SCOTTISH EXECUTIVE

HEALTH DEPARTMENT

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

SEPTEMBER 2002

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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 set out in Section 62(1) of the Mental Health (Scotland) Act 1984 (the 1984 Act). The explanations which it 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. This Memorandum 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 (notably the Mental Health (Scotland) Act 1984, the SOHHD Notes on the Act and Code of Practice, 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, NHS Trusts, hospitals and local authority and other services must ensure satisfactory working procedures and communication between all relevant parties in relation to the patients concerned. In addition, the principles of the Mentally Disordered Offenders Care Pathway Document (CPD) sets out the range of services and processes that should be available to mentally disordered offenders at various stages on their care pathway. It makes sense for the care and support packages for restricted patients to adopt the processes offered in the CPD.

1.3 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 60**.

1.4 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 290 restricted patients in the system at any one time. Just over 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, NHS Trusts and hospitals to review their internal procedures in relation to restricted patients to comply with the guidance set out in this paper.

1.5 The designation "**restricted patients**" is used, solely, throughout the remainder of this Memorandum, in keeping with the legislation, although the colloquial term "state" patients has been widely used previously.

1.6 Under the 1984 Act the Secretary of State was empowered to take decisions on restricted patients. These powers transferred under the provisions of the Scotland Act 1998 to Scottish Ministers.

1.7 This Memorandum indicates, therefore, that decisions on restricted patients are taken by Scottish Ministers. In practice, however, the First Minister personally makes 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.

1.8 The First Minister personally takes all decisions relating to transfer to a hospital of lesser security, conditional or absolute discharge and lifting of a restriction order for all restricted patients and leave of absence relating to those restricted patients who are also life sentence prisoners. As Minister for Justice, the views of the Deputy First Minister are invited on the release on life licence (and simultaneous absolute discharge) of life sentence prisoners. However, the final decision on their release is a matter for the Parole Board for Scotland ("Parole Board").

1.9 The First Minister generally delegates to officials all other decisions relating to the management of restricted patients.

1.10 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.

1.11 Notwithstanding these delegated powers, SEHD officials will refer to the Scottish Ministers any particular case where their views are specifically required.

Role of the Mental Welfare Commission

1.12 The Mental Welfare Commission is an independent body. All detained patients, including restricted patients, may ask the Commission to review the matter of their detention. This is normally limited to one review in any one period of detention. Whilst the Commission cannot order the release of a restricted patient they can make recommendations to Scottish Ministers for their consideration. Further information is contained in the Commission's booklet "In your interests …. A guide for all patients admitted to a psychiatric ward after criminal proceedings".

Enquiries

1.13 Any enquiries on this Memorandum should be addressed to the Scottish Executive Health Department, Public Health Division, Room 3E.06, St Andrew's House, Edinburgh, e-mail fiona.currie@scotland.gsi.gov.uk

2. CHAPTER TWO - ADMISSION OF A RESTRICTED PATIENT 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: -

- A restriction order under section 59 of the Criminal Procedure (Scotland) Act 1995 (the 1995 Act) 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.

- Section 69 of Mental Health (Scotland) Act 1984 (the 1984 Act) includes a provision for Scottish Ministers to direct that members of the armed forces, who, as a result of court martial proceedings, are found to be insane and are ordered to be detained at Her Majesty's Pleasure to be detained in hospital. This order has the effect of a hospital order together with a restriction order.

- A transfer order in respect of an untried prisoner under section 70 of the 1984 Act. In accordance with section 70(3), such an order also has the effect of a hospital order and a restriction order. It should be noted that section 70 restrictions remain in force until **the case is finally disposed of by the court or the proceedings are dropped or the patient is considered well enough to return to prison**.

- A restriction direction made by Scottish Ministers under section 72 of the 1984 Act, in addition to a transfer direction under section 71 in respect of a person serving a sentence of imprisonment. (A restriction direction made under section 72 has the same effect as a restriction order.)

- 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.

2.2 The following orders were available under the 1975 Act prior to the introduction of the 1995 Act. Some patients in the system may have originally entered hospital under these orders:

- 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).

Effect of Special Restrictions

2.3 A patient who is subject to special restrictions cannot be transferred or granted leave of absence for specified occasions unless Scottish Ministers have given consent. Discharge of such a patient from hospital (whether conditional or absolute) can only be authorised by Scottish Ministers or by the Sheriff on appeal**.** Scottish Ministers also have a power to lift the special restrictions, as described in Chapter 9. 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 a transfer order under section 70(1) of the 1984 Act, once the case is finally disposed of by the Courts or proceedings dropped (unless a hospital order and a restriction order are made);

- when a determinate or extended sentence prisoner who is also subject to a transfer 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 direction or hospital direction is released on life licence.

Transfers from outwith Scotland

2.4 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.

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

3. CHAPTER THREE – ROLES AND RESPONSIBILITES 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 Under the 1984 Act, the authority of Scottish Ministers is required at key points in the care of restricted patients:

- transfer between hospitals or to another hospital unit within a hospital and which involves a reduction in the level of security (section 29(1) as modified by Schedule 2 Part II para 6 of the 1984 Act);
- transfer between hospital and prison (section 74(3) of the 1984 Act);
- leave of absence out with the hospital grounds (section 27 of the 1984 Act as modified by Schedule 2 Part II para 4 of the 1984 Act);
- conditional discharge (section 68(2) of the 1984 Act);
- recall from conditional discharge (section 68(3) of the 1984 Act);
- removal of restriction order (section 68(1) of the 1984 Act); and
- absolute discharge (section 68(2) of the 1984 Act).

3.3 **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 otherwise for the request. Scottish Ministers' aims are to provide for the protection of and security of the public and to secure a patient's rights and freedoms under the law. The decision of Scottish Ministers will be relayed to the RMO by Scottish Executive Health Department (SEHD) officials. Where they do not authorise any request the reason for this will be given.

3.4 **It is important that RMOs allow sufficient time for such decisions to be considered by Scottish Ministers.** 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 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

3.5 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 leave, transfer and discharge. 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 and Annex B2.

3.6 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;
- Officials in Public Health Division of the SEHD who are responsible for administrative matters generally in relation to case work on restricted patients and for the preparation and submission of specific recommendations about a patient for consideration by Scottish Ministers.

Role of Psychiatric Adviser

3.7 The role of the Psychiatric Adviser is to provide advice to Scottish Ministers on restricted patients. The Psychiatric Adviser will visit and report to Scottish Ministers 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 prior to any recommendation going forward to Scottish Ministers for 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.

3.8 When visiting a patient, the Psychiatric Adviser will normally discuss the patient and their progress with their RMO and care 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 and to the Mental Welfare Commission for Scotland.

3.9 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.

3.10 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 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.

3.11 In addition, it is often helpful if the Psychiatric Adviser, and/or possibly 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 Scottish Ministers' 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.

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

Officials in the Public Health Division of SEHD

3.13 Officials in Public 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.

3.14 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 restricted 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 or, conditional discharge is being considered, officials will ensure that the RMO is 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. 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

3.15 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 in advance of the patient's PQD or other date on which a review for suitability of early release on licence is due. This report 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).

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

3.16 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 of cases relating to restricted patients. Such advice is not normally made public.

3.17 Solicitors will provide advice to officials on relevant legislation, on Scottish Ministers' responsibilities under the 1984 Act as amended by the 1999 Act and where it is appropriate to do so, will defend any appeals by restricted patients on behalf of Scottish Ministers.

4. 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 Section 62 and Part II of Schedule 2 of the 1984 Act set out the effect of special restrictions on a patient to whom these apply (i.e. restriction orders, transfer orders, restriction directions and those detained under section 69) and, in particular, restrict certain decisions on the patient's care to Scottish Ministers. Section 62A(5) sets out the restrictions resulting from hospital directions. It is the responsibility of the RMO to recommend to the Psychiatric Adviser any action to be considered by Scottish Ministers.

4.4 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

4.5 Under section 62(2) of the 1984 Act the RMO must, at such intervals as Scottish Ministers may direct (not exceeding one year), examine and report on the patient to Scottish Ministers. Every report shall contain such particulars as Scottish Ministers may require (see Annex B1, Page 64, for guidance). 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

4.6 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 or the date of admission to another hospital following transfer). 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 Treatment Plan Reports

4.7 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

4.8 **Scottish Ministers require that RMOs should prepare and submit a report on each restricted patient annually on the anniversary of their admission to hospital.** When a patient transfers to a new hospital, their next annual report will be due on the anniversary of their admission to the new hospital. 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 multi-disciplinary team caring for the patient.

Content of reports

4.9 **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 17 of the Mental Health (Scotland) Act 1984.)

Guidance on reporting on Patient's mental state and detainability

4.10 The Mental Health (Public Safety and Appeals) (Scotland) Act 1999, the competence of which has been upheld after a legal challenge in the Court of Session and the Privy Council, must be taken into account in providing all reports to Scottish Ministers. Therefore the 1984 Act as amended by the 1999 Act must be addressed by any report provided by the RMO.

4.11 The RMO must provide their present diagnosis for the patient including whether they consider that the patient suffers from a mental disorder. The definition of mental disorder in section (1)2 of the 1984 Act has been amended (by the 1999 Act) to include personality disorder specifically.

Public Safety Test

4.12 If the RMO is of the view that the patient is suffering from a mental disorder, they must consider the effect of that disorder. They must consider whether the effect of it is such that it is necessary, in order to protect the public from serious harm, that the patient continues to be detained in a hospital, whether for medical treatment or not. 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 multi-disciplinary assessment of potential risks. The RMO should take into account all relevant circumstances, including the patient's past history.

4.13 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.

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

Appropriateness, Safety and Treatability Tests

4.15 In reporting on the effect of the patient's mental disorder, the RMO will find it helpful to consider whether the disorder falls within any of the 4 categories:

- a mental illness; or
- a persistent disorder one manifested only by abnormally aggressive or seriously irresponsible conduct, where medical treatment is likely to alleviate or prevent a deterioration of his condition; or
- a mental handicap comprising mental impairment (where such treatment is likely to alleviate or prevent a deterioration of his condition); or
- severe mental impairment.

4.16 If the disorder which the RMO has diagnosed falls into any of those 4 categories, the RMO must go on to assess the following matters:

- is that mental disorder of a nature and degree which makes it appropriate for the patient to receive medical treatment in the hospital?;
- is it necessary for the health and safety of that person or for the protection of others that he should receive such treatment?; and
- the treatment cannot be provided unless he is detained under the Act.

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 the Department 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 – 4.23 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 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 leave of absence, 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 his present circumstances and his history. **Details of the information required on the patient to fully assess risk are listed at Annex B2, Page 65.** 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 leave of absence, transfer, etc. It would, therefore, be appropriate for the RMO to provide full, multi-disciplinary risk assessment information to the SEHD at significant points in a patient's care.

4.22 When the RMO provides additional information to the SEHD, 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 leave of absence, 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 by the SEHD.

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; and
- care plan objectives and leave of absence 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 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 out on leave of absence 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 power to agree to or withhold permission for restricted patients to marry in the widest sense. 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 which forms a legal impediment to a marriage and is set out at section 5(4)(d) 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 1984 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 outwith the hospital, Scottish Ministers' consent will be required for leave of absence.

Withholding Mail

4.28 Section 115 of the Mental Health (Scotland) Act 1984 sets out the statutory powers of managers of **a State Hospital** 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 it would be in the interests of the safety of the patient and for the protection of others; or
(c) subject to subsection (3) of this section, if the managers of the hospital consider that the postal packet is likely –

(i) to cause distress to the person to whom it is addressed or to any other person (not being a person 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 the State Hospital. Section 115(3) of the 1984 Act sets 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 for Scotland.

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 - LEAVE OF ABSENCE

Legislation

5.1 The power of the RMO under section 27 of the 1984 Act to agree leave of absence is modified for restricted patients (i.e. those subject to restriction orders, transfer orders, restriction directions and section 69 detainees) by section 62 and by Schedule 2 Part II of the 1984 Act. (The restrictions in relation to hospital directions are set out in section 62A.) This restricts the leave of absence that a restricted patient may receive to specified occasions and makes all leave from hospital subject to Scottish Ministers' consent. Scottish Ministers must, therefore, approve all leave of absence from hospital (either escorted or unescorted) by a restricted patient. Current legal advice is that the maximum consecutive period of leave of absence should be restricted to 5 days (which may include 4 overnight stays) in any one week. (Leave within the grounds of the hospital, both escorted and unescorted, is at the discretion of the RMO.)

Reasons for leave of absence

5.2 Scottish Ministers recognise that well-thought-out leave, which is carefully and sensitively executed, has an important part to play in the treatment and rehabilitation of restricted patients by 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 or into the community can safely be made. It is important that leave programmes should be designed and conducted in such a way as to sustain public confidence in the arrangements as a whole, and so as to respect the feelings and possible fears of victims and others who may have been affected by the offences.

5.3 In general, the Scottish Executive Health Department (SEHD) will consider leave of absence 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 5.22 below.

Requests for leave of absence

5.4 The RMO should address the request for leave of absence to the SEHD Psychiatric Adviser. Requests are easier to consider and approve where full and up-to-date information about the patient is held on their case file. When making a request the RMO should include details of the matters mentioned at paragraphs 5.10 along with the following additional information:

- the purpose of, and arrangements for, the leave envisaged on any particular occasion;
- the patient's current mental state;
- the arrangements for escorting the patient, where necessary;
- any social work or other reports prepared in relation to the planned leave of absence (particularly where it is a first visit to the home of family or friends);
- whether any children will be present at the location to be visited and any special arrangements required to protect them; and
- for restricted patients in the State Hospital, whether the use of handcuffs has been considered necessary and if so the reasons for this and the arrangements for their use.

5.5 Where a patient is being escorted to court by the police, permission must still be sought from the SEHD.

5.6 Permission for leave of absence from the **State Hospital** is sought by submitting an appropriately completed "Patient Outing Application Form" to the Psychiatric Adviser. For patients in **local hospitals**, the RMO should write to the Psychiatric Adviser.

Timing of Requests

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

5.8 Consideration of requests takes some time. **It is important that, where possible, the SEHD is given at least 14 days notice of a request for leave of absence.** It is appreciated that it is very upsetting for a patient (and where involved, the patient's family) when leave planned by the care 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 leave of absence 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 where insufficient information on which to base a decision has been provided must, therefore, be refused.

Information to support requests

5.9 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 leave of absence. Where the leave 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 leave of absence takes place between hospital staff. Where consideration is being given to a patient being allowed compassionate or rehabilitation leave of absence 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 leave. **Where a patient is visiting the home of a relative or friend for the first time, a social work report on the location to be visited, will be required to inform consideration of the request for leave of absence.**

Consideration of requests

5.10 Each request for leave is considered on its merits by the SEHD having regard to all the relevant factors. These include:

- the assessment of any risk of harm to the patient or the public arising from the proposal, and the nature and adequacy of safeguards against any specific identified risk;
- the aims of the proposal and its planned benefits to the patient's treatment and/or rehabilitation;
- the contribution which the leave is expected to make to future assessments of the patient's likely behaviour and to plans for managing the patient's future rehabilitation;
- any reasonable public concerns which the leave would be likely to arouse, and any measures proposed in response to such concerns; and
- 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; and any measures proposed in response to such concerns.

5.11 Leave for rehabilitation or quality of life reasons should relate to an overall care and treatment programme and set personal objectives for the patient; and the request to the Psychiatric Adviser should explain the part which leave will play in the overall plan.

5.12 All requests should explain what, specifically, the leave will seek to achieve and how it will be monitored, whether by escorting staff or through the patient's own report or both. Each application for leave should include an up-to-date assessment of risk or express confirmation that the assessment remains the same as in the last report to the SEHD.

Series of leaves of absence

5.13 Where it is intended that the patient makes a series of similar leaves of absence over a known time span (such as a series of hospital appointments, pre-transfer visits or attendance at college), a single detailed request may be submitted for the planned leave. 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 leave of absence would be subject to the patient's mental state being stable on the day. It would be the RMO's responsibility to ensure that this was so and to notify the SEHD of any changes.

Report of leave of absence

5.14 It is essential that the SEHD receives feedback on leave of absence received by restricted patients. This is particularly important when the patient has been on leave of absence for the first time or to a new location or is preparing for transfer or discharge. The

RMO should also ensure that this feedback is shared with all members of the clinical team, including social work.

5.15 A report must be made to the SEHD if any leave of absence is terminated or if an incident takes place on the leave of absence. When leave is cancelled the reasons for this should be made known and whether it is planned that the leave of absence should be rearranged at a future date.

Compassionate leave of absence

5.16 Compassionate leave of absence will be given serious consideration by the SEHD. It should be noted that such leave is more likely to be considered acceptable if efforts have been made to ensure a low profile for the leave, 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 outwith 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.

5.17 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.

Requests for unescorted leave of absence

5.18 For patients whose rehabilitation is well advanced, it is helpful to the RMO and the SEHD to provide a full plan of all the leave proposed. 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 leave of absence for a patient. Any changes in the circumstances involving a patient should be made known to the SEHD.

Leave of absence for life sentence prisoners

5.19 **Scottish Ministers personally approve all requests for unescorted leave of absence for life sentence prisoners. It is, therefore, helpful to draw up a programme of leave for a period of time for which approval can be sought in advance -** one-off requests for unescorted leave of absence for life sentence prisoners are not encouraged. 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 leave of absence. 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.

Leave in case of Emergency

5.20 Telephone requests by the patient's RMO or the duty RMO may be made in compassionate or emergency circumstances which necessitate urgent leave for the patient (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 Notification of Incidents Circular at Annex A1.** Where permission is not obtained in advance of very 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 Appearances

5.21 Where a patient is being charged in a criminal court then they are entitled to be at court for their trial. A request for leave of absence as detailed at paragraph 5.4 should be submitted to the Psychiatric Adviser and will normally be approved. If the RMO considers that the patient is not sufficiently well to attend court, the RMO should inform the court of this.

5.22 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 leave would need to be made. Where the court case involves an appeal under the 1984 Act, the patient should be allowed to go to court subject to the health provisions in section 113 of the Act. Where the RMO considers that the patient should attend court, a request for leave of absence as detailed at paragraph 5.4 should be submitted for consideration. Where the RMO considers that the patient is not sufficiently well to attend court, this should be indicated by the RMO to the Sheriff who will ensure that the patient's representative is given an opportunity to be heard.

Patients on conditional discharge

5.23 Requests for leave 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 leave 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 Chapter 10.

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, as set out in the Memorandum, 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. A checklist of information required when reporting an incident is attached at Annex A2.**

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 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 leave (escorted or unescorted) outwith hospital building.

In any of the cases outlined above, the Mental Welfare Commission for Scotland should also be informed.

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 PR 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 60**). **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. If any of the following apply:

- the assessment is that the patient is "dangerous"; or
- that the patient's recent conduct indicates that there may be some danger 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 "dangerous", the statement will be low key giving only 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. 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 leave of absence, 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, low key 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 the police or prison authorities 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 abscondee is recaptured. Press Health 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 Trust or Health 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 leave, full details of what occurred while the patient was absent should be provided, including any misdemeanours or suspected misdemeanours.

7. CHAPTER SEVEN – TRANSFERRED PRISONERS

Background

7.1 Most patients who are transferred to hospital while serving a prison sentence are on a Transfer Direction WITH a Restriction Direction under sections 71 and 72 of the Mental Health (Scotland) Act 1984. 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 section 74(9) and (10) of the 1984 Act) should be taken.

7.2 **A patient in this category cannot be transferred or given leave of absence without the permission of Scottish Ministers**. There is also during that period, no possibility of absolute or conditional discharge from hospital under the 1984 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. If the patient recovers to an extent which would justify the conditional discharge of a restricted patient other than a transferred prisoner, under section 71A of the 1984 Act, Scottish Ministers may decide that the patient should remain in hospital for the time being rather than be returned to prison. Where a patient who is a transferred prisoner appeals successfully against transfer to hospital, the Sheriff 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 (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 74 of the 1984 Act. Attached at Annex G is a Patient Guide to the current provisions.

Transferred Prisoners serving Determinate or Extended Sentences

7.5 A restriction 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 as a restricted patient, careful note should be taken of the date on which he or she must be released and on

which the restriction direction will therefore cease to have effect (this is known as the earliest date of liberation or 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.

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 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 (absolute or conditional) 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 restriction direction ceases to have effect, under section 74 of the 1984 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

restriction 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 subsection (9) of section 74 of the 1984 Act. Where the transferred prisoner was sentenced on or after 1 October 1993, and a report is furnished under section 74(9), his or her detention will continue as though he or she had been admitted in pursuance of an application for admission approved on the date on which the restriction direction ceased to have effect. In either case, however, the patient will be entitled to appeal to the Sheriff as if authority for detention had been renewed.

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 restricted transfer 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 H.**

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, a restriction direction will always be given and 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 74 of the 1984 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 and restriction directions 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 1984 Act.

7.18 Where a transferred prisoner subject to such a sentence no longer meets the criteria for detention in hospital and the patient should not be discharged, 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 a formal recommendation 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 Scottish Ministers, from the wider perspective of public safety, may be unable to authorise discharge. The RMO

should ensure that the patient's expectations about the timing of their discharge 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 and restriction directions 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.

Restricted Patients Detained Temporarily under Section 70

7.23 A person detained in custody whilst awaiting trial or sentence may be transferred to a hospital by order of the Sheriff under section 70 of the 1984 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, in terms of section 73, subject to the right of the Courts to make a hospital order with or without restrictions under the 1995 Act. The hospital authorities should include the SEHD in their notification system when any section 70 patients are admitted to hospital and when their cases are disposed of by the Court (or proceedings are dropped). **The SEHD must be notified of the precise Court outcome (or dropping of proceedings)** although this may, if necessary, follow the basic notification of the patient's leaving the hospital to attend Court. The RMO should ensure, via close liaison with other parties within the hospital or, if necessary, the Court authorities, that the information is established quickly and conveyed to the SEHD in a short letter.

7.24 Where a section 70 patient has clearly recovered from their mental disorder in advance of their anticipated court appearance, it will be appropriate for the RMO to contact officials in the SEHD, or the Psychiatric Adviser, on the question of whether Scottish Ministers would wish to direct the patient's return to prison or other place of custody to await trial or sentence.

7.25 **It should be noted that subsection (3) of section 73 of the 1984 Act has been repealed with effect from 1 October 1993.** Consequently, there is no longer any automatic provision for the continued detention in hospital of a section 70 patient where the transfer order ceases to have effect under section 73(1) because the proceedings have been dropped or the person has been acquitted. In such circumstances, the continued detention of the patient should, where necessary, be effected under Part V of the Act.

Hospital Directions

7.26 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.

7.27 Further guidance on hospital directions will be issued shortly by the SEHD. In the meantime, Scottish Prison Service (SPS) Circular 55A/99, issued on 25 May 1999, provides guidance on the procedures for the return to prison of hospital direction patients. A copy can be obtained from officials in Public Health Division.

8. CHAPTER EIGHT - TRANSFERS BETWEEN HOSPITALS OR DISCHARGE 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 Amendments to the Mental Health (Scotland) Act 1984 by the Crime and Punishment (Scotland) Act 1997 introduced a power for the courts and Scottish Ministers to specify hospital units. This was 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.

8.3 Scottish Ministers must personally approve all transfers to conditions involving a drop in security i.e. from the State Hospital or from the Orchard Clinic (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. 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 care 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 SEHD 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 B3.**

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 clinical 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 clinical 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 leave of absence should be submitted in the usual way. Where a number of pre-transfer visits are considered appropriate, a block request may be submitted.

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.

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

Transfer to hospital with same level of security

8.11 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.

8.12 Transfers to a hospital with the same level of security do not require Scottish Ministers' personal approval but must be approved by the SEHD following consultation with the SEHD 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 leave of absence procedure for restricted patients. Where a number of pre-transfer visits are considered appropriate, a block request may be submitted.

8.13 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.

Transfer to another ward within the same hospital

8.14 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

8.15 A patient who is the subject of a transfer direction and a restriction 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, is not liable for recall and may be absolutely discharged under the 1984 Act. The RMO is also required to address Section 74 as amended by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. The result of section 74(1B) is that Scottish Ministers are not required to remit back to prison a person who is suffering from a mental disorder where the effect of it is such that it is necessary, to protect the public from serious harm, to continue to detain him in hospital, whether for medical treatment or not.

8.16 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.

8.17 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 8.15-8.16 apply.

8.18 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.

8.19 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.

The Mental Welfare Commission for Scotland will be notified of the patient's discharge under the 1984 Act and return to prison.

Transfer to Scotland

8.20 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.

8.21 **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.

8.22 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.

8.23 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.

8.24 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 outwith Scotland at the end of any visit.

8.25 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

8.26 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.

8.27 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.

8.28 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.

8.29 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 B3. 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.

8.30 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.

8.31 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 leave of absence 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

8.32 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.

8.33 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.

8.34 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 liase with the RMO to ensure provision of a transfer warrant for the patient at the appropriate time.

8.35 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.

8.36 The SEHD will notify the Mental Welfare Commission for Scotland of the patient's transfer.

Other Transfers

8.37 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 under section 74(1)(b).

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

9. CHAPTER NINE - LIFTING OF SPECIAL RESTRICTIONS

Introduction

9.1 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

9.2 Under section 68(1) of the 1984 Act, Scottish Ministers may, if satisfied that a restriction order in respect of a patient is no longer required for the protection of the public from serious harm, direct that the patient shall cease to be subject to the special restrictions and the restriction order will fall. Scottish Ministers will consider a recommendation from an RMO to remove the restriction order. The hospital order would in such circumstances remain in force until the RMO decided that it was no longer necessary.

9.3 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.

9.4 It might be appropriate for the RMO to ask Scottish Ministers to consider such a step 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

9.5 It will be necessary for the RMO to provide sufficient information for Scottish Ministers to make the decision 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.

9.6 This would include:

- 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 a mental health officer) ; and
- plans for patient's future care.

How it is achieved

9.7 Once in receipt of appropriate information, the Scottish Executive Health Department's (SEHD) Psychiatric Adviser will visit the patient and his RMO to discuss the recommendation and plans for the patient's current and future care.

9.8 A case will then be put forward to Scottish Ministers with an appropriate recommendation.

9.9 In the event that Scottish Ministers authorise the removal of the restriction order, officials in the SEHD will inform the RMO of this. They will also provide written details of the precise date at which the restriction order will be removed in order that the RMO can manage this appropriately. The Mental Welfare Commission for Scotland will also be informed of the removal of the patient's restriction order.

How it is managed

9.10 The effect is that the patient ceases to be a "restricted patient", is no longer subject to the restrictions of section 62(1) of the 1984 Act and should now be detained in hospital as if admitted under a hospital order (without a restriction order) made by the Court on the date of the lifting of 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 Mental Health (Scotland) Act 1984 which would apply to any patient who has been compulsorily detained by hospital order. Once the restriction order has been lifted Scottish Ministers' special responsibilities for the patient will cease.

10. CHAPTER TEN – CONDITIONAL DISCHARGE

10.1 Section 68(2) of the 1984 Act enables Scottish Ministers to consider discharging a patient subject to conditions or absolutely.

10.2 Scottish Ministers will usually decide to make a restricted patient's discharge from hospital 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 by Scottish Ministers are those of residence at a stated address, supervision by a social worker and psychiatric supervision. The Sheriff on appeal is also likely to make discharge directions conditional either for the protection of the public or of the patient, and to impose similar conditions. Scottish Ministers may vary these conditions at any time under section 64(5).

10.3 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 multi-disciplinary 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

10.4 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.

10.5 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, will the RMO recommend the patient's conditional discharge. The Scottish Executive Health Department (SEHD) Psychiatric Adviser will assess the patient on behalf of Scottish Ministers once a recommendation has been received and flag up to the RMO any issues which may need to be addressed.

What information is required?

10.6 **Further details of the type of information required for Scottish Ministers are contained in Annex C**.

How is it achieved?

10.7 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 RMO should alert the Director of Social Work for the receiving local authority area as soon as pre-discharge planning begins, copying the letter to SEHD.** The Director will then identify a social work supervisor following consultation with the RMO. In most cases, the social work supervisor should be 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.) However, circumstances vary from case to case and the SEHD will consider alternative arrangements where appropriate.

10.8 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.

Pre-discharge procedures

10.9 As outlined in 10.7 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 clinical 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 clinical 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 clinical 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.

10.10 As soon as these issues are resolved and 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 multi-disciplinary care 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 care 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 care team meeting minutes are copied to the Psychiatric Adviser for information.

10.11 The supervising psychