Ministers' approval but in practice this is done by SEHD officials in consultation with the Psychiatric Adviser. The RMO should write to the Psychiatric Adviser with details of the reason for the transfer, the receiving hospital and RMO, evidence that the RMO has agreed to accept the patient, and the initial care plan following transfer. The Psychiatric Adviser will consider whether it is necessary to arrange a visit to the patient and RMO. Pre-transfer visits by the patient to the receiving hospital should be considered and SEHD approval sought for these through the normal suspension of detention procedure for restricted patients. Where a number of pre-transfer visits are considered appropriate, a block request may be submitted – see Chapter 5 for details.

8.14 Once the SEHD, in consultation with the Psychiatric Adviser, has approved the transfer, officials will write to the RMO indicating that the transfer is approved. Thereafter officials will liaise with the RMO to ascertain the date of transfer. A letter will issue to the Medical Directors and RMOs of both hospitals. The letter must remain with the patient's medical records as the formal record of the transfer. Following transfer, the new RMO must write to the Psychiatric Adviser to confirm their view on the appropriateness of continuing the same level of suspension of detention prior to transfer. **The new RMO must not assume that the approval given previously for suspension of detention transfers with the patient.**

Transfer to another ward within the same hospital

8.15 Transfers to another ward within the same hospital do not require Scottish Ministers' personal approval. However, where a patient is moving from a locked to an unlocked ward the RMO should consult with SEHD and the Psychiatric Adviser. The RMO should write to the Psychiatric Adviser with details of the reason for the transfer, the new ward and RMO (if appropriate) and the initial care plan following transfer. The Psychiatric Adviser will consider whether it is necessary to arrange a visit to the patient and RMO. All other ward to ward transfers are at the discretion of the RMO, who should inform the SEHD when such a transfer takes place.

Transfer back to prison

8.16 A patient who is the subject of a transfer for treatment direction from prison to hospital may be considered for transfer back to prison once the RMO considers that the patient no longer needs to be detained in hospital for treatment and may be absolutely discharged under the 2003 Act. The RMO is required to consider the conditions set out in section 206(4) and 207(3) of the Act.

8.17 When considering "serious harm", it is relevant to consider the environment into which he will be transferred. Different considerations may apply depending on whether he is being released into the community or back to prison.

8.18 A patient who is subject to a hospital direction may also be transferred to prison to complete his sentence. The same tests as set out in paragraphs 8.16-8.17 apply.

8.19 In considering such a move, the SEHD will need to be reassured about the patient's progress and behaviour, why the patient is considered to no longer need treatment in hospital and what plans there are for the ongoing care of the patient's mental health while in prison, if appropriate. The Psychiatric Adviser will assess the patient and provide a view to the SEHD. The SEHD will need to be reassured that the patient no longer presents a risk of serious harm to the public as a result of their mental disorder.

8.20 The information required by the SEHD will therefore include:

- Patient's treatment and progress while in hospital;
- Evidence of patient's current mental disorder and behaviour;
- Confirmation that the prison medical team has assessed the patient and are prepared to accept the patient into their care; and, if appropriate,
- details of any Care Programme Approach (CPA) arrangements made.

8.21 Under section 210(2) of the 2003 Act, where Scottish Ministers are satisfied that the patient no longer requires to be detained in hospital, they shall revoke the direction to which the patient is subject and return them to prison. The patient will be returned to the prison from which they were originally transferred.

8.22 Where Scottish Ministers decide not to revoke a transfer for treatment direction or hospital direction, they shall make a reference to the Mental Health Tribunal in terms of section 210(3) of the 2003 Act.

8.23 The Mental Welfare Commission will be notified of the patient's return to prison.

Transfer to Scotland

8.24 Transfer to a hospital in Scotland may be appropriate for a patient who is Scottish or who has close family ties in Scotland. While the legislation permits such a transfer, there are some particular issues to be addressed before it may be approved. It should be noted that a patient may only be transferred if they would be legally detainable under equivalent Scottish legislation.

8.25 **Immediately the receiving hospital is contacted about the transfer and before agreeing to it, the RMO approached must contact the SEHD about the transfer.** This is especially important where the patient is a transferred prisoner as it is not possible to transfer a prisoner from prison in England to a hospital in Scotland. SEHD officials will liaise with the Home Office, Northern Ireland Office or country of origin and will seek background information on the patient including:

- diagnosis and detainability;
- index offence and criminal history;
- police reports;
- details of patient's care and treatment in hospital; and
- reasons for transfer (if this relates to family circumstances, a social work report will be required).

SEHD officials will also require a copy of the receiving RMO's assessment of the patient including their view on the patient's detainability.

8.26 SEHD officials will seek the views of the Office of the Solicitor to the Scottish Executive (OSSE) on whether the patient would be legally detainable under Scottish legislation. If this is not the case, the patient cannot be transferred.

8.27 Once it is agreed in principle that the patient may be accepted, the receiving RMO may proceed to liaise with the patient's current RMO in arranging the transfer.

8.28 If pre-transfer visits are required, these should not take place before the patient's detainability under Scottish legislation has been confirmed. Thereafter, it is the responsibility of the sending hospital to arrange such visits with the receiving hospital. The Home Office or Northern Ireland Office will prepare and issue a warrant for the patient's transfer to the receiving hospital in Scotland. It should be noted, however, that the patient will require a transfer warrant from the SEHD for return to hospital out with Scotland at the end of any visit.

8.29 Once the SEHD, having consulted the Psychiatric Adviser, has agreed that the patient may be accepted for transfer, officials will notify the receiving RMO and the Home Office/Northern Ireland Office/country of origin. The receiving RMO should liaise with the patient's present hospital to arrange the transfer. A warrant will be required. The SEHD should be informed when the patient has been transferred. After 3 months, an admission report will be required on the patient with annual reports thereafter.

Transfer out of Scotland

8.30 Patients may be transferred to hospitals in other jurisdictions in appropriate circumstances. For instance, a patient who is not Scottish may wish to return to their home area or to be nearer family and friends. For some patients, it may be beneficial to transfer them for a period to a hospital which can cater specifically for their special needs and/or give them treatment which is not available in Scotland. Patients from Northern Ireland who have been transferred to the State Hospital because of their requirement for conditions of special security should be returned to Northern Ireland when they no longer require such conditions.

8.31 Transfers between jurisdictions require some additional consideration to ensure that the process is completed successfully. The information required would depend on whether the transfer is to a hospital with the same level of security or to conditions of lesser security. It is also necessary for SEHD officials to liaise with the officials in the receiving jurisdiction to ensure that they are content to receive the patient before the transfer can be finalised.

8.32 It is the responsibility of the RMO to identify a receiving hospital and to ensure that any financial considerations are managed satisfactorily. If this should prove difficult to finalise, the RMO should contact the SEHD who may be able to provide some assistance through liaison with officials in the receiving country.

8.33 In considering transfer requests involving a drop in the level of security, Scottish Ministers will need the same type of information as contained in Annex C. Information on the following will also be required:

- why it is considered appropriate to transfer the patient to another jurisdiction;
- whether the patient is in agreement with the transfer; and
- the plans for his future care.

8.34 On receipt of the transfer request and supporting information, the Psychiatric Adviser will visit the patient and discuss with the RMO the plans for transfer. Notwithstanding the distances involved, it may still be helpful to hold a full case conference with both care teams and, if necessary, officials from the SEHD to discuss any matters of concern and ensure that the arrangements proceed smoothly.

8.35 Pre-transfer visits should be given serious consideration by the care teams. If arranged, they will require approval in the normal way and a transfer warrant to accompany the patient to the new hospital if the suspension of detention includes an overnight stay. A similar transfer warrant must be issued by the appropriate department of the receiving jurisdiction when the patient returns to hospital from the visit.

8.36 The SEHD will also contact officials in the receiving jurisdiction to gain their approval to the transfer which is necessary before final approval for the transfer can be sought.

8.37 Thereafter, if the transfer is to conditions of lesser security, the SEHD officials will prepare a case for Scottish Ministers' consideration. It is at this point that the officials may identify any further information required and request this from the RMO. Once all arrangements are agreed and after the patient has successfully completed any agreed pre-transfer visits, officials will seek Scottish Ministers' agreement to the transfer.

8.38 Where the transfer is to a hospital with the same level of security and can be approved by the SEHD, officials will let the RMO know when the transfer is agreed. Officials will continue to liaise with the RMO and the Home Office, Northern Ireland Office or country of origin to ensure provision of a transfer warrant for the patient at the appropriate time.

8.39 On receiving approval from Scottish Ministers to a transfer to lesser security, the SEHD will notify the RMO. Before the patient's actual transfer, the Department will prepare and issue to the RMO a transfer warrant. This warrant must accompany the patient on their transfer to the new hospital and be filed in the patient's medical records as the formal record of the transfer.

8.40 Where Scottish Ministers agree to the removal of a patient from Scotland, they shall give written notice to: the patient; the patient's named person; the mental health officer; and the Mental Welfare Commission. In a case where removal is to a place in the UK, this notice will be given at least 7 days before the proposed removal date, and this period extends to 28 days where the removal is to a place out with the UK. Where the patient consents to transfer or where urgent transfer is required, Scottish Ministers may waive the need for prior notice. However, they must inform the Mental Welfare Commission of their decision to waive notice and the reasons for this decision.

Other Transfers

8.41 There are other types of transfer which an RMO may encounter, for instance, the transfer of a restricted patient on conditional discharge, the transfer back to the home country of a person held in hospital and transferred from prison.

8.42 The RMO should contact SEHD officials for specific advice about any planned transfers.

9. CHAPTER NINE - APPLICATIONS AND REFERENCES TO THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

Introduction

9.1 The Mental Health (Care & Treatment) (Scotland) Act 2003 brings with it the introduction of the Mental Health Tribunal for Scotland ("the Mental Health Tribunal") – a body set up to make decisions in a wide range of situations relating to compulsory detention and treatment of those persons considered to be suffering from a mental disorder.

9.2 The Mental Health Tribunal will consist of three groups of members: legal; medical and general members. Decisions on most individual cases will be taken by a team of three members, one from each group. In restricted patient cases the legal member, who is also the convenor, must be a sheriff or the President of the Tribunal.

9.3 The intention is that Mental Health Tribunal hearings will take place locally where possible, e.g. in the hospital where the patient is detained. NHS Boards and Local Authorities are required, where practical, to provide accommodation where hearings can be held. However, where this is not possible, a purpose built hearing suite will be available at the Mental Health Tribunal's headquarters in Hamilton.

Applications and Referrals

9.4 A restricted patient's case may be put forward for consideration by the Mental Health Tribunal by:

- an application or appeal by the patient or their named person; or
- an application or reference by Scottish Ministers.

A list of approved forms can be found at **Annex J, Page 111**, and details of their use are contained in the following paragraphs.

Application by the patient or their named person

9.5 Under section 192 of the 2003 Act, a patient subject to a compulsion order and restriction order (or equivalent), and their named person, may make an application to the Mental Health Tribunal for an order under section 193 of the Act –

(a) conditionally discharging the patient;
(b) revoking the restriction order to which the patient is subject;
(c) revoking the restriction order and varying the compulsion order by modifying the measures specified in it; or
(d) revoking the compulsion order to which the patient is subject.

The patient or their named person cannot make an application until at least 6 months after the compulsion order and restriction order are first applied and may only make one application in any 12 month period. In such cases, the Mental Health Tribunal convenor could be the Tribunal President rather than a sheriff.

9.6 Where a patient makes an application to the Mental Health Tribunal, Scottish Ministers will receive notice of the application from the Tribunal Administration and will be expected to respond to them within 14 days indicating whether they intend to resist the application and, if so, the reasons for this or the position they intend to take. Prior to making their reply on behalf of Scottish Ministers, SEHD officials will contact the Responsible Medical Officer (RMO) to discuss the appropriateness of the application. A written report will also be required from the RMO and, in some cases, further reports may be sought from the social worker, psychologist or an independent clinician.

9.7 **An ongoing application to the Mental Health Tribunal by a restricted patient should not halt or delay the normal progress of their care and treatment**. An ongoing application does not affect the Scottish Ministers' decision making powers. The RMO should continue to report on progress and request permission for suspension of detention, etc., where appropriate. If a patient is progressing towards transfer or conditional discharge the pre-transfer or pre-discharge planning process should continue as normal. Where there is a likelihood that an application for discharge will be successful, the RMO should inform the relevant local authority and other agencies to allow contingency planning to be put in place. It is important for this to be done at an early stage. The Early Discharge Protocol NHS HDL (2002) 85 is based on the principles of the Care Programme Approach and provides guidance in respect of a small number of patients who may no longer meet the grounds for detention under the mental health legislation but may continue to pose a significant risk

Application by Scottish Ministers

9.8 Section 188 of the 2003 Act confers on Scottish Ministers a duty to keep compulsion orders and restriction orders under review. This duty is separate from a recommendation having been received from an RMO or notification having been received from the Mental Welfare Commission that it requires a reference to be made to the Mental Health Tribunal. The Act states that Scottish Ministers shall from time to time consider the continued appropriateness of the compulsion order and restriction order (the tests as set out in Chapter 4 paragraphs 4.10 to 4.14 refer). Where they are not satisfied that the patient continues to meet the criteria they may make an application to the Mental Health Tribunal, under section 191, for an order –

(a) conditionally discharging the patient;
(b) revoking the restriction order to which the patient is subject;
(c) revoking the restriction order and varying the compulsion order by modifying the measures specified in it; or
(d) revoking the compulsion order to which the patient is subject.

The application is made using form **CORO2**.

9.9 When Scottish Ministers make an application to the Mental Health Tribunal, they will give notice of the making of the application to the following –

(a) the patient;
(b) the patient's named person;
(c) any guardian of the patient;
(d) any welfare attorney of the patient;
(e) the patient's RMO;

(f) the mental health officer; and
(g) the Mental Welfare Commission.

9.10 Scottish Ministers may also make an application to the Mental Health Tribunal under sections 267 and 271 of the 2003 Act. However, these provisions relate to the patient's right of appeal against conditions of excessive security and are not yet in force. They will come into force in May 2006 and further guidance will be issued by SEHD nearer the time.

Reference by Scottish Ministers

9.11 The 2003 Act places a duty on Scottish Ministers to make a reference to the Mental Health Tribunal in respect of the compulsion order and restriction order to which a patient is subject, following –

(i) a recommendation from the RMO (sections 185 & 210 of the Act);
(ii) notice from the Mental Welfare Commission (sections 187 & 211); or
(iii) a reference under 189(2) where no reference made for two years

A reference is made using form **CORO1**, **CORO2** or **HD2**.

9.12 When making a reference to the Mental Health Tribunal, Scottish Ministers must include the name and address of the patient; the patient's named person; the recommendation submitted by the RMO; or the reason given by the Mental Welfare Commission or Scottish Ministers for making the reference. They must also give notice of the making of the reference to those persons listed in paragraph 9.8 above.

9.13 Further guidance on the procedures for RMOs to make a recommendation for conditional or absolute discharge or revoking of the restriction order is contained in Chapters 10, 11 and 12.

Mental Health Tribunal Hearings

9.14 Hearings will take place on a date and venue agreed by the Mental Health Tribunal. The Tribunal Administration will notify all relevant parties of the arrangements and will issue a "hearing bundle" no less than 7 days prior to the hearing date. The bundle will consist of reports and other documents submitted by the applicant or authority making the reference, and the respondent. Decisions on most individual cases will be taken by a team of three members: one legal, medical and general. In restricted patient cases the convenor must be a sheriff or the President of the Mental Health Tribunal.

9.15 It is envisaged that most restricted patients will have legal representation at Tribunal hearings and that members of the patient's clinical team may be invited to give oral evidence. Scottish Ministers may be represented by officials from SEHD and the Officer of the Solicitor to the Scottish Executive (OSSE). Although it is anticipated that Scottish Ministers will provide written representation in the majority of cases with only the more complex cases involving representation by Counsel with support from OSSE and the Scottish Executive..

Appeals

9.16 The patient and their named person may appeal to the Mental Health Tribunal against Scottish Ministers decision to vary the conditions of a patient's discharge; to recall a patient from conditional discharge; to transfer a patient from prison to hospital; to transfer a patient from one hospital to another (regardless of level of security); or to transfer a patient between jurisdictions (cross border transfer).

9.17 The patient and their named person, and Scottish Ministers, may appeal to the Court of Session against a decision taken by the Mental Health Tribunal. A patient may not be transferred or conditionally discharged until the expiry of the appeal period or, where an appeal is lodged, until the decision of the Court of Session is known.

9.18 Both of these appeal rights are dealt with in Chapter 13.

10. CHAPTER TEN – REVOKING A RESTRICTION ORDER

Introduction

10.1 A restriction order is made by the Court for a patient where it considers that this is required to protect the public from serious harm. While a restriction order is made without limit of time it is recognised that in particular circumstances where the patient no longer presents a risk of serious harm to the public that it should be possible to remove the patient's restriction order.

When this might be appropriate

10.2 Under sections 185 and 187 of the 2003 Act, Scottish Ministers have a duty to refer a case to the Mental Health Tribunal where they receive a recommendation from the RMO, or the Mental Welfare Commission, to revoke the restriction order to which the patient is subject. The effect of such an order being that the patient would cease to be subject to the special restrictions. The compulsion order would in such circumstances remain in force until the RMO decided that it was no longer necessary.

10.3 The RMO should consider very carefully why this option is preferred to conditional or absolute discharge for the patient. It is unlikely to be appropriate for a patient who is detained in conditions of special security.

10.4 It might be appropriate for the RMO to recommend such a step to Scottish Ministers for reference to the Mental Health Tribunal when the patient has not, for a long time exhibited the type of behaviour which initially gave rise to concern and the imposition of the restriction order and there is evidence that the patient is no longer a serious risk to him/herself or the general public but does still require compulsory care in hospital. This might arise, for instance, when the patient is no longer physically active, as a result of age or physical illness, and no longer represents a risk of serious harm but still requires to be detained in hospital.

What information is required

10.5 Scottish Ministers have a duty to make a reference to the Mental Health Tribunal upon receipt of a recommendation from the RMO. Thereafter it will be for the Tribunal Members to satisfy themselves that they have enough information upon which to make a decision. It will be necessary for the RMO to provide sufficient information for Scottish Ministers to make a reference to the Mental Health Tribunal to remove the restriction order and, in particular, to be assured that the patient no longer represents a serious risk to the public before doing so.

10.6 However, Scottish Ministers are separately required to take a view on the recommendation made by the RMO and submit their view to the Mental Health Tribunal for consideration at the hearing. In practice, it will largely be the information provided by the RMO which allows SEHD officials to assess the merits of the recommendation. It would be helpful therefore if the RMO could provide the following information along with their recommendation:

- information on patient's current mental state;
- why RMO considers patient no longer presents risk to public safety;

- a full risk assessment;
- a social work report (from the mental health officer); and
- plans for patient's future care.

10.7 Where a recommendation for lifting of restriction order is being considered by the multidisciplinary team, the Psychiatric Adviser will visit the patient and RMO to discuss the plans for the patient's current and future care.

How it is achieved

10.8 In the event that the Mental Health Tribunal authorise the revocation of the restriction order, the Tribunal Administration will inform Scottish Ministers, the patient, the RMO, the Mental Welfare Commission and any other relevant parties. They will provide written confirmation of the date on which the order to revoke the restriction direction takes effect (on form **CORO2**) in order that the RMO can manage this appropriately.

How it is managed

10.9 The effect is that the patient ceases to be a "restricted patient", is no longer subject to special restrictions. From that date it will, of course, be necessary to observe in respect of the patient the statutory provisions and procedures specified in the 2003 Act which would apply to any patient who is subject to a compulsion order. Once the restriction order has been revoked Scottish Ministers' special responsibilities for the patient will cease.

11. CHAPTER ELEVEN – CONDITIONAL DISCHARGE

Introduction

11.1 The Mental Health Tribunal are empowered to order the conditional discharge of a patient who no longer requires to be detained in hospital for treatment or for the protection of others and to impose such conditions as it sees fit. This chapter may be subject to change as a result of recommendations contained in the Mental Welfare Commission's report following the case of a patient on conditional discharge who killed. The report is not expected until the end of the year at the earliest.

11.2 In general, a restricted patient's discharge from hospital is subject to certain conditions, the exception being those restricted patients who are also life sentence prisoners. Please refer to Chapter 7 for guidance on these patients. The conditions usually imposed are those of residence at a stated address, supervision by a social worker and psychiatrist. However, additional conditions may be recommended either for the protection of the public or of the patient. Under the 2003 Act, a recommendation may be made to Scottish Ministers to vary these conditions at any time.

11.3 The purpose of formal supervision resulting from conditional discharge is to protect the public from further serious harm in two ways: firstly, by assisting the patient's successful reintegration into the community after what may have been a long period of detention in hospital under conditions of security; and secondly, by closely monitoring the patient's mental health for any perceived increase in the risk of danger to the public so that steps can be taken to assist the patient and protect the public. Conditional discharge also allows a period of assessment of the patient in the community before a final decision is taken on whether to remove the control imposed by the restriction order by means of an absolute discharge. It is important to stress the need for the multidisciplinary team to work closely to ensure that effective and thorough pre-discharge planning takes place and that each agency is aware of its respective procedures and protocols.

When Conditional Discharge might be appropriate

11.4 On admission of a restricted patient to hospital, the RMO will, together with the rest of the multi-disciplinary clinical team, seek not only to treat the patient's mental disorder but to understand the relationship, if any, between the disorder and the patient's behaviour. The aim will be to understand what led to the dangerous behaviour which resulted in the patient's detention and, as the mental disorder is treated in hospital, to assess the extent to which that treatment has reduced the risk of the patient behaving in a dangerous manner if returned to the community.

11.5 In some cases, this period of assessment and treatment may take several years. Only when the patient's condition has so improved that the level of risk to the public is reduced to the extent that detention in hospital is no longer considered necessary, should the RMO recommend the patient's conditional discharge. The Scottish Executive Health Department (SEHD) Psychiatric Adviser would usually assess the patient when plans for discharge are well underway and flag up to the RMO any issues which may need to be addressed. When the RMO considers it appropriate, he should make a recommendation to Scottish Ministers, who will then automatically refer the case to the Mental Health Tribunal. It should be noted that the Mental Health Tribunal has the power to order a "deferred conditional discharge",

which is a provisional decision and is likely to be used when a full care package is not yet in place.

What information is required?

11.6 **Further details of the type of information required are contained in Annex D, page 87**. It will be for the Mental Health Tribunal to determine the sufficiency of evidence in each case.

How is it achieved?

11.7 The clinical team in the detaining hospital will begin preparations for a patient's conditional discharge before authority for discharge is sought. These preparations include the patient's personal preparation for life outside the hospital, consideration and choice of suitable accommodation, employment or other daytime occupation and identification of a social work supervisor and a supervising consultant psychiatrist. **The Scottish Executive will alert the Director of Social Work for the receiving local authority area as soon as pre-discharge planning begins, copying the letter to the RMO.** The Director will then identify a social work supervisor following consultation with the RMO. In all cases, it is recommended that the social work supervisor is a mental health officer. (A mental health officer will generally be a qualified and experienced social worker who has undergone added accredited training in mental disorder and mental health law.) In some cases, particularly if the patient has a history of offending behaviour or a diagnosis of personality disorder it is recommended that the social worker has forensic training and experience.

11.8 The supervisors should ensure that the patient has adequate support and monitoring to make a successful transition to life in the community. They should ensure that the overall approach they adopt is based on the principles of the Care Programme Approach (CPA). It assumes that use of the CPA is standard practice for all patients who have required treatment in secure conditions and who require continuing support to minimise risk. The CPA care plan forms the basis for discharge, through-care and aftercare arrangements and specifies individual and agency responsibilities. The arrangements for future contact with the patient's supervisors should be discussed, and the patient should be assured that his supervisors are there to help. The patient should be advised how to get in touch with his supervisors should any difficulty arise between the times of formal visits.

11.9 The 1999 policy statement on health, social work and related services for mentally disordered offenders in Scotland set out guidance for the organisation of safe care and accommodation, supported by joint working between all relevant agencies. The policy and principles are well understood by the Partnership Agencies. A care pathway document published in 2001 provided a planning and audit tool on which to base service re-design or measure progress towards overall objectives. The guidance promotes multi-agency and multi-disciplinary working to ensure services provide quality care and rehabilitation that responds to individual needs, under conditions of appropriate levels of security and with regard for public safety. Guidance published in 2000 on the management and reduction of risk in mental health care settings generally also highlights the factors to be taken into account when considering patient, staff and public safety and offers advice on a range of key issues and approaches including procedures to review critical incidents.

11.10 In addition, an amendment to the Management of Offenders Bill, which comes into force in spring 2006, provides a robust statutory framework for ensuring that justice and health work in partnership in providing services to those deemed to pose a continuing risk to the public. The amendment offers an opportunity to review and update the current general policy for integrated care management in respect of mentally disordered offenders. A sub-group of the Forensic Mental Health Managed Care Network will take forward the revision of the care programme approach guidance.

Pre-discharge procedures

11.11 As outlined in 11.7 above, the clinical team in the detaining hospital must consider a number of issues when making preparations for a patient's conditional discharge. However, prior to identifying such things as suitable accommodation, employment or other day-time occupation, the multidisciplinary team must consider **where they intend to discharge the patient**. In some cases there may be reasons why the patient should be discharged out of the area in which the hospital is located and, in such cases, the multidisciplinary team must make a thorough assessment of all of the factors involved. These might include:

- support from the patient's family and friends, if appropriate, and whether this would be available out of area;
- the patient's care needs and whether an appropriate package and care team, knowledgeable in the needs of the patient, could be organised out of area;
- the views and location of the victim and/or victim's family;
- the views of the patient on the resettlement plan and their attitude to moving to a new area;
- is such a resettlement in the best interests of the patient, e.g. because of risk to or from the victim or because of a detrimental influence from peers who may lead the patient astray?;
- what are the risks of a change of area and care at such a vulnerable stage in the patient's rehabilitation and do these outweigh the benefits of such a move?;
- possible adverse publicity.

In summary, the rights and wishes of the patient have to be balanced against those of the victim with due consideration being given to effect of the added complexities of an out of area discharge and change of multidisciplinary team at a vulnerable transition in the patient's care. Where the clinical team are in any doubt, they may seek advice from the Psychiatric Adviser or other officials at the SEHD.

11.12 A carefully thought out programme of suspension of detention will also form part of the essential pre-discharge procedures. Overnight stays in the patient's identified accommodation are a key part of the programme and will enable the clinical team to appropriately assess how well the patient is adapting to their new lifestyle. **SEHD recommend that a patient complete at least 4 months of overnight stays building from one night per week to the maximum of four nights per week on monthly increments.** In exceptional circumstances it may be possible to extend this further.

11.13 As soon as the prospective social work supervisor and the prospective supervising psychiatrist are known, they should discuss the patient's after-care and supervision arrangements. **A care programme meeting should be arranged at least three months prior to the proposed discharge date and the patient placed on the Care Programme**

Approach (CPA). In areas where CPA does not exist, a multidisciplinary team will need to be set up based on the principles of the CPA and should meet regularly both before and after the patient is discharged. These discussions are important both as a means of combining hospital and community expertise in the setting up of practical arrangements most suited to the patient and also in enabling the prospective supervisors to familiarise themselves with the patient before discharge. The multidisciplinary team should consider, where appropriate, including representatives from the housing association or local council housing department, or the police in the care planning process and ensure that copies of the CPA or multidisciplinary team meeting minutes are copied to the Psychiatric Adviser for information.

11.14 The supervising psychiatrist must visit the hospital at least once to meet the patient before discharge. Ideally, the supervising social worker will also visit the patient at least once before discharge. In addition, the supervising psychiatrist should peruse all the patient's notes and make their own assessment and take part in at least one multi-disciplinary case conference. By doing so, they will be able to discuss the case with the RMO and the staff of all disciplines who know the patient. On this visit contact must also be made with the social work supervisor. If it should happen that the supervising psychiatrist is not invited by the discharging hospital to take part in pre-discharge discussions and preparations, the supervising psychiatrist should ask, in the first place directly, for a suitable contact with the hospital multidisciplinary team. In the unlikely event of no response (or of an inadequate response), officials in the SEHD may be able to help.

Provision of written information by the discharging hospital

11.15 In addition to the pre-discharge contact recommended in paragraph 11.14, it is essential that the supervising psychiatrist and social worker should receive, as early as possible before discharge, detailed written information about the patient which can be retained for reference.

11.16 Discharging hospitals are advised that the full package of information provided to the supervising psychiatrist and social work supervisor for retention should cover the following aspects of the case:

- a pen-picture of the patient including his diagnosis and current mental state, present medication and reported effects and any side-effects;
- admission, social and medical history including any use of drugs and alcohol;
- psychiatric history;
- criminological history including its relationship to illness and other problem areas and a detailed note of the index offence* (if the patient is a sex offender, it should refer to his statutory requirement to register with the police following discharge);
- summary of progress in hospital;
- a report on present home circumstances;
- **a risk assessment and management plan**, including any warning signs which might indicate a relapse of his mental state or a repetition of offending behaviour together with the time lapse in which this could occur; and
- supervision and after-care arrangements which the hospital considers both appropriate and inappropriate in the particular case. (This could be supplemented by a copy of the CPA minutes or community care plan.)

* Where there are difficulties in obtaining details of the index offence, e.g. summary of court proceedings, the RMO should contact officials in the SEHD who may be able to assist in obtaining this information.

11.17 The supervising psychiatrist should receive this information from the discharging hospital before agreeing to accept the patient into his care and should inform SEHD officials if this information is not received within a reasonable time to enable them to assist in obtaining this necessary information.

11.18 In addition, the discharging hospital should provide details of the circumstances of the offence which led to the patient's admission to hospital and of the legal authority for that admission. Again if this information is not received, SEHD officials should, if notified, be able to assist in obtaining this.

Conditions of Discharge

11.19 The conditions of discharge may be varied, if necessary, from time to time. Should the supervisors wish to recommend a change in any of the formal conditions of discharge, e.g. the patient's address, they should make a recommendation to Scottish Ministers. Examples of specific conditions of discharge are:

- address;
- compliance with medication;
- regular psychiatric and social work supervision;
- victim issues;
- drug/alcohol testing; and
- psychological interventions.

This list is by no means exhaustive. Conditions are designed to meet the needs and manage the risks posed by individual patients. A patient may make an application to the Mental Health Tribunal to vary their conditions of discharge or they may appeal to the Tribunal against any variation in their conditions by Scottish Ministers.

Reporting

11.20 In addition to the supervising psychiatrist and social work supervisor, the Community Psychiatric Nurse (CPN) may also be asked to provide reports on a patient's progress in the community. CPNs often form a key part of the multidisciplinary team and have a good knowledge of the patient. All supervisors will be asked to complete report forms at specified intervals, initially on a monthly basis (see specimen forms at Appendices 1 and 2 (pages 119 and 120 respectively) but should naturally take the initiative in contacting the SEHD quickly should the patient be involved in any unusual or serious incidents and or should the patient's mental condition deteriorate sufficiently to give cause for concern. When completing reports supervisors should consider the following, although not exhaustive, list of issues:

- any change in mental state;
- any concerning behaviour;
- failure to attend appointments with supervisors or other members of the multidisciplinary team;

- non-compliance with medication or proposed change to medication;
- abuse of drugs/alcohol;
- any change of address; and
- any changes to the level of supervision/support or other aspects of the care plan.

11.21 Besides reporting to Scottish Ministers on a regular basis, the two supervisors should keep in touch with each other (and other social care agents in the community) about the patient. The psychiatric supervisor will be required to provide annually a report on the patient's condition and progress, i.e. in addition to supplying the more frequent reports mentioned earlier. It is expected that the patient will remain on the Care Programme Approach for the duration of their conditional discharge.

11.22 Conditions of discharge must be stringently adhered to by the patient and monitored closely by the supervising team. **In the event of a breach of any of the conditions of discharge, this should trigger automatically formal consideration or whether recall is appropriate.** This might best be carried out in a Care Programme Approach setting or similar. If recall is not considered to be appropriate, the justification for not recalling the patient and what steps the team are taking to monitor the patient following the breach must be clearly set out and reported to officials in SEHD immediately.

Right of Appeal

11.23 When the Mental Health Tribunal orders conditional discharge they will advise patients of their appeal rights. Patients should continue to be reminded of these rights, and of their right to approach the Mental Welfare Commission on any aspects of their care about which they might feel aggrieved. In addition, each patient's case will automatically be referred to the Mental Health Tribunal after 2 years, where no other reference or application has been made during that period.

11.24 **Annex F, Page 91, covers in more detail the role of the Psychiatric Supervisor and Annex G, Page 100, the role of the Social Work Supervisor**.

12. CHAPTER TWELVE - ABSOLUTE DISCHARGE

12.1 The Mental Health Tribunal are empowered to discharge a restricted patient absolutely once they are fully satisfied that the patient is no longer suffering from mental disorder as defined in the 2003 Act, and thus no longer presents as a result of mental disorder a serious danger to the public. The exception being those restricted patients who are also life sentence prisoners. Please refer to Chapter 7 for guidance on these patients.

When it might be appropriate

12.2 In most cases, it will have been appropriate for the patient to have undergone a period of supervision in the community, on conditional discharge, before a decision about absolute discharge can be taken. It is not, however, unprecedented for a patient to be discharged absolutely direct from hospital. It may be helpful for the Responsible Medical Officer (RMO) to discuss a recommendation for absolute discharge in the first instance with the Scottish Executive Health Department's (SEHD) Psychiatric Adviser. When a formal recommendation is submitted to Scottish Ministers, it will automatically be referred for consideration by the Mental Health Tribunal.

12.3 To enable Ministers to take an early view on the recommendation and make their position clear to the Mental Health Tribunal, it would be helpful if the following information could be provided:

- the RMO's clear confirmation that in their view, the patient is no longer suffering from mental disorder which requires detention in hospital and no longer presents a risk to the public; and
- a report from the social work supervisor providing a full comprehensive community care assessment to support the viability, safety and effectiveness of any proposed absolute discharge.

For further details of the information required see Annex E, Page 89.

How it is achieved?

12.4 Scottish Ministers will make a reference to the Mental Health Tribunal under the 2003 Act, following a recommendation from the RMO or the Mental Welfare Commission. Scottish Ministers can also make applications to the Tribunal following on from their ongoing duty to keep the compulsion order and the restriction order under review. Patients may also make an application to the Mental Health Tribunal for an order revoking the compulsion order and the restriction order. It will be for the Mental Health Tribunal to determine the sufficiency of evidence and to seek any additional information which they consider relevant to their deliberations.

How it is managed?

12.5 Once a patient is absolutely discharged, Scottish Ministers no longer have a formal role to play in the patient's care. In most cases, informal contact is maintained by the multi-disciplinary care team, including the social worker following absolute discharge.

Early Discharge Protocol for patients in secure hospital settings

12.6 In response to one of the recommendations in the Mental Welfare Commission's 'Report of the Inquiry into the care and treatment of Noel Ruddle', the Scottish Executive, together with local authorities and NHS Trusts, set up a working group with a remit to develop an Early Discharge Protocol. The Protocol complements the proper application of the established Care Programme Approach (CPA), and applies to all patients in the State Hospital who no longer, or may no longer meet the criteria for compulsory intervention under the 2003 Act or the Criminal Procedure (Scotland) Act 1995, as amended, but who have complex needs and continue to pose a significant risk to public safety. See HDL (2002)85 for further guidance.

13. CHAPTER THIRTEEN - APPEALS

Introduction

13.1 This section deals with the various rights of appeal available to restricted patients under the Mental Health (Care & Treatment) (Scotland) Act 2003. There are two main routes:

(a) an appeal to the Mental Health Tribunal against a decision of Scottish Ministers; and
(b) an appeal to the Court of Session against a decision of the Mental Health Tribunal.

Appeals to the Mental Health Tribunal

13.2 Restricted patients may appeal to the Mental Health Tribunal against any decision by Scottish Ministers in respect of:

- a variation in the conditions imposed on conditional discharge;
- recall from conditional discharge;
- transfer to a hospital other than the State Hospital;
- transfer to the State Hospital; or
- transfer between jurisdictions (cross border transfer).

Against variation of the conditions imposed on conditional discharge

13.3 Section 200 of the 2003 Act gives Scottish Ministers the right to vary conditions set by the Mental Health Tribunal when conditionally discharging a patient under section 193(7) of the Act. In so doing, Scottish Ministers must give written notice to the patient, their named person, Responsible Medical Officer (RMO) and Mental Health Officer (MHO).

13.4 Under section 201, the patient and their named person may appeal to the Mental Health Tribunal against any variation in conditions, within 28 days of receipt of the written notice of variation in terms of section 200(3) of the 2003 Act.

Against recall from conditional discharge

13.5 Under section 202 of the 2003 Act, Scottish Ministers may recall a patient from conditional discharge if they are satisfied it is necessary for the patient to be detained in hospital.

13.6 Under section 204, the patient and their named person, are entitled to appeal to the Mental Health Tribunal against this decision, within 28 days of their return to hospital.

Against transfer to a hospital other than the State Hospital

13.7 Under section 218 of the 2003 Act, a patient may be transferred between hospitals following the consent of Scottish Ministers and the agreement of the hospital managers. The patient and their named person should be given 7 days notice of the transfer. However,

where this is not possible, transfer may still take place in urgent cases and notification completed afterwards. No notification is required if the patient consents to transfer.

13.8 Under section 219, a patient and their named person may appeal to the Mental Health Tribunal against the patient's proposed or actual transfer from the date of receipt of notice of transfer up to 28 days after the actual date of transfer. For the patient's named person this extends to 28 days after their receipt of written notice of transfer.

13.9 If, when the Mental Health Tribunal receives notice of an appeal, the transfer has not yet taken place, the managers of the hospital shall not transfer the patient as proposed. However, the Tribunal may, if satisfied that pending consideration of the appeal the patient should be transferred as proposed, make an order that the patient be so transferred.

Against transfer to the State Hospital

13.10 Under section 218 of the 2003 Act, a patient may be transferred to the State Hospital following the consent of Scottish Ministers and the agreement of the hospital managers. When considering such an appeal the Mental Health Tribunal will consider the test laid out in section 102(1) of the National Health Service (Scotland) Act 1978 which is the same as that contained in S29(4) of the 84 Act which has now been repealed. In general, transfers to the State Hospital, by their nature, take place at short notice. Under the 2003 Act, managers of the hospital need not give notice in advance of transfer where it is necessary that the patient be transferred urgently. This is covered in paragraph 13.7.

13.11 Under section 220, a patient or their named person may appeal to the Mental Health Tribunal against Scottish Ministers' decision to transfer them to the State Hospital. They may appeal from the date of receipt of notice of transfer (where given) up to a period of 12 weeks after the date of transfer. For the patient's named person this extends to 12 weeks after receipt of written notice of transfer.

13.12 Where an appeal is made to the Mental Health Tribunal under section 201, 204, 219 or 220, Scottish Ministers will be notified by the Tribunal Administration and will require to respond to them within 14 days indicating whether or not they intend to defend the appeal. In such cases, SEHD officials will seek the views of the Responsible Medical Officer and, where appropriate, the Mental Health Officer before responding on behalf of Scottish Ministers.

Against transfer to another jurisdiction (cross-border transfer)

13.13 Where notice is given by Scottish Ministers of their intention to transfer a restricted patient from Scotland, the patient may, during the period between the day on which the notice is given and the patient's removal from Scotland, appeal to the Mental Health Tribunal against the proposed removal. On receipt of such an appeal, the Mental Health tribunal may make or refuse to make and order that the proposed removal shall not take place.

13.14 Should the Mental Health Tribunal refuse the application, the patient may appeal this decision to the Court of Session, under section 322 of the 2003 Act. Where on appeal, the Mental Health Tribunal or Court of Session refuse to make an order that the proposed removal shall not take place, the proposed removal shall not take place within 21 days of the decision, except where the patient consents in writing to the removal.

Against conditions of excessive security

13.15 From 1st May 2006, under sections 264 and 268 of the 2003 Act, the patient, their named person, any guardian, any welfare attorney and the Mental Welfare Commission, may make an application to the Mental Health Tribunal stating that the patient is being held in conditions of excessive security. [The appeal may not take place within the first 6 months from the date of the order being made or the first 6 months in a particular hospital.] If satisfied, the Mental Health Tribunal may make an order declaring that the patient is being held in conditions of excessive security and, in making that order, it gives the relevant Health Board a period not exceeding 3 months to identify an appropriate hospital in which the patient could be suitably detained.

13.16 If, within the specified period, the Mental Health Tribunal does not receive notification from the Health Board that the patient has been transferred to an appropriate hospital, the Mental Health Tribunal must hold a hearing. At this hearing, the Mental Health Tribunal may grant the Health Board a further period, again not exceeding 3 months. If the patient is still not transferred within this period, the Mental Health Tribunal will hold a final hearing under section 266 or 269 of the 2003 Act at which they may make a final order to the effect that the Health Board has 28 days to find a suitable place for the patient.

13.17 Should the Health Board fail to comply with a final order of the Mental Health Tribunal, the Mental Welfare Commission may, under section 45(b) of the Court of Session Act 1988, take the Health Board to court for failure to perform their statutory duty. However, this legal action could not be taken until the Mental Health Tribunal process had been exhausted. This is without prejudice to any rights that the patient has to raise an action under section 45(b).

Appeals to the Court of Session

13.18 Under section 322(2) of the 2003 Act, any relevant party (i.e. the patient, their named person, guardian or attorney, or Scottish Ministers) may appeal to the Court of Session against a decision of the Mental Health Tribunal. Although the Act also confers a right of appeal to the Sheriff Principal in certain circumstances (under section 320), all restricted patient appeals will be heard by the Court of Session.

13.19 An appeal can be made on a point of law; that there was procedural impropriety in the conduct of a hearing relating to the application or reference; that the Tribunal acted unreasonably in exercising its discretion; or that the Tribunal's decision was not supported by the facts found to be established.

13.20 In allowing an appeal under section 322(2), the Court of Session may remit the case to the Mental Health Tribunal for consideration anew. The Court of Session can direct that the Mental Health Tribunal be differently constituted from when it made its original decision; and can issue other directions to the Tribunal for its consideration of the case, as it deems appropriate. The Court of Session can also substitute it's own decision for that of the Mental Health Tribunal.

13.21 The patient may not be discharged until (a) the expiry of the appeal period or (b) in the event of an appeal being lodged and intimation received that Scottish Ministers do not

intend to appeal; or the Court of Session refuse to make an order; or the recall of any such order. However in those cases where Scottish Ministers have not contested conditional discharge and do not intend to appeal SEHD officials will write to the Court of Session confirming we do not intend to appeal and copy the letter to the Tribunal and the patient's Responsible Medical Officer. It will then be open to the RMO to consider recommending that the patient should be authorised suspension of detention until the final warrant of conditional discharge can be issued by the Mental Health Tribunal.

Preparation of reports and attendance at hearings

13.22 The Office of the Solicitor to the Scottish Executive (OSSE) will act on behalf of Scottish Ministers in all appeals by restricted patients. Counsel will be instructed by OSSE for all Court of Session hearings and they may also be required for Mental Health Tribunal appeals. (Appeals by non-restricted patients are handled by Central Legal Office, the legal advisers to the NHS.)

13.23 On receipt of papers indicating an appeal to the Mental Health Tribunal, the SEHD will write to the RMO requesting a report containing their view of the patient's mental disorder, detainability and any other aspect of their case which is relevant to the appeal.

13.24 Appeals to the Court of Session will be heard on the basis of evidence previously presented to the Mental Health Tribunal. No additional reports or oral evidence will be admitted. Where the court decides to remit the case back to the Mental Health Tribunal for further consideration, it may also issue directions to the Mental Health Tribunal about the consideration of the case as it deems appropriate.

13.25 In cases where Scottish Ministers intend defending an appeal to the Mental Health Tribunal, the SEHD may instruct a second medical report on the patient from a consultant psychiatrist with appropriate experience relating to the patient's mental disorder. It should also be noted that the SEHD Psychiatric Adviser will examine, and thereafter give an opinion on the patient's case and that will be factored in to Scottish Ministers' position in relation to the appeal.

13.26 SEHD officials will keep the RMO appraised of all matters including any decision to defend the appeal and of the general progress of the case. In particular, the SEHD will inform the RMO of date(s) for any hearing and whether the RMO will be required to attend as a witness as soon as those date(s) are known.

14. CHAPTER FOURTEEN - SHARING OF INFORMATION

Introduction

14.1 Confidentiality of personal health information is the cornerstone of the patient/doctor relationship. Restricted patients are entitled to the same rights to confidentiality as any other patient. Nevertheless, sharing of information between agencies involved in the care and treatment of restricted patients is an essential part of risk management. When a patient is admitted into the mental health system, the Responsible Medical Officer (RMO) will receive details of their index offence and any previous medical or social circumstances reports. Additional intelligence on the patient's background, mental disorder and risk will continue to be gathered throughout their stay in hospital and will be used to inform the decision-making process at key stages in their rehabilitation, e.g. suspension of detention, transfer and discharge. Where appropriate, consideration should be given to explaining to the patient what information is being shared, who with and why.

14.2 Formal assessment of risk may take place at a number of stages in the patient's progress and will be reviewed and updated as circumstances change. It is therefore important that all relevant information on a patient is shared with the multidisciplinary team on a need-to-know basis. Where a patient is subject to the Care Programme Approach (CPA), the dissemination of information may be broadened to include external agencies such as local authority housing departments, care providers and the police. Equally, the CPA process may offer opportunities for gathering additional information, e.g. local police intelligence. Decisions on how and when to share information, and who with, will be taken on a case by case basis and should take account of patient confidentiality considerations. Staff should be able to justify in court why they shared information.

Patient confidentiality

14.3 There is legislation which governs and protects confidentiality of information relating to patients and there is additional guidance from the NHS and a range of health professional bodies. The centrepiece of a patient's right to confidentiality is the common law duty of confidentiality. The Data Protection Act 1998 now takes account of the European Directive on Data Protection (Directive 95/46/EC) and covers both electronic and paper records. The revision of legislation came into force on 1 March 2000.

14.4 The principal new areas covered by the legislation are:

- the Data Protection Commissioner becomes the Information Commissioner;
- the Data Protection Act 1998 extends the provision to manually held records (the previous Act applied only to computer records);
- the Access to Health Records Act 1990 was repealed by the 1998 Act with the exception of the provisions relating to the records of deceased persons;
- applicants are now entitled to access their own record whenever created. (Previously applications for access to health records applied only to records compiled after 1 November 1991.); and
- a requirement to obtain explicit consent from the data subject in order to use subject identifiable information for purposes other than its original intended use.

14.5 The Scottish Executive Health Department (SEHD) has issued a range of guidance to patients and the NHS beginning with factual information about the Act. This chapter should be read in conjunction with that guidance - NHS MEL (2000) 17 and NHS HDL (2001) 1.

14.6 SEHD facilitated the Confidentiality and Security Advisory Group for Scotland (CSAGS) to help guide its response to the Data Protection Act 1998. CSAGS published its final report 'Protecting Patient Confidentiality', which followed a public consultation, on the NHS Show website http://www.show.scot.nhs.uk/csags in Spring 2002. SEHD published its response in NHS HDL (2003) 37 'The Use of Personal Health Information in NHSScotland to Support Patient Care' in August 2003. A key requirement on all NHS Boards arising from this HDL is to ensure that all staff are issued with, and supported in their compliance with, the new NHS Code of Practice on Protecting Patient Confidentiality, which is also published on the website http://www.show.scot.nhs.uk/confidentiality/publications/6074NHSCode.pdf. This chapter should be read in conjunction with the Code of Practice.

Release of information to patient

14.7 Restricted patients, whether in or out with hospital, are entitled to regular discussions with their supervisors about their care, progress and the use of their information. Patients will normally be invited to attend for at least part of any case conference held on their care. They should be made aware from the outset that medical information will be shared, on a need to know basis, with the multidisciplinary team caring for them in order to facilitate their care. As far as possible, a patient's wish to have particular sensitive information kept confidential should be respected.

14.8 Patients may be given informal access to their health records by their RMOs but they also have certain statutory rights under the Data Protection Act 1998. The reports which are sent to Scottish Ministers on an individual patient may, for example, have to be disclosed by Hospital Managers if faced with a formal request in writing by a patient under the 1998 Act to access their health records.

Release of information to Third Parties

14.9 There may be times when a restricted patient's supervisor needs to consider the release of information about the patient to a third party such as the police or a potential landlord.

14.10 Guidance on handling personal health information rests on the Code of Practice on Confidentiality of Personal Health Information, issued to the NHS in Scotland, in 1990. The Code sets out the main principles which have to be followed by all NHS staff. The overriding principle of the Code is that information about the health and welfare of a patient is confidential in respect of that patient and such information should not be disclosed to other persons without the consent of the patient, except in certain well defined circumstances. These are :

- where disclosure is in the wider public interest;
- where disclosure is necessary to prevent serious injury or damage to the health of a third party;
- where disclosure is in the best interests of the patient.

14.11 Further guidance and a revised Code of Practice were published in 2003. Details in paragraph 14.6.

14.12 It is for the health professional with overall responsibility for clinical care for the patient to determine in each case whether the circumstances described outweigh the rights of a patient to confidentiality. For instance, the RMO should consider whether the police should be informed about the discharge of a restricted patient into the community in the interest of the patient's safety or the safety of the public.

14.13 In reaching a decision, all relevant circumstances should be taken into account including advice from the multidisciplinary team, the need to protect the public and any rights of the patient to have confidentiality of personal information about him or her protected. While it is essential for each case to be considered in the light of its own facts, the need to protect the public means that the balance may come down in favour of disclosure. Where a decision is made to disclose personal information, only the minimum information necessary to protect the public interest should be divulged. Care should also be taken that the information is relayed to the appropriate person in the receiving body, for instance, a police/hospital liaison officer, to ensure that its handling adheres to the requirements of the Data Protection Act 1998.

14.14 Information in the public domain or a matter of public record is not subject to the duty of confidence.

Discharge of restricted patients

14.15 The police are no longer routinely informed when a restricted patient is discharged from hospital, unless he/she is a registered sex offender. However, the Mental Health Tribunal has to balance patient confidentiality against the wider public safety. Where there are clear implications for public safety in any particular case the Mental Health Tribunal will be required to make a decision on whether the police should be informed. Where they consider this appropriate they will liaise with the RMO to seek the consent of the patient to inform the police about the patient's discharge. Where this is not forthcoming, the Tribunal will take a decision on whether it is necessary to breach patient confidentiality.

Concordat on sharing of information regarding sex offenders

14.16 The Concordat for sharing information on sex offenders stemmed from the work of the Expert Panel on Sex Offending. The Panel recognised that a large number of agencies including the police, prosecutors, courts, prison service, criminal justice social work, as well as housing, health and education authorities play a role in managing the risk posed by sex offenders. The Concordat provides a framework for information sharing and joint working and will be issued shortly.

Management of Offenders Bill

14.17 In addition, an amendment to the Management of Offenders Bill, scheduled to come into force in spring 2006, will establish joint arrangements between the police, local authorities and the Scottish Prison Service as responsible authorities to manage the risk from sex offenders and violent offenders and those offenders who continue to pose a risk to the community. Building on the arrangements in the Bill, an amendment was introduced at

stage 2 of its progression through Parliament which provides also for the health service to become a responsible authority in the establishment of joint arrangements for the assessment and management of mentally disordered offenders who are also sex offenders and violent offenders. This will provides a robust statutory framework for ensuring that justice and health work in partnership in providing services to those deemed to pose a continuing risk to the public. Significantly, they will allow the Health Service to formalise the Care Programme Approach and sharing of information between agencies on restricted patients The Forensic Network have agreed to take the development of revised care programme guidance forward in a multi-disciplinary, multi-agency setting as part of their ongoing work.

15. CHAPTER FIFTEEN - OTHER RELEVANT ACTS

Criminal Procedure (Scotland) Act 1995 - Schedule 1 Offenders – offences against children under age of 17

15.1 Schedule 1 of the Criminal Procedure (Scotland) Act 1995 lists a number of offences against children under 17. Section 21 of the 1995 Act confers a power on a police constable in certain circumstances to take people into custody without a warrant if they have committed any of the offences mentioned in Schedule 1 of the 1995 Act or the constable has reason to believe they have committed the offences. Such offenders are commonly termed 'Schedule 1 offenders'. It should be clear in the records of a restricted patient whether the patient falls into this category. However, if it is not, legal advice should be sought.

Sexual Offences Act 2003

15.2 A patient will be identifiable as a sex offender under the Sexual Offences Act 2003 from a comparison of his offence(s) with those listed in Schedule 3 to the 2003 Act. The notification requirements of Part 2 of the 2003 Act replace, with amendments, the notification requirements of the Sex Offenders Act 1997. The 1997 Act came into effect on 1 September 1997.

15.3 The 2003 Act applies equally to:

- mentally disordered offenders who, on 1 September 1997, were detained in a hospital under Part VI of the Mental Health (Scotland) Act 1984 or Part VI of the Criminal Procedure (Scotland) Act 1995; and

- offenders dealt with under these provisions following a conviction on or after 1 September 1997.

15.4 For these purposes, conviction includes a finding of not guilty by reason of insanity or by virtue of a finding of having done the act charged in respect of a specified offence but where the accused was unfit for trial.

15.5 Where it is not clear whether a patient is required to register under the 2003 Act, legal advice should be sought by the patient. The RMO should advise the patient about this.

15.6 Registration involves notifying the patient of their obligations under the 2003 Act. Relevant sex offenders are required to notify the police within 3 days of discharge from hospital of their name, date of birth and home address, in person at designated police stations. Measures also include allowing the police to take photographs and fingerprints on initial registration. Section 96 of the 2003 Act provides powers to Scottish Ministers to make regulations requiring those responsible for an offender who is subject to the notification requirements of the 2003 Act while he is in detention, to notify other relevant authorities of his release or transfer to another institution.

15.7 NHS MEL (1997) 48 and Police Circulars Nos. 9/2000 and 6/2001 provide full guidance on the implementation of the Act, as amended. Regulations and guidance arising from section 96 will be provided separately. Clarification on this will appear in the final version of the revised MOP.

Sex Offender Order

15.8 Sexual Offences Prevention Orders (SOPOs) and interim SOPOs are intended to protect the public from the risks posed by offenders by placing restrictions on their behaviour. The SOPO updates and replaces Sex Offender Orders (introduced on 1 December 1998 under section 20 of the Crime and Disorder Act 1998). The decision to apply for a SOPO lies with the police. It can be used against anyone with a previous conviction for an offence listed in Schedule 3 to the Sexual Offences Act 2003. A SOPO is a civil order that requires a civil standard of proof: however a breach constitutes a criminal offence, and attracts a maximum penalty on indictment of five years imprisonment. The police can apply for an order against anyone with a conviction for a sex offence whose present behaviour in the community gives them reasonable cause for concern that an order is necessary. The order may impose any prohibitions on the person's behaviour, which are considered necessary to protect the public from serious harm. The orders require sex offenders to register under the Sexual Offences Act 2003 while they are in effect.

Schedule 1 Offenders and Sex Offenders

15.9 It should be noted that offenders who have to register under the Sexual Offences Act 2003 are only a particular subset of those who might be considered to be sex offenders and to present a risk to women or children. Not being required to register does not preclude a restricted patient being treated as a risk to women or children where his index offence, past history or recent behaviour indicates this is the case.

15.10 Hospitals should have in place their own policy and procedures covering children visiting patients or accompanying adults who are visiting patients. These should take account of the particular considerations relating to Schedule 1 and Sex Offenders.

15.11 Care must be also taken when arranging any visits or outings for such restricted patients where the patient might come into contact with children. Attending hospital for a hospital appointment, visiting a sick relative or making a visit to any home situation should be given careful consideration. When planning visits to public places, and in particular to leisure facilities and tourist attractions, the likelihood of children at the particular venue at the time of the visit should be considered and the visit adjusted accordingly. Arguably assessing the patient's reaction to contact with children is part of the rehabilitation. The care team must take account not only of the possibility of physical contact with a child but also the potential for distress to children and their carers by behaviours, such as ogling or sexually suggestive behaviour. In general, the rights of the child are paramount and it is preferable to plan to avoid such contacts wherever possible until rehabilitation has reached a stage where it is reasonable to consider the risk to be manageable and the risk of causing distress minimal.

15.12 For these offenders, and others who it is considered may present a risk to women or children, the Scottish Executive Health Department (SEHD) finds it very helpful to have a social work report on the offender and, where a visit to a home setting is planned, on the parties involved in the visit and the setting. RMOs should take the initiative in arranging these reports from the social workers attached to the hospital and provide a copy to SEHD.

DNA Testing

15.13 Sections 19A and 19B of the Criminal Procedure (Scotland) Act 1995 confer powers which cover the taking of samples etc from sexual and violent offenders. These powers extend to patients detained in hospital under the Criminal Procedure (Scotland) Act 1995 or its predecessors by virtue of a compulsion order with or without a restriction order, a hospital direction and any order under section 57(2)(a) or (b) of the 1995 Act. It is appreciated that particular care will need to be exercised when the police are taking samples from mentally disordered offenders.

Patients Detained in Hospital

15.14 Police forces have been advised to contact hospitals where a relevant patient is detained in advance to ensure that suitable accommodation can be arranged for the taking of the sample and that a member of the clinical staff can be in attendance during the taking of the sample. Police forces have been asked to ensure that these arrangements cause the minimum disruption to the normal running of the hospital and to the treatment of the patient.

15.15 Following initial contact with the hospital, the police have been asked to ensure that the patient is given prior notification in writing, copied to his RMO, of the intention to take a non-intimate sample under the provisions of section 19A of the 1995 Act. The practical arrangements for notification should be discussed with the hospital manager in advance. There may be, for example, some circumstances where the patient's RMO may consider that the taking of a sample from a patient should be deferred because the patient's mental state may be such that this action would be counter-therapeutic and may be delayed until the patient's mental state improves. In these circumstances, the police have been advised to make alternative arrangements with the hospital to take the sample at a later date.

15.16 In cases where the patient refuses to co-operate freely with the sample-taking procedure, either as a result of their mental condition or any other reason, it may not be desirable for the patient's clinical team to be involved in taking the sample by force. In such cases, consideration should be given in discussion with the hospital manager as to whether the sample should be taken without a member of the multidisciplinary team being present, whether a third party might be asked to be present, i.e. someone akin to an appropriate adult, or whether the taking of the sample should simply be deferred.

Patients Living in the Community

15.17 A number of patients who have been discharged and are living in the community have already been required to provide samples for the police. In these circumstances, the police should liaise with the patient's RMO and have been asked to keep visits to individual homes as low key as possible and preferably by officers in plain clothes. The patient has the right to decide whether to give the sample immediately at home or at the nearest police station. The patient can also choose to have the sample taken at the hospital with staff the patient is familiar with present.

Insane in Bar of Trial

15.18 Those patients (s174 of the Criminal Procedure (Scotland) Act 1975) who have not been convicted but found to be insane in bar of trial prior to the 1995 legislation coming into

force, may not fall within the scope of the new legislation. In such cases, where the police insist on taking a sample, the advice of a solicitor should be sought. Patients who have been found to be insane in bar of trial and an examination of facts has taken place, i.e. Section 57(2)(a) and (b) of the Criminal Procedure (Scotland) Act 1995, are required to provide samples if they meet the criteria outlined in paragraph 15.13.

ANNEX A1

NOTIFICATION OF INCIDENTS CIRCULAR

In Office Hours

1. In the event of an escape or abscond, other serious incident, or urgent request for leave of absence involving a Restricted Patient, the RMO (or duty RMO) should telephone immediately to one of the following officers in the Scottish Executive Health Department (in order of priority shown):

Dr M Sturrock	0131 244 2809 (All)
Mrs R A Toal	0131 244 2510 (All)
Miss F Currie	0131 244 2459 (Surnames A-Go)
Mrs N Brown	0131 244 2546 (Surnames Gr-Ma including all the "Mc's")
Mrs J McNeill	0131 244 1818 (Me -Z)
Mrs J Craigie	0131 244 2457 (Surnames A - McCa)
Mrs D Mitchell	0131 244 2171 (Surnames McCl– Z)
Mr G Huggins	0131 244 3749

Out with Office Hours

2. Out with office hours (5pm to 8.30am) and on weekends and public holidays immediate contact should be made with one of the officials listed above*

3. Where exceptionally no contact can be made with an official then a message may be left with the Security Guards at Victoria Quay by dialling the main Scottish Executive phone number - 0131 556 8400. Security will relay the message to an official as soon as possible. Please note that on no account should patient details be left as part of such a message.

*Note: out of hours numbers available only to NHS staff responsible for the management of restricted patients

The Scottish Executive Health Department
St Andrew's House

ANNEX A2

NOTIFICATION OF INCIDENTS - CHECKLIST

1. Date and time of call:

_____

2. Name of caller and designation (i.e. Doctor, Nurse, etc):

_____

3. Name of Hospital, Telephone Number and Extension:

_____

4. The incident being reported, including details leading up to it, what happened, when, where and how.

_____

_____

_____

_____

5. The patient's:

Name: _____

Date of Birth: _____

Home Address: (In the case of abscond or escape have relatives been informed?)

_____

_____

6. Index Offence and Section:

_____

_____

7. Background (i.e. if Life Sentence Prisoner, transferred prisoner, on remand, originally held in State Hospital and, if so, date of transfer):

_____

_____

8. **RMO'S VIEW ON PERCEIVED LEVEL OF RISK PATIENT POSES TO HIMSELF AND THE PUBLIC** (This is of great importance **PARTICULARLY** if Index Offence involved culpable homicide, murder or rape, and patient has escaped or absconded). It may not be possible to get RMO view out of hours - in which case the most recent risk assessment or the view of staff on duty will be important.

_____

_____

_____

_____

9. Summary of patient's recent conduct i.e. any worrying incidents:

_____

_____

10. Mental state on day of incident:

_____

_____

11 Medication (i.e. when last received, when next due and whether recent compliance with medication has been good):

_____

_____

_____

12. Have the Police been informed? If so, when? Contact name and telephone number of police to be obtained:

_____

_____

13. Is there a victim at risk? Has consideration been given to breaching medical confidentiality to inform victim of escape or abscond?

_____

_____

14. Does the Hospital have a PR Company and/or Press Officer - if so, names and telephone numbers must be obtained and passed to the Duty Press Officer

_____

_____

ANNEX B1

INFORMATION REQUIRED IN ANNUAL REPORTS TO SCOTTISH MINISTERS

1. The RMO is required to provide the following reports on restricted patients:
   - admission report/3 month report;
   - treatment plan reports (State Hospital patients only); and
   - annual report.

2. Each report (except treatment plan reports) on the patient must provide the RMO's opinion of the patient's mental state and detainability under the 2003 Act. **See also Annex B2 (Page 78) on risk assessment**.

Annual reports

3. This should detail the patient's progress in hospital since the last annual report and should include the following information:

- nursing and other care;
- medication;
- psychological assessment and treatment;
- account of changes in mental state since the last annual report;
- social work assessment;
- any child protection issues; any issues in relation to sex offending registration;
- patient's relations with staff and other patients;
- patient's participation in activities while in hospital;
- freedoms available to patient e.g. open door, leave within hospital grounds and suspension of detention in the community, etc and how they are used;
- patient's relations with family and friends out with hospital;
- plans for patient's future care including plans for patient's further rehabilitation, where appropriate; and
- **RMO's opinion of the patient's mental state and detainability under the 2003 Act.**

4. 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 Executive Health Department (SEHD) has been important in informing the current understanding of the patient, where new information has come to light in the course of the year or where old information has been proved inaccurate, the SEHD should be informed as part of the annual report. The SEHD should also be informed if there has been a change of understanding by the multidisciplinary team of information previously known about the patient.

ANNEX B2

RISK MANAGEMENT

1. The criteria for a restriction order is set down in section 59(1) of the Criminal Procedure (Scotland) Act 1995. 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 and current index offence and its circumstances.

2. When a person is given a compulsion order and restriction order (or equivalent) and admitted to the mental health system, the Scottish Executive Health Department (SEHD) is responsible for assessing and managing the risk that person presents. To do this it is necessary to have good quality information on particular aspects of the patient's background and their treatment and progress in hospital. Detailed risk assessment is a key part of this process.

3. Risk assessments may be carried out using protocols or assessment tools that have proven validity for the category of people that the assessed patient falls into (e.g. mentally disordered offenders, prisoners, sex offenders). 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 patient 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; and
- other relevant risk factors for the population group the patient falls into (e.g. sex offender risk factors).

4. In preparing reports for the SEHD it is important that the RMO should also address the issues below:

- whether the patient is detainable under the 2003 Act and if so for what reasons;
- the level of security which the patient requires;
- the potential risk factors in the future (e.g. non-compliance with medication, substance abuse potential);
- the patient's attitude to his index offence, other dangerous behaviour and any previous victims;
- what is known about the circumstances of the victim and the victim's family;
- whether the patient still shows undesirable interest in the victim or victim type;
- any access to the victim or victim type and the patient's attitude towards them;
- the outward evidence of change, how has the patient responded in stressful situations. Describe any physical, verbal or sexual aggression by the patient;
- if substance or alcohol abuse were relevant factors in the patient's previous behaviour the patient's present attitude to these and the therapeutic inputs which have addressed these;
- any outstanding issues which need to be addressed with the patient. Set out the short and longer-term treatment plans; and

- patient's attitude to supervision and the quality of their relationship with the multidisciplinary team.

5. Where the patient has a mental illness the report should address the following:

   - How, if at all, the patient's dangerous behaviour relates to his mental illness;
   - which symptoms of mental illness remain;
   - whether the patient's condition is currently stable and whether this been tested in various circumstances;
   - the effect of medication on the patient's illness and how important is it in maintaining the patient's stability;
   - the extent of the patient's insight into their illness and the need for medication;
   - whether the patient complies with medication in hospital, whether they do so reluctantly and whether they are likely to continue with medication outside the hospital setting; and
   - what are the early signs which indicate a relapse in the patient's illness and what signs would indicate immediate action was required by the patient's multidisciplinary team.

6. Where the patient has mental impairment:

   - whether the patient benefited from treatment or training and if so how;
   - whether their behaviour is now more acceptable, whether the patient is unpredictable or impulsive, and how this might be managed safely; and
   - whether the patient now learns from experience and takes into account the consequences of their actions.

7. Where the patient has a personality disorder:

   - which characteristics are useful and which cause problems;
   - which personality issues are considered to relate to the index offence;
   - what treatment approaches have been adopted;
   - how effective the treatment has been and in what ways this shows;
   - how generalised the patient's learning has become and shows itself and how much is context specific; and
   - which areas of functioning continue to be a problem, how this showed in the past and present, and how it may be managed in the future.

ANNEX B3

APPLICATION FOR SUSPENSION OF DETENTION –
REQUESTS BY RESPONSIBLE MEDICAL OFFICERS

Please note that our target for reaching a decision on these requests is three weeks, provided that we have all of the information that we need.

(In addition, the RMO may also attach a copy of the suspension of detention plan prepared locally in the hospital)

Patient's Name:

Date of Birth:

CHI:

Type of suspension of detention requested:

Escorted/unescorted/overnight

(if escorted, please state the number of escorts)

Frequency

Timing

(if the proposal is for a phased programme of leave which would develop according to the patient's reactions, mental state and behaviour, please set out proposal in full)

Purpose/Objective of suspension of detention

In cases of a first visit to family or friends a social work report must accompany the request for suspension of detention.

Monitoring arrangements by the hospital

Arrangements for reporting to the Scottish Executive

To enable us to consider a request for escorted or unescorted suspension of detention you should comment on the following points (see also the checklist at Annex B2 of the Memorandum of Procedure):

1. Mental state

- Do you consider the patient's mental state to be stable?
- If so, how long has the patient been stable?
- To what extent does the patient have insight into his/her illness and the need for medication?
- What are the patient's current attitudes to index offence?
- Does the patient continue to express delusional/abnormal beliefs?
- If so, to what extent, and would such beliefs pose a risk to the public?

2. Behaviour

- Has the patient shown any evidence of physical or verbal aggression since the last annual statutory report?
- If so, give details and action taken.
- Has the patient attempted any self harm since the last annual statutory report?

3. Treatment Plan

What is the nature of counselling/therapy the patient has received?

- What is the degree to which the patient has shown improvement as a result?
- What are the therapeutic goals that will be set for the suspension of detention?
- What is the contribution that this suspension of detention will make:
    - to the longer-term programme of rehabilitation?
    - to the overall treatment plan? and
    - how will the milestones and achievements that will mark the leave a success be measured?

4. Sex Offenders

- Has the patient shown any inappropriate sexual behaviour towards anyone since the last annual statutory report?
- What are current plans regarding attendance at a Sex Offenders Group?

5. Substance Abuse and its effect on the patient's mental state

- What role, if any, did substance abuse play in the index offence?
- What effect does substance abuse have on the patient's mental state?
- If substance abuse is a concern, will the patient be tested on return from leave?
- If so: at random? routinely?

6. Risk to Victims and Others

- What is your assessment of the risk (s)he would present to
    - past victims
    - any specific group of people
    - the public in general?
- What is the patient's attitude to any previous victims?
- How would any risks be managed?

7. Suspension of detention

You may also attach a copy of the suspension of detention plan prepared locally in the hospital

- Has the patient had any leave in the hospital grounds?
    - escorted/unescorted?
- If so, how often is this used?
- Have you at any time rescinded leave in the hospital grounds? If so, why?
- What are the key issues that the suspension of detention will test in respect of:
    - the risk assessment?
    - the patient's mental disorder?
- Are there any special sensitivities about particular venues to be visited e.g.
    - the area where the index offence took place, or
    - possible encounter with victims or family, or
    - local hostility towards the patient?

- If so, how would they be managed?

- If the crime or the patient are high public profile locally or nationally, how do you propose to minimise the risk of publicity?

8. Abscond Risk

- Have there been any incidents of absconding?

- What risk do you believe the patient would present now of absconding?

- What plans are in place if the patient were to abscond? (e.g. give details of discussions that have taken place with police and social work)

9. General

- Is this request supported by all members of the multidisciplinary team and the patient?

- Please give below comments from other members of the multidisciplinary team:

- Is there anything else we should be made aware of?

Signed:

Responsible Medical Officer (RMO)

Date:

ANNEX B4

REPORT TO SCOTTISH MINISTERS ON SUSPENSION OF DETENTION

RMO must submit a report on completed suspension of detention 3 months after the implementation of the suspension of detention

Patient's Name:

Date of Birth:

CHI:

Type of suspension of detention:

Escorted/unescorted/overnight
(if escorted state number of escorts)

Duration/frequency of suspension of detention:

Date completed:

Purpose/objective of suspension of detention:

Monitoring arrangements:

Any incidents or concerns noted:

Any other comments from the multidisciplinary team:

Signed:_____

Responsible Medical Officer

Date:_____

ANNEX C

INFORMATION REQUIRED FOR SCOTTISH MINISTERS – TRANSFER TO LESSER SECURITY

1. Details which should be provided include:

- patient's treatment and progress while in hospital including response to suspension of detention;
- evidence of patient's current condition and behaviour;
- patient's insight into mental disorder and need to accept treatment;
- confirmation that the new RMO has personally visited the patient and studied the case notes and is prepared to accept the patient into their care;
- request for block of pre-transfer visits (if not undertaken reasons why these visits are not necessary), and the patient's reactions and behaviour on these;
- details of the initial treatment and care plans for the patient in the new hospital following transfer. In particular, details of what security is considered appropriate for the patient on transfer and how quickly it is planned to move him to more open conditions; and
- information in relation to victim or victim's family if transfer is to the area in which the index offence took place.

ANNEX D

GUIDANCE ON TYPE OF INFORMATION REQUIRED WHEN CONSIDERING CONDITIONAL DISCHARGE

1. A full risk assessment and management plan should be submitted and should include the following information:

- progress in hospital;
- an opinion of whether the mental disorder the patient suffers from is such that it is no longer necessary to continue to detain the patient in hospital in order to protect the public from serious harm;
- a copy of the minutes of the Care Programme Approach or pre-discharge multidisciplinary team meeting convened prior to conditional discharge. This should include details of who will be responsible for the patient's psychiatric and social work supervision in the community, including, if appropriate, details of Community Psychiatric Nurse (CPN) involvement;
- frequency and nature of supervision;
- details of how the patient will occupy his/her time on conditional discharge;
- details of the patient's existing drug treatment and which symptoms, if any, of their mental illness remain;
- details of the patient's attitude and compliance with treatment and relationship with therapists;
- details of the patient's current attitude to the index offence, other dangerous behaviour and any previous victims;
- is the victim or victim's family living in the locality in which it is proposed to transfer the patient and if so what is known about the victim or victim's family;
    - how has the patient responded to leave of absence out with the hospital? Has he been fully tested?;
    - details of the support the patient obtains from his family/friends;
    - whether alcohol or illicit drugs have affected the patient in the past and contributed to the offending behaviour. If so, what is the patient's current attitude to drugs and alcohol. What specific therapeutic approaches have there been towards substances abuse. Whether the patient will be subject to alcohol/drug testing;
    - what issues, if any, still need to be addressed; and
    - is it necessary to alert the Police to the patient's discharge and if not, why not?

- would you wish any additional conditions to be added to the warrant e.g. no alcohol, no unsupervised contact with children, regular drug testing, prohibited from visiting a certain area;

2. For patients with mental impairment, please include the following additional information:

- how has the patient benefited from treatment/training;
- is their behaviour more acceptable? Please give evidence;
- is the patient's behaviour explosive or impulsive? Please give evidence; and
- does the patient now learn from experience and take account of the consequences of their action? Please give evidence.

3. Where a nursing home is proposed as accommodation, the Care Commission must be consulted. (This will be done by SEHD following notification of the care home name and address.)

ANNEX E

GUIDANCE ON TYPE OF INFORMATION REQUIRED WHEN CONSIDERING ABSOLUTE DISCHARGE

1. Current formulation:

- Current understanding of situation by RMO;
- RMO's current diagnosis and the state or presence of mental disorder of any kind; and
- RMO's view of continuing risk to the patient themselves or the public.

2. Details of the patient's conduct under supervision:

- A full comprehensive Community Care Assessment from local authority services to support the viability, safety and effectiveness of the proposed absolute discharge.
- what is the multidisciplinary team's current understanding of the factors underpinning the index offence and previous dangerous behaviour;
- what change has taken place in respect of those factors (i.e. to affect the perceived level of dangerousness);
- what is the outward evidence of change i.e. in relating to staff, patients and victim? Give specific examples;
- how has the patient responded to stressful situations?;
- has there been any physical violence or verbal aggression in the last year?;
- co-operation with psychiatrist, overall mental health and current medication;
- co-operation with social worker;
- employment status/prospects; and
- sexual attitudes and intimate relationships and their relevance.

3. **An opinion from the RMO that the patient no longer presents a serious risk to the public.**

4. Social situation:

- resourcefulness, motivation;
- personal and domestic hygiene;
- way of spending their time;

- employment status and prospects;
- physical fitness/exercise taken;
- interests and hobbies;
- family contacts/support; and
- social contacts.

5. Future Plans:

- how the patient's situation would change, if at all;
- what plans the patient has and how realistic these are;
- whether the patient would continue in contact with social work and psychiatric services informally;
- how contact might be expected to change;
- whether the same support services would be available to the patient if given absolute discharge; and
- what plans the services have in place in the event of relapse.

ANNEX F

ROLE OF PSYCHIATRIC SUPERVISOR - (PATIENTS ON CONDITIONAL DISCHARGE)

1. These Notes are for the guidance of consultant psychiatrists who take on the role of supervising psychiatrist to a patient who, having been made subject to special restrictions, is conditionally discharged from hospital by the Mental Health Tribunal under section 193(7) of the 2003 Act. They may also be of value to other clinical staff, such as Community Psychiatric Nurses (CPNs), who become involved with the psychiatric supervision of such patients. The Notes cover the responsibilities of those involved with the patient after discharge from hospital and the action to be taken in some of the circumstances which may arise while the patient is in the community. The Notes are not intended to limit the clinical freedom of the supervising psychiatrist to treat the patient as he or she sees fit. They are intended, however, to cover those aspects of the work which may not be familiar and to give examples of, and guidance in, procedures and practices which have been found, over the years, to be most effective.

2. At any time, there are around 60 restricted patients on conditional discharge and under supervision in the community.

THE ROLE OF THE SUPERVISING PSYCHIATRIST

3. It is Scottish Ministers' aim that, by means of conditional discharge of a restricted patient, any risk should be minimised by effective supervision, by appropriate support in the community or by recall to hospital if need be. It is recognised that this places great reliance on the personal skills and dedication of individual supervisors. While it will not always be possible to predict and thus prevent dangerous behaviour, it is important that the supervisor sets out to provide more than just crisis intervention. This is underpinned by good risk assessment prior to the patient leaving hospital.

4. The supervising psychiatrist, in any case, is ultimately responsible for all matters relating to the mental health of the patient, including the regular assessment of the patient's condition, the monitoring of any necessary medication and the consideration of action in the event of deterioration in the patient's mental disorder.

5. The supervising psychiatrist will be expected to indicate prior to discharge the appropriate manner and frequency of psychiatric supervision and treatment, in any particular case. The minimum frequency of contact is determined by the interval which the Mental Health Tribunal directs that reports on the patient's progress should be made to Scottish Ministers. However there will, of course, be many cases in which the supervising psychiatrist considers more frequent contact appropriate. Reports to Scottish Ministers are dealt with separately in Chapter 11 and paragraphs 26 to 29 below.

6. The supervising psychiatrist should be prepared to be directly involved in the treatment and rehabilitation of the patient and to offer constructive support to the patient's progress in the community, rather than simply checking that the patient is free from symptoms and 'staying out of trouble'. The supervising psychiatrist should also be prepared to work with other professionals involved in the patient's care, including the social work supervisor and possibly the general practitioner, CPN and hostel staff. It will normally be expected that this is placed in the context of a multidisciplinary team and Care Programme

Approach (CPA). It is good practice for CPA planning to take place at least 3 months prior to the proposed discharge. In addition, the principles of the Integrated Care Pathway Framework for Mentally Disordered Offenders should be applied (NHS HDL (2001) 9).

7. Scottish Ministers recognise that many supervising psychiatrists have had little or no experience of restricted patients and the legislation and procedures entailed. However, there is a great deal of support available from various sources. Scottish Executive Health Department (SEHD) officials and the SEHD Psychiatric Adviser can provide information about an individual case or advice on any aspect of supervision, including the legal framework.

8. While requests for change in status and reports require to be made in writing, telephone contact for discussion and updating is encouraged and SEHD officials and the Psychiatric Adviser will make themselves available, where possible, to meet multidisciplinary teams and discuss care plans and related issues. Responsible Medical Officers are encouraged to use this resource.

9. RMOs may choose to supervise their own restricted patients after conditional discharge. This is an obvious course if the patient is to be discharged into the immediate vicinity of the discharging hospital. In other cases a supervising psychiatrist should be chosen who is within easy travelling distance of the patient and can easily keep in touch with the other professionals involved in the case, particularly the social work supervisor. It may be appropriate, in some cases, for the RMO to supervise the patient for an initial period of several months and then to make arrangements for a local consultant psychiatrist to take over as supervising psychiatrist. Whenever such a handover occurs, the change of RMO should be notified to the SEHD and the supervising social worker, and the RMO should ensure that the new RMO is given all necessary information on the patient, ideally, through a CPA meeting.

10. Important elements in effective supervision include the development of a close relationship with the patient and working in partnership with the social work supervisor. The social work supervisor is also responsible for overseeing that the patient meets the requirements of the licence and takes action where there is any default. The frequency of supervision should be such as to detect any deterioration in the patient's mental health or behaviour at an early stage. This will often be augmented by community psychiatric nurse visits in between contact with the supervising psychiatrist. It is understood that the doctor/patient relationship may be made more difficult by the fear or resentment of a conditionally discharged patient of being "policed" by the supervisors.

MEDICATION

11. For many conditionally discharged patients, continuation of medication is crucial to avoid a relapse and the attendant possibility of increased risk. It is important, therefore, that the supervising psychiatrist is fully informed, before discharge, of the patient's medical history, including details of current medication and what is known of its effects, side-effects and the effect on the patient's condition and behaviour if medication is stopped. The supervision of medication after discharge is the responsibility of the supervising psychiatrist but the social work supervisor, the patient's general practitioner and, where appropriate, the community psychiatric nurse and hostel staff will also need to have basic information about medication.

12. Medication issues should be covered in periodic discussions about a patient between the psychiatric and social work supervisors. Immediately after discharge and again when any change or cessation of medication has been made, the supervising psychiatrist should inform other members of the multidisciplinary team of the arrangements made, including when, where and by whom medication is to be given. Unless this information is clearly understood by all concerned, there is potential for confusion resulting in adverse consequences for the patient and for others.

13. Where CPNs have been involved in the after-care and supervision of restricted patients, they have proved extremely helpful, especially in respect of the administration and monitoring of medication. However, the supervising psychiatrists may make whatever arrangements they think fit for patients to receive their medication and for the monitoring of those arrangements.

14. Under the provisions of the 2003 Act, compliance with medication can be made a compulsory condition of discharge.

LIAISON BETWEEN THE SUPERVISING PSYCHIATRIST AND OTHER PROFESSIONALS INVOLVED, AND THEIR ROLE:

The social work supervisor

15. The social work supervisor may have more frequent contact with the patient than the supervising psychiatrist and will provide practical support to the patient in his everyday life, especially in matters relating to accommodation, relationships and employment. **Separate guidance for social work supervisors is at Annex G, Page 100.**

16. The social work supervisor may be the key worker in the necessary liaison between all those involved with a patient in the community, having contact with those providing accommodation, employers or day care staff, relations, general medical practitioners and the supervising psychiatrist. However, provisions vary from area to area and this key worker role may also be taken by the CPN.

17. Meetings may take place in the patient's home, the supervisor's office or other venues. Visits should normally be at least once a week for the first month after discharge reducing to once each fortnight and then once each month as the supervisor judges appropriate. The social work supervisor may consider more frequent contact to be necessary, particularly while the patient settles down after release from hospital. **Where a social work supervisor recommends a change in the frequency of supervision, they should first discuss this with the supervising psychiatrist and then notify the Psychiatric Adviser in writing as soon as possible.**

18. Close liaison between the supervising psychiatrist and the social work supervisor is essential if supervision is to be effective. Both supervisors should be involved in the pre-discharge discussions about the patient's community care as part of the CPA process. They should agree a common overall approach to the patient's treatment, after-care and reintegration into the community and discuss how they can liaise effectively after discharge.

19. As paragraph 11 above recommends, the supervising psychiatrist should inform the social work supervisor of the nature of any medication, its effects on the patient's condition

and behaviour and any possible side-effects. The psychiatrist should also inform the social work supervisor of the arrangements to be made for the medication to be given, including when, where and by whom, and of any changes in those arrangements. With this information, the social work supervisor, whilst not primarily concerned with the patient's mental health during his or her regular contact with the patient, may identify indicators of medication difficulties (and, possibly, indicators of other problems arising) which are helpful to the psychiatrist.

20. **The supervising psychiatrist should send a copy of all reports to the Psychiatric Adviser to the social work supervisor, who should reciprocate**.

21. On receipt of the social work supervisor's reports and at any other time during supervision, the supervising psychiatrist should be ready to contact him or her to discuss the patient's case and review progress.

Liaison with other professionals

22. All conditionally discharged patients should be registered with a general medical practitioner and arrangements for this should be made before discharge by the discharging hospital. The discharging hospital should inform the general practitioner of the names and addresses of the patient's supervising psychiatrist and social supervisor. The supervising psychiatrist should, at least, contact the general practitioner to give him brief details of the patient's background and current status as a conditionally discharged patient, to explain his or her role as supervising psychiatrist and to provide the general practitioner with a point of contact in the event of any concern about the patient's mental condition. It is understood that in some circumstances, the general practitioner may appropriately be an active participant in the CPA and should, at least, receive copies of the CPA minutes.

23. The work of other clinical personnel involved with the patient, such as psychiatric nurses or psychologists, should be under the general direction of the supervising psychiatrist who should consult them periodically about the patient's progress.

24. The availability of a well-developed community psychiatric nursing service is of key importance to successful rehabilitation in many cases. It is understood that the best support and supervision occurs when the community psychiatric nurse and psychiatrist work together in any case as part of a team.

25. As regards other professionals involved, such as social workers, hostel staff, day care staff and voluntary sector workers, the social work supervisor may be the key worker in liaison. However, it is expected that all will work under the leadership of the supervising psychiatrist within the CPA.

REPORTS TO THE SCOTTISH MINISTERS

26. Once a patient has been conditionally discharged, Scottish Ministers require reports on the patient's progress from both the supervising psychiatrist and the social work supervisor each month. **It is essential that these reports are provided timeously and any failure to provide reports will be followed up by SEHD officials, by telephone and in writing. Repeated failure to provide reports may result in a letter being issued to the Medical Director of the local NHS Board.** Reports are submitted to the SEHD whether the

patient was discharged by authority of Scottish Ministers (prior to October 2005) or by the Mental Health Tribunal. In some cases, Scottish Ministers may ask for more frequent reports in the initial period after discharge. This would be made clear at the beginning of supervision.

27. **After a period in the community of not less than a year** when a conditionally discharged patient has settled and is maintaining a steady pattern of life, **the supervising psychiatrist may consider it appropriate to submit reports to the SEHD at longer intervals.** A recommendation may be made to the SEHD that reports be made at three monthly intervals (the maximum interval permissible).

28. **It is helpful if reports to the SEHD are completed in the manner shown on the sample form attached at Appendix 1.** After the completion of initial summary data, the report itself should convey sufficient information to enable Scottish Ministers to consider whether the patient may remain in the community or whether, for the protection of the public, steps should be taken to return him to hospital. The report should include a detailed account of the issues outlined in Chapter 11 paragraph 11.20, as well as any other issues which supervisors feel may be of relevance.

29. As indicated at paragraph 20 above, all reports to the SEHD should be copied to the social work supervisor, and they should be discussed with him or her as necessary. Regular CPA meetings should continue. In addition, for about a year, a copy of each report should be sent for information to the patient's former RMO at the hospital from which the patient was discharged (if the RMO is not also the supervising psychiatrist).

Changes in address

30. If the patient wishes to change his address the supervising psychiatrist or social work supervisor MUST write to Health Department officials to seek agreement to the change of address.

Change in supervising psychiatrist

31. Although the name of the supervising psychiatrist is not usually entered on a warrant of discharge, **it is important that the SEHD are notified as soon as possible of any change of supervising psychiatrist**. If a supervising psychiatrist moves from a post and is unable to continue supervision of the patient, they should make arrangements for another suitable consultant to take over the case as soon as possible and alert SEHD to the name of the new psychiatric supervisor.

32. **The social work supervisor should be informed of any impending change of supervising psychiatrist**.

Patients' holidays

33. A conditionally discharged patient is not precluded, by his status, from having holidays away from home. However, the patient should always discuss plans for such holidays with both the social work supervisor and supervising psychiatrist. If a period of absence is agreed, the supervising psychiatrist will wish to consider whether any special medication arrangements will be necessary. Any proposals for the patient to leave the United

Kingdom which should include details of the patient's plans, any perceived risk attached to the holiday proposals, and any work which has been done to reduce these should be put to Departmental officials for their observations. **While it is not unknown for patients on conditional discharge to holiday out with the United Kingdom, this would not normally be advisable in the first year following discharge.**

POST-DISCHARGE CONTACT WITH THE DISCHARGING HOSPITAL

34. The practice of copying supervisors' reports to the discharging hospital for a period of about a year after discharge can have practical benefits for both the hospital and the supervisors. It is clearly helpful for the hospital staff to know how their former patient is progressing in the community and their knowledge and experience of the patient at close quarters may enable them to make helpful suggestions about the patient's management during the early stages of his discharge. A supervising psychiatrist needing further background information about a patient or to discuss the patient's behaviour should make direct contact with the previous RMO. All hospitals will expect and welcome such approaches.

ACTION IN THE EVENT OF A BREACH OF CONDITIONS OR CONCERN ABOUT THE PATIENT'S CONDITION

35. Conditions of discharge must be stringently adhered to by the patient and monitored closely by the supervising team. **In the event of a breach of any of the conditions of discharge, this should trigger automatically formal consideration or whether recall is appropriate.** This might best be carried out in a Care Programme Approach setting or similar. If recall is not considered to be appropriate, the justification for not recalling the patient and what steps the team are taking to monitor the patient following the breach must be clearly set out and reported to officials in SEHD immediately.

36. If a supervising psychiatrist is concerned about a conditionally discharged patient's mental state or behaviour or has reason to fear for the safety of the patient or of others, he may decide to take immediate local action to admit the patient to hospital for a short period with the patient's consent.

37. Telephone discussion in such circumstances is welcomed by the Psychiatric Adviser or officials in the SEHD. In normal office hours an officer should be contacted at the Scottish Executive Health Department, St Andrew's House, Regent Road, Edinburgh EH1 3DG. Officials may also be contacted out of office hours, if required. **Details of appropriate office hours contact numbers can be found at Annex A1, Page 73.**

Recall to Hospital

38. Under section 202 of the 2003 Act, Scottish Ministers have the power to recall a patient from conditional discharge. In practice, a formal warrant of recall is issued by SEHD officials following a recommendation from the supervising psychiatrist and consultation with the Psychiatric Adviser. In cases of urgency, the warrant can be faxed to the RMO. Formal recall cannot take place without a warrant issued by Scottish Ministers. It is not possible to specify all the circumstances in which Scottish Ministers may decide to exercise their powers to recall to hospital a conditionally discharged patient, but in considering the recall of a patient they will always have regard to the safety of the public. A report to the SEHD must always be made in a case in which:

a. there appears to be an actual or potential risk to the public;

b. contact with the patient is lost or the patient is unwilling to co-operate with supervision;

c. the patient's behaviour or condition suggest a need for further in-patient treatment in hospital; or

d. the patient is charged with or convicted of an offence.

e. the patient breaches any of the conditions of discharge

f. the patient takes illicit drugs

39. Consideration of a case for recall will take into account any steps taken locally to remove the patient from the situation in which he presents a danger. Where the supervising psychiatrist decides not to formally recall the patient, they should provide a brief report to the SEHD outlining the reasons for their decision. This should be copied to the social work supervisor.

40. Scottish Ministers have no objection to a conditionally discharged patient being admitted to a hospital, informally for a short period of observation or treatment. The SEHD should be kept informed in these circumstances since the patient will again be subject to the formal conditions of his earlier discharge when he leaves hospital. However, it is generally inappropriate for a conditionally discharged patient to remain in hospital for more than a short time (e.g. a few weeks) informally, and Scottish Ministers would usually wish to consider the issue of a warrant of recall if the period of in-patient treatment seemed likely to be protracted. However, each case is considered on its individual circumstances and there may be occasions where a longer, informal admission is considered appropriate. The supervising psychiatrist is encouraged to discuss such cases with the Psychiatric Adviser, if they are in any doubt.

41. Where a conditionally discharged patient is admitted to hospital informally, the supervising psychiatrist should consider whether the patient is able to consent to treatment. The RMO should also consider whether, if the patient chose to discharge themselves, they would allow them to do so. If they would not, the supervising psychiatrist should give consideration to formal recall to prevent any possibility of breaching the patient's rights under the European Convention on Human Rights [HL v UK (Bournewood) 5 October 2004]. Where there is any doubt about the appropriateness of continued informal admission, the supervising psychiatrist is encouraged to contact the Psychiatric Adviser for further advice.

42. Whether Scottish Ministers decide to recall a patient depends largely on the degree of danger which the particular patient might present in relation to deterioration in his mental disorder. Where the patient has in the past shown himself capable of serious violence, comparatively minor irregularities in behaviour or failure of co-operation would be sufficient to raise the question of the possible need for recall. On the other hand, if the patient's history does not suggest that he is likely to present a serious risk, Scottish Ministers may not wish to take the initiative unless there are indications of a probable physical danger to other persons. There are cases in which recall to hospital for a period of observation can be seen as a

necessary step in continuing psychiatric treatment. Each case is assessed on its merits by SEHD and a decision is reached after consultation with the doctor(s) concerned and with the social work supervisor.

43. Where recall is considered by Scottish Ministers to be necessary and a warrant is signed to that effect, the patient may be returned in the most appropriate manner to the hospital specified on the warrant. If the patient will not return to hospital willingly, on being told of his recall, then the police should be informed. There is a general duty to inform a patient, within 72 hours of his recall to hospital, of the reasons for that recall. Officials in the SEHD should be informed as soon as a recalled patient is back in hospital or in case of any difficulty.

44. After recall, a patient is once again detained as a restricted patient in pursuance of the legal authority which was operating immediately before the conditional discharge. In some cases the supervising psychiatrist may be able to recommend the patient's further discharge after only a short while, but in other cases what has been learned about him in the community or slow response to treatment may point to a need for a longer period of compulsory detention in hospital. The patient, or the patient's named person, has the right of appeal to the Mental Health Tribunal within 28 days of formal recall.

Absconding patients

45. A conditionally discharged patient may leave the approved address and break off contact with both supervisors. In such cases, the social work supervisor should report the fact to the SEHD immediately and make every effort to locate the patient. The SEHD may decide to wait until the patient's whereabouts are known. If necessary, however, Scottish Ministers will issue a warrant for the recall of the patient, thus providing the police with the powers to bring the patient into custody.

46. If a conditionally discharged patient is suspected of having left his approved address to go abroad, Scottish Ministers may decide to issue a recall warrant and alert the immigration authorities who would detain the patient on re-entry to the country. Any ensuing publicity which may arise as a result of a patient returning from abroad should be dealt with in accordance with the guidance issued in Chapter 6.

Further offending

47. If a patient has committed an offence and a prosecution is pending, and if he is in custody and he is no danger to himself, Scottish Ministers will usually let the law take its course. In that event, the court will be able to decide whether the patient needs a fresh medical disposal, whether some other non-medical disposal is called for, or whether the most appropriate course would be for the patient to be recalled to hospital. In this last event, the court may, for example, convict the patient but impose no penalty or only a nominal penalty in the knowledge that Scottish Ministers have in mind to recall the patient at once to hospital.

48. 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, the terms of the previous conditional discharge will continue and the supervisors should resume their roles.

49. If a conditionally discharged patient is convicted of a further offence and the court imposes a sentence of imprisonment, Scottish Ministers will often reserve judgement on the patient's status under the 2003 Act until he nears the end of his prison sentence. Scottish Ministers may decide to make a reference to the Mental Health Tribunal recommending the patient's absolute discharge, so ending his liability to detention under the 2003 Act. Or they may decide to allow his continued conditional discharge under conditions of residence, social work supervision and psychiatric supervision; or to direct his recall to hospital on release from prison. Whatever decision Scottish Ministers take, and its timing, will depend on the length of the prison sentence imposed, the nature of the offence and the patient's mental state, both at the time of the offence and during the sentence of imprisonment, and the risk of danger to the public.

LENGTH OF SUPERVISION AND ABSOLUTE DISCHARGE

50. Scottish Ministers normally require active supervision and reporting to be kept up for at least five years after discharge from hospital when the offence which resulted in the patient's admission to hospital was a serious one, and for at least two years in less serious cases. However where, for example, a patient requires continued medication in the community for the control of symptoms which might otherwise lead to dangerous behaviour, it may be necessary to retain conditions for a much longer period.

51. Where both supervisors agree that neither social work nor psychiatric supervision is required, both should write to the Psychiatric Adviser to recommend the patient's absolute discharge. The social worker should include a full community care assessment to support the viability, safety and effectiveness of the proposed absolute discharge. Scottish Ministers will make a reference to the Mental Health Tribunal and if the Tribunal agrees to the absolute discharge of a conditionally discharged patient, a warrant will be issued and copied to both the patient and the supervisors. Such a decision does not, of course, preclude continuing contact between the patient and the supervisors on a non-statutory basis.

52. A conditionally discharged patient has the right to make an application to the Mental Health Tribunal seeking a variation in the conditions of their discharge or seeking an absolute discharge.

ANNEX G

ROLE OF SOCIAL WORK SUPERVISOR (PATIENTS ON CONDITIONAL DISCHARGE)

1. The term "social work supervisor" is used throughout the Notes to mean the mental health officer who has responsibility to report to Scottish Ministers on the progress in the community of such a patient. The social work supervisor will be identified by the Chief Social Work Officer in the local authority area in which the patient will reside on conditional discharge following a referral from the RMO. **Reports are initially completed on a monthly basis and a copy of the form used for this purpose is attached at Appendix 2.**

2. It is essential that the social work supervisor should receive, as early as possible before discharge, detailed written information (if this is not already available) about the patient which can be retained for reference in the files of the supervising agency. It will normally be expected that this information will be received at least 3 months prior to discharge and form part of the CPA planning process. This will ensure that there is full written information about the case on record if required for an incoming supervisor or senior officers in the agency at any time.

3. The Responsible Medical Officer at the discharging hospital is advised that the full information provided to the social work supervisor for retention should cover the following aspects of the case:

a) a pen-picture of the patient including his diagnosis and current mental state;

b) admission social and medical history;

c) summary of progress in hospital;

d) present medication, duration of medicine/treatment intervals, reported effects and any side effects;

e) **a risk assessment and management plan**, including any warning signs which might indicate a relapse of mental state or a repetition of offending behaviour together with the time lapse in which this could occur;

f) a report on present home circumstances; and

g) supervision and after-care arrangements which the hospital considers appropriate and inappropriate in the particular case (this could be provided in a copy of the CPA minutes or care plan).

4. If a social work supervisor has not received the information detailed prior to the date of discharge, it should be requested from the discharging hospital. If such a request is not met, officials of the Scottish Executive Health Department (SEHD) should be notified.

POST DISCHARGE PROCEDURES

5. It is Scottish Ministers' hope that, by means of conditional discharge of a restricted patient, any risk should be minimised by effective supervision, by appropriate support in the

community or by recall to hospital, if necessary. It is recognised that this hope places great reliance on the personal skills and dedication of individual social work supervisors. While it will not always be possible to predict and thus prevent dangerous behaviour, it is important that the social work supervisor sets out to provide more than just crisis intervention.

6. The specific requirements of supervision will vary from case to case and an individual patient's needs will vary over time. It is impossible, therefore, to draw up a blueprint for successful supervision. However, there are some elements in the role of a social work supervisor which are important if supervision is to be effective in achieving its purpose.

7. A social work supervisor may have many difficult decisions to make when working with a conditionally discharged patient. The patient should consult the supervisor when considering any significant change in circumstances, for example, a new job, new home, financial matters or a holiday. Careful consideration of risk should precede any such proposal and the supervisor should advise the patient against taking any step which, in the supervisor's view, would involve an unacceptable degree of risk. Some proposals will involve the social work supervisor making a special report to the SEHD (see references to change of address and holidays in paragraphs 28 to 31 below).

8. A sound knowledge of the case is essential if the social work supervisor is to be able to spot warning signs before dangerous behaviour occurs. As a matter of good practice, the social work supervisor should be involved in the Care Programme Approach meetings prior to conditional discharge and have an opportunity before discharge to meet the patient and discuss the patient with those in hospital who know him best. Social work supervisors should seek to build on this initial background to the case by establishing a close working relationship with the patient after discharge. If the patient is in close contact with, or living with, friends or relatives the social work supervisor should also see them regularly.

9. The protection of the public from serious harm is enhanced by the successful reintegration into the community of the patient. Supervisors should, therefore, have a positive and constructive approach towards the patient's rehabilitation rather than simply monitoring progress.

10. It is recommended that meetings should take place at least once a week for at least the first month after discharge reducing to once each fortnight and then once each month as the social work supervisor judges appropriate. These are considered to be minimum periods. Sometimes the SEHD will request that more frequent meetings take place. Generally, individual supervisors will consider more frequent meetings appropriate, particularly for the initial period of the first year during which the patient settles down to life in the community. Meetings may take place at the supervisor's office, in the patient's home or other venues. The social work supervisor's visits to the "home territory" should be in accordance with good practice and local risk management protocols. If, after a period of not less than a year, a social work supervisor considers that supervision at monthly intervals is unduly frequent, then he should consider the case for recommending 3 monthly intervals - see paragraph 25 below.

11. When a social work supervisor is absent from his or her post even for a short period, for example when on leave, it is important that responsibility for the case should be transferred to a colleague and that both the patient and the supervising psychiatrist should know whom to contact as social work supervisor. If absences are to be for longer than two

months, the Chief Social Work Officer of the Local Authority and SEHD should be informed. Paragraph 29 below deals with permanent changes of social work supervisor.

12. When changes in social work supervisors occur, it is important that the outgoing supervisor passes to his successor full information about the case and supplements this with oral briefing. A change of supervisor may be upsetting for a patient and care should be taken to ease the transition.

13. As well as the importance of a close and informed relationship between the supervising social worker and the patient, the most valuable element in successful supervision is liaison with other professionals involved in the case. This aspect is discussed separately in paragraphs 16 to 20 below.

SHARING OF INFORMATION

14. This is covered briefly in Chapter 14 of this Memorandum. Except where medical information is concerned, it will usually be the social work supervisor who has to make decisions. Those to whom it may be appropriate to disclose information about a patient's background include hostel staff, landladies or landlords, employers, those providing voluntary work or placements and, in some circumstances, partners. In all cases information should only be disclosed on a "need to know" basis and only of the essential details.

15. Decisions about sharing of information should be taken by the social work supervisor in the light of their knowledge of the case, their professional judgement and in cases of doubt they are advised to consult managers or other members of the clinical team. In general, information about the patient should be disclosed only on a "need to know" basis and only with the full knowledge and agreement of the patient. Information should only be given against the patient's wishes when there are strong overriding reasons for doing so. Such reasons, include the patient's known propensity for offending in circumstances to which the accommodation, or job, may give rise. For example, the supervisor of a patient with a history of offending against a child should be particularly conscious of the fact in discussions with those providing accommodation which does or may also contain children or those providing employment or voluntary work which may bring the patient into contact with children.

LIAISON WITH OTHERS INVOLVED IN THE PATIENT'S CARE

<u>The supervising psychiatrist</u>

16. The consultant psychiatrist who acts as the supervising psychiatrist to a conditionally discharged patient is responsible for all matters relating to the mental health of the patient. The manner in which that responsibility is carried out in a particular case will depend on the needs of the patient. However, the psychiatrist, like the social work supervisor, is asked to report to the SEHD on the patient's condition on a monthly basis initially after discharge.

17. Should the patient's mental health deteriorate, the supervising psychiatrist will consider whether steps are necessary to arrange for the patient to receive additional out-patient treatment or to be admitted to hospital for treatment either voluntarily or by recall (see also paragraphs 32-39 below). Any decision to admit the patient for short-term treatment on a voluntary basis will generally be taken with the knowledge of, and often in consultation

with, the social work supervisor as part of the regular review process. In all cases he should be advised when the patient is admitted or discharged in these circumstances.

18. Close liaison with the supervising psychiatrist is essential if supervision is to be effective. Both supervisors should be involved in the pre-discharge discussions about the patient's after-care and it is expected that they will meet at least once at this stage, probably at the Care Programme Approach meeting. They should agree a common overall approach to the patient's treatment, after-care and reintegration into the community and discuss how they can liaise effectively after discharge.

19. If the patient will be taking medication, the supervising psychiatrist should inform the general practitioner and the social work supervisor of the nature of the medication, its effects on the patient's condition and behaviour and any possible side effects. The psychiatrist should also inform the social work supervisor of the arrangements to be made for the medication to be given, including when, where and by whom, and of any changes in those arrangements. With this information the social work supervisor, while not primarily concerned with the patient's mental health, may identify changes in the patient's state of mind during his or her regular contact with the patient which may be helpful to the psychiatrist.

20. The social work supervisor should send a copy of all reports to the SEHD to the supervising psychiatrist, who should reciprocate.

Other professionals

21. All conditionally discharged patients should be registered with a general medical practitioner and arrangements for this should be made by the discharging hospital. The supervising psychiatrist and the social work supervisor should always keep the general practitioner informed of any significant development in the case.

22. Other clinical staff involved may include a community psychiatric nurse or a psychiatric nurse based at the supervising psychiatrist's hospital whose responsibilities would include visiting the patient to administer and/or monitor his medication.

23. Finally, hostels and centres providing day care are likely to have several members of staff involved with the patient on a day-to-day basis.

24. The social work supervisor may be the key worker in liaison between those involved in the patient's care and support. At the beginning of supervision and with subsequent changes in arrangements, the social work supervisor should discuss the broad approach to the patient's after care with others involved and invite them to contact him or her if there is any cause for concern about the patient's condition or behaviour.

REPORTS TO SCOTTISH MINISTERS

25. Scottish Ministers require reports on the patient's progress from both supervisors one month after conditional discharge and every month thereafter until it is recommended by both supervisors that three monthly intervals is sufficient. **It is essential that these reports are submitted timeously and any failure to provide reports will be followed up by the SEHD, by telephone and in writing.** The SEHD Psychiatric Adviser should be consulted

and agreement reached prior to the reports being changed from one month to three months. Reports are submitted to the SEHD whether the patient is discharged by Scottish Ministers (prior to October 2005) or the Mental Health Tribunal.

26. After a period of at least 12 months in the community, when a conditionally discharged patient has settled down and is maintaining a steady pattern of life, the social work supervisor may consider it appropriate to submit reports to the SEHD at longer intervals, reflecting a belief that the patient can manage well with supervision. The social work supervisor may write to the Psychiatric Adviser recommending that his or her reports be made at three monthly intervals. **The SEHD will not agree to reporting intervals of more than three months while supervision continues.**

27. **It is helpful if reports to the SEHD are completed in the manner shown on the sample form attached at Appendix 2**. Initially, reports will be on a monthly basis. After the completion of initial summary data, the report itself should convey sufficient information to enable the SEHD to consider whether the patient may remain in the community or whether, in the patient's own interests or for the protection of the public, steps should be taken to return him to hospital. The report should include a detailed account of the issues outlined in Chapter 11, paragraph 11.20, as well as any other issues which a supervisor may consider relevant. If the social work supervisor has identified any signs of deterioration in the patient's mental health or behaviour, these should be described in detail, together with any steps already taken to improve the situation and any further proposals for doing so. Finally, the report should include the social work supervisor's plans for the patient's continued support and rehabilitation. To provide such reports it is essential that all incidents, contacts, reviews and developments are clearly and comprehensively recorded on the patient's social work file.

Changes in address

28. **If the patient wishes to change his address or to be away from the address for more than a short absence**, and the social work supervisor agrees that the new accommodation proposed is suitable, **the supervising psychiatrist or social work supervisor MUST write to the Psychiatric Adviser to seek agreement to the change.** (Although, in an emergency the social work supervisor may have to agree to a change of address without prior reference to the SEHD in which case he should contact the Psychiatric Adviser as soon as possible thereafter.) Agreement to routine changes of address may be sought at any time before the proposed change and need not await the next report. It would be helpful if details were given of the new accommodation proposed and the reasons for the change. The supervising psychiatrist should be kept informed (see paragraph 20).

Change in Social Work Supervisor

29. **Allocation of a new social work supervisor should be done through the Chief Social Work Officer of the Local Authority. SEHD must be notified as soon as there is a permanent change of social work supervisor**. (Paragraph 11 above deals with temporary absences from work of the social work supervisor, for example during leave.)

Patient holidays

30. A conditionally discharged patient is not precluded by his status from having holidays away from home. The patient should always discuss plans for such holidays with the social work supervisor so that the suitability of the arrangements can be considered. During the first six months after discharge, for absences from home of two weeks or more, the social work supervisor should notify the Social Work Department in the holiday area and should inform the patient whom to contact there in case of problems arising. Holidays abroad do not allow any form of supervision to continue and should be considered very carefully. Any proposals for the patient to leave the United Kingdom should be put to the Psychiatric Adviser for approval. However, it is worth noting that a request for a patient to go abroad would not normally be considered until they had been on conditional discharge for at least a year.

31. The supervising psychiatrist should be informed of any of the above proposals. In the case of proposed absences from the patient's home, consideration of special medication arrangements to cover the absence may be necessary.

ACTION IN THE EVENT OF A BREACH OF CONDITIONS OR CONCERN ABOUT THE PATIENT'S CONDITION

32. Conditions of discharge must be stringently adhered to by the patient and monitored closely by the supervising team. **In the event of a breach of any of the conditions of discharge, this should trigger automatically formal consideration or whether recall is appropriate.** This might best be carried out in a Care Programme Approach setting or similar. If recall is not considered to be appropriate, the justification for not recalling the patient and what steps the team are taking to monitor the patient following the breach must be clearly set out and reported to officials in SEHD immediately.

33. If the social work supervisor has reason to fear for the safety of the patient or of others, he should contact the supervising psychiatrist immediately. The consultant may decide to initiate local action to admit the patient to hospital without delay with the patient's consent. Whether or not such action is taken, and even if the supervising psychiatrist does not share the social work supervisor's concern, the social work supervisor should report to the SEHD at once.

34. Telephone discussion in such circumstances is welcomed by SEHD officials, who may be contacted at the Scottish Executive Health Department, St Andrew's House, Edinburgh EH1 3DG. Officials may also be contacted out of office hours, in the event of an emergency. **A list of contact numbers is attached at Annex A1, Page 73.**

Recall to hospital

35. Under section 202 of the 2003 Act, Scottish Ministers have the power to recall a patient from conditional discharge. In practice, a formal warrant of recall is issued by SEHD officials following a recommendation from the supervising psychiatrist and consultation with the Psychiatric Adviser. In cases of urgency, the warrant can be faxed to the RMO. Formal recall cannot take place without a warrant issued by Scottish Ministers. It is not possible to specify all the circumstances in which Scottish Ministers may decide to exercise their powers to recall to hospital a conditionally discharged patient, but in considering the recall of a patient they will always have regard to the safety of the public.

A report to the SEHD must always be made in a case in which:

(a) there appears to be an actual or potential risk to the public;

(b) contact with the patient is lost or the patient is unwilling to co-operate with supervision;

(c) the patient's behaviour or condition suggest a need for further in-patient treatment in hospital; or

(d) the patient is charged with or convicted of an offence.

36. Consideration of a case for recall will take into account any steps taken locally to remove the patient from the situation in which he presents a danger. Where the supervising psychiatrist decides not to formally recall the patient, they should provide a brief report to the SEHD outlining the reasons for their decision. This should be copied to the social work supervisor.

37. Scottish Ministers would have no objection to a conditionally discharged patient being admitted to a hospital informally for a short period of observation or treatment but the SEHD and the social work supervisor should be kept informed in these circumstances since the patient will again be subject to the formal conditions of his earlier discharge when he leaves hospital. However, it is generally inappropriate for the conditionally discharged patient to remain in hospital for other than a short time informally and Scottish Ministers would usually wish to consider the issue of a warrant of recall if the period of in-patient treatment seemed likely to be protracted. Each case is assessed on its merits by the Psychiatric Adviser in consultation with the Department and a decision is reached after consultation with the doctor(s) concerned and with the social work supervisor.

38. Where recall is considered by Scottish Ministers to be necessary and a warrant is signed to that effect, the patient may be returned in the most appropriate manner to the hospital specified on the warrant. If the patient will not return to hospital willingly, on being told of his recall, then the police should be informed. There is a general duty to inform a patient, within 72 hours of his recall to hospital, of the reasons for that recall. Where a social work supervisor is involved in returning the patient to hospital, this duty should be borne in mind. The SEHD should be informed as soon as a recalled patient is back in hospital, or in case of any difficulty.

39. After recall, a patient is once again detained as a restricted patient in pursuance of the legal authority which was operating immediately before the conditional discharge. In some cases, the patient may need to return to hospital for a short while but, in others, the lessons learned in the community may point to the need for a longer stay in hospital. The patient has a right of appeal to the Mental Health Tribunal within 28 days of recall.

Absconding patients

40. A conditionally discharged patient may leave the approved address without approval and break off contact with both supervisors. In such cases, the social work supervisor should report to the SEHD immediately and make every reasonable effort to locate the patient,

contacting colleagues in other areas if there is reason to believe that the patient may have gone to a particular place in a different locality. The SEHD may decide simply to wait until the patient's whereabouts are known. If necessary, however, Scottish Ministers will issue a warrant for the recall of the patient, thus providing the police with the powers to bring the patient into custody.

41. If a conditionally discharged patient is suspected of having left his approved address to go abroad Scottish Ministers may decide to issue a recall warrant and alert the immigration authorities who would detain the patient on re-entry to the country. Any ensuing publicity which may arise as a result of a patient returning from abroad should be dealt with in accordance with the guidance issued in Chapter 6.

Further offending

42. If a conditionally discharged patient has committed an offence and legal proceedings are pending, Scottish Ministers will usually consider it advisable, if the patient is in safe custody and presents no danger to others, to let the law take its course so that the court may reach a fresh decision on the need for medical treatment or other measures, rather than recall the patient to hospital. The patient may be recalled if that is in agreement with the court's wishes and the doctors concerned agree that the patient meets the criteria for detention in hospital (for example if the court decides on conviction, to take no action or to impose a notional penalty in the knowledge that the patient will be returned at once to hospital.)

43. If a conditionally discharged patient is convicted of a further offence and the court imposes a non-custodial sentence, the terms of the previous conditional discharge will continue and the supervisors should resume their roles.

44. If a conditionally discharged patient is convicted of a further offence and the court imposes a sentence of imprisonment Scottish Ministers will usually decide to reserve judgement on the patient's status under the 2003 Act until he is near the end of his prison sentence. At that stage, Scottish Ministers will decide, on the medical recommendation, whether to make a reference to the Mental Health Tribunal recommending absolute discharge, to allow his continued conditional discharge under conditions of residence, social supervision and psychiatric supervision or to direct his recall to hospital on release from prison. Whatever decision is taken will depend largely on the length of the prison sentence imposed, the nature of the offence, the patient's mental state, both at the time of the offence and during the sentence of imprisonment, and the risk of danger to the public.

LENGTH OF SUPERVISION AND ABSOLUTE DISCHARGE

45. Each case should be assessed in accordance with the individual's mental health and other needs. However, Scottish Ministers would normally require active supervision and reporting to be kept up for at least 5 years after discharge in serious cases, and for at least two years in less serious ones. In some cases, for example, where a patient requires continued medication in the community for the control of symptoms which might otherwise lead to violent behaviour, it may be necessary to retain conditions for a much longer period.

46. If a social work supervisor considers that the patient no longer requires active supervision and that the safety of the public would not be at risk if the patient were not subject to supervision, the matter should be discussed with the supervising psychiatrist before

an appropriate recommendation is put forward to the Psychiatric Adviser. The social work supervisor must provide a full comprehensive Community Care Assessment to support the viability, safety and effectiveness of the proposed absolute discharge. Evidence of a prolonged period of stability in the community which has been tested by a variety of normal pressures or experiences will be important. Supervisors should use their judgement and put forward a recommendation for an end to formal supervision whenever they consider it appropriate. Care should be taken, however, not to raise the patient's expectations as ultimately a decision on whether to grant an absolute discharge rests with the Mental Health Tribunal. The Psychiatric Adviser will then assess the patient and, if he/she is agrees with the recommendation, Scottish Ministers will make a reference to the Tribunal.

47. Such a decision does not, of course, preclude continuing contact between the patient and the supervisors on a non-statutory basis.

ANNEX H

PATIENT'S GUIDE TO TRANSFER FOR TREATMENT DIRECTION

1. Most patients who are transferred to hospital while serving a prison sentence are on a Transfer for Treatment Direction.

2. This has the effect of a compulsion order and restriction order. If you are subject to such an order, you are a restricted patient and cannot be transferred or given suspension of detention without the permission of Scottish Ministers.

3. From 1 October 1993 early release provisions under the Prisoners and Criminal Proceedings (Scotland) Act 1993 Act apply to you even although you are in hospital.

4. If, before you are released, Scottish Ministers are satisfied that you no longer require hospital treatment or protection, they must send you back to prison or such other place where you were held.

5. If Scottish Ministers think that you still need further treatment, they may decide to keep you in hospital rather than send you back to prison.

6. If you are sent back to prison, the transfer for treatment direction falls.

7. However, this direction may continue to affect you if your original detention was under the Immigration Act 1971.

8. If you are granted early release, the transfer for treatment direction falls.

9. At the same time, you may be released from hospital on licence until the Sentence Expiry Date, unless your Responsible Medical Officer obtains reports that you should remain in hospital.

10. If you need to remain in hospital, the RMO will make an application to the Mental Health Tribunal for a compulsory treatment order. You have a right to apply to the Tribunal to cancel or change this order, but not until 3 months after the date on which the order began.

11. You may appeal to the Mental Health Tribunal against your transfer to hospital (immediately after transfer) or against your continuing detention in hospital, at any point during your admission.

ANNEX I

PAROLE AND LIFE SENTENCE REVIEW DIVISION CONTACT LIST

Name	**Patient Surname**	**Telephone Number**
Mrs Annette Sharp	Patient Surname – A to Ge	0131 244 8543
Mrs Lorraine McDonald	Patient Surname – Gf to Mc/Mac	0131 244 8529
Mr John Hislop	Patient Surname – M to Z	0131 244 8535

The address for written contact is:

Scottish Executive Justice Department
St Andrews House
Regent Road
EDINBURGH
EH1 3DG

ANNEX J

MENTAL HEALTH (CARE & TREATMENT)(SCOTLAND) ACT 2003 –
LIST OF FORMS RELATING TO RESTRICTED PATIENTS

ADM1	Notification by hospital managers of the admission of a patient following criminal justice proceedings.
AO/TO	Medical report in respect of person (not in custody) awaiting trial or sentence: Assessment Order or Treatment Order
AO Review	Responsible Medical Officer's review report in respect of person subject to an Assessment Order
DISC1	Notification by hospital managers of the discharge of a patient subject to criminal justice proceedings.
CORO1	Responsible Medical Officer's (RMO) review of a compulsion order and restriction order.
CORO2	Application by Scottish Ministers to the Mental Health Tribunal. Reference by Scottish Ministers to the Mental Health Tribunal. Record of application made by the patient to the Mental Health Tribunal. Record of Mental Health Tribunal determination.
CORO3	Record of appeal by the patient to the Mental Health Tribunal against a variation of conditions imposed on conditional discharge. Record of appeal by the patient to the Mental Health Tribunal against recall from conditional discharge. Record of the Mental Health Tribunal determination.
HD1	RMO's review of a hospital direction or transfer for treatment direction.
HD2	Record of Scottish Ministers' decision whether or not to revoke the direction to which the patient is subject, following receipt of report from RMO. Reference made by Scottish Ministers to the Mental Health Tribunal. Record of application by the patient to the Mental Health Tribunal. Record of direction made by the Mental Health Tribunal. Record of revocation of direction by Scottish Ministers.
MHT Annex A	Medical Report: Application for an Assessment Order in respect of person in custody awaiting trial or sentence
MHT Annex B	Medical Report: Application for a Treatment Order in respect of person in custody awaiting trial or sentence
MHT Annex C	Medical Report: Transfer for Treatment Direction in respect of person serving a sentence of imprisonment

SUS3	Suspension of detention certificate granted by RMO Revocation of suspension of detention certificate by RMO or Scottish Ministers and record of notifications.
TX1	Notification by hospital managers of patient transfer out with Scotland.
TX2	Notification by hospital managers of patient transfer within Scotland.
TX3	Appeal by patient against transfer within Scotland.
TX4	Appeal by patient against transfer out with Scotland.

All of the forms listed above are available on the Scottish Executive website at: www.scotland.gov.uk/health.mentalhealthlaw

ANNEX K

LIST OF RELEVANT CIRCULARS AND GUIDANCE RELATING TO THE MENTAL HEALTH (SCOTLAND) ACT 1984

MH(S)A 1984 Information to be given to patients detained in hospital or subject to guardianship, and to their nearest relatives	NHS1984(Gen)23	Sept 84
MH(S)A1984 Mental Health Officers: Appointed Day	SW3/1986	Mar 86
Mental Health (Detention) (Scotland) Act 1991	SOHHD GEN1992/6	Mar 92
Code of practice: MH(S)A 1984	NHS MEL(1992)43	Aug 92
Medical negligence: Financial arrangements for central reimbursement of the cost of large damages awards	NHS 1992(Gen)30	Nov 92
MH(S)A 1984 powers of Health Boards in relation to property of patients	NHS MEL(1993) 13	Feb 93
Amendment to MH(S)A 1984 by the Prisoners and Criminal Proceedings(Scotland) Act 1993	HOS/19/2/35	Sept 93
The Mental Health (Class of Nurse) (Scotland) Order 1994	NHS MEL (1994) 83	Aug 94
NHS Responsibility for Continuing Care	NHS MEL (1996) 22	Mar 96
MH(S)A 1984 (As Amended by the Mental Health (patients in the Community) Act 1995)-Forms	NHS MEL(1996)27	Mar 96
MH(S)A 1984 as amended by the Mental Health (patients in the Community) Act 1995 (superseded)		Mar 96
Criminal Procedure (Scotland) Act 1995 Sections relating to Mental Disorder	HD 6/1996	Mar 96

Amendment to MH(S)A 1984 by the Criminal Procedure (Consequential Provisions) (Scotland) Act 1995	NHS MEL(1996)38	Apr 96
Telecommunications policy and management and the NHS Net	NHS MEL(1996) 80	Sept 96
Community Care: Care programme approach for people with severe and enduring mental illness including dementia	SWSG16/96:DD38/96	Oct 96
MH(S)A 1984 MHO- New Directions by the SOS	SWSG19/96	Dec 96
Guidance on the use of facsimile transmissions for the transfer of personal health information within the NHS in Scotland	NHS MEL (1997)45	5 Aug 97
Amendment to MH(S)A 1984 by the Crime and Punishment (Scotland) act 1997	NHS MEL (1997)46	Aug 97
Sex Offenders Act 1997: Guidance on Implementation	NHS MEL(1997)48	Aug 97
Advocacy: A Guide to Good Practice	NHS MEL(1997)61	Sept 97
Framework for Mental Health Services in Scotland	NHS MEL(1997)62	Sept 97
Local Government Finance Act 1992 Council Tax Discount for People with Severe Mental Impairment	NHS MEL(1997) 64	Sept 97
Amendments to the MH(S)A 1984 by the Crime (Sentences) Act 1997 Transfers of CD patients between jurisdictions	NHS MEL(1997) 67	Oct 1997
Crime & Punishment (Scotland) Act 1997: Section 48 DNA sampling of Sexual Offenders	Police Circular 14/1997	Nov 1997
Criminal Procedure (Scotland) Act 1995: Provisions relating to Mental Disorder	HD 18/1997	Dec 1997

Emergency Detention Procedures under section 24 & 25 of the MH(S)A 1984	NHS MEL(1997) 82	Dec 1997
Amendments to the Mental Health (Scotland) Act 1984 by the Crime and Punishment (Scotland) Act 1997	NHS MEL(1997) 86	Dec 1997
Criminal Justice (Scotland) Act 1995 and Criminal Procedure Act 1995 Supervision & Treatment Order Guidance	SWSG 4/98	Mar 1998
Interviewing people who are Mentally Disordered: Appropriate Adult Schemes	NHS MEL (1998)43	June 98
Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland	NHS MEL (1999)5	Jan 99
Caldicott Guardians	NHS MEL(1999)19	March 99
Authority to Incur Capital Expenditure On Behalf of Incapax Patients	NHS MEL(1999)25	March 99
Services for Women with Postnatal Depression	NHS MEL(1999)27	March 99
Invitation to Trial National Standard Definition of Delayed Discharge	NHS MEL(1999)33	March 99
SPS Circular: Crime and Punishment (Scotland) Act 1997 Hospital Directions	SPS 55A/99	May 1999
CP(S)A 1995 Probation Orders: With a Requirement for Treatment for a Mental Condition: The Responsibilities of SW and Health Services	SWSG 5/99	July 99
Community Care: The role of social circumstances reports in the planning and care of people detained in hospital.	CC Circ 1/1999	August 1999
The Disability Discrimination Act (1995) Equality for Disabled People in the NHSiS Good Practice	NHS MEL (1999) 67	Sept 99
Mental Health (Public Safety and Appeals) (Scotland) Act 1999	NHS MEL (1999) 73	Sep 99
Protection of the Finances and other Property of People Incapable of Managing their own Affairs	Community Care Circ CCD2/1999	Oct 99

The Mental Health (Scotland) Act 1984 as amended by the Mental Health (Patients In the Community) Act 1995 Updated Guidance on the provisions of the 1995 Act	NHS MEL(1999) 81	Dec 99
Roles and Responsibilities of General Practitioners and Police Dealing with Potentially Violent Mentally Disordered Persons in the Community	Community Care Circ 3	Dec 99
Mental Health (Amendment) (Scotland) Act 1999: The "Clarke" Act	NHS MEL (2000) 1	Jan 2000
Data Protection Act	NHS MEL (2000) 17	14 April 00
Community Care (Direct Payments)Act 1996 – Community Care (Direct Payments) (Scotland) Amendment Regulations 2000	Community Care Circ CCD4/2000	30 June 00
Police Circular – Sex Offenders Act 1997: Revised Guidance	Police Circular No 9/2000	Aug 00
Patients Remanded to Hospital from Court	NHS HDL(2000) 7	05 Sep 00
NHS Circular: Mental Health and Wellbeing Support Group Risk Management Report	NHS HDL (2000) 16	Oct 00
The use of personal health information, submission of records to information statistics division, disease registers and the confidentiality and security advisory group for Scotland (CSAGS)	NHS HDL(2001)1	Jan 01
Services, Care, Support and Accommodation for Mentally Disordered Offenders in Scotland: Care pathway Document	NHS HDL (2001)9	Feb 01
Police Circular- Criminal Justice and Court Services Act 2000: Amendments to the Sex offenders Act 1997	Police Circular No: 6/2001	June 01
Framework for Mental Health Services in Scotland: Psychological Interventions and Eating Disorders	NHS HDL (2001)75	Oct 01
HD Circular: Managing incidental drug misuse and Alcohol problems in mental health care settings	NHS HDL (2002) 41	May 02

AWI(S)A 2000 – Part 4 Management of Resident's Financial Affairs – Codes of Practice	NHS HDL (2003) 34	July 03
Mental Health (Scotland) Act 1984 Appeals against detention	NHS HDL (2003) 57	Nov 03
Framework for Mental Health Services in Scotland: Perinatal Mental Illness/ Postnatal Depression Hospital Admission and Support Services	NHS HDL (2004) 6	Mar 04
NHSSCOTLAND Guidance on Establishing the Responsible Commissioner	NHS HDL (2004) 15	Mar 04
Electronic Monitoring as a Condition of Release: Parole and Non-Parole Licences	SPS (2004) 44A/04	Dec 04
Amendments to the Mental Health(Scotland) Act 1984 By the Crime and Punishment (Scotland) Act 1997 The Use of Hospital Directions	NHS HDL (2005) 4	Feb 05

Many NHS Circulars can be viewed in the publications section of the Scottish Health on the Web Web-site: www.show.scot.nhs.uk

LIST OF RELEVANT CIRCULARS AND GUIDANCE RELATING TO THE MENTAL HEALTH (CARE & TREATMENT) (SCOTLAND) ACT 2003

(TO BE UPDATED AT A LATER DATE)

The Mental Health (Care and Treatment) (Scotland) Act 2003 ((Transitional and Savings Provisions) Order SSI 2005/452	NHS HDL (2005) 42	Sept 05

Many NHS Circulars can be viewed in the publications section of the Scottish Health on the Web Web-site: www.show.scot.nhs.uk

APPENDIX 1

PSYCHIATRIC SUPERVISOR'S REPORT

MEDICAL RESTRICTED

To: Scottish Executive Health Department
Mental Health Division
Room 2N.08
St Andrew's House
Edinburgh
EH1 3DG

Report to Scottish Ministers from the Psychiatric Supervisor of a Conditionally Discharged Restricted Patient

1. Name and address of patient. [Pre-printed]

2. Present address if different from above ……

……..

3. Reporting interval ……. monthly

4. Date of patient's conditional discharge ……

5. Frequency of meetings and dates with the patient since last report ……

6. Does the patient show signs of becoming a danger to himself or others? ……..

7. If the answer to 6 is Yes, what action do you recommend?

……

……

8. Any other relevant information

……

……

Please continue overleaf if required
Report (please see Annex F of the Memorandum of Procedure for the guidance to psychiatric supervisor)

Name and Address of Supervisor [Pre-printed]

Contact telephone number ……..……..

Signed …….

Date …….

N.B. **One copy should be sent to the supervising social worker**.
To be returned on the last day of **2005**

APPENDIX 2

SOCIAL WORK SUPERVISOR'S REPORT

MEDICAL RESTRICTED

To: Scottish Executive Health Department
Mental Health Division
Room 2N.08
St Andrew's House
Edinburgh EH1 3DG

Report to Scottish Ministers from the Social Work Supervisor of a Conditionally Discharged Restricted Patient

1. Name and address of patient. [Pre-printed]

2. Present address if different from above ……

……..

3. Reporting interval ……. monthly

4. Date of patient's conditional discharge ……

5. Frequency of meetings and dates with the patient since last report ……

6. Does the patient show signs of becoming a danger to himself or others? ……..

7. If the answer to 6 is Yes, what action have you recommended to the RMO ?

……

……

8. Any other relevant information

……

……

Please continue overleaf if required
Report (please see Annex G of the Memorandum of Procedure for the guidance to the social work supervisor)

Name and Address of Supervisor [Pre-printed]

Contact telephone number ……..……..

Signed …….

Date ……

N.B. **One copy should be sent to the psychiatric supervisor**.
To be returned on the last day of **2005**

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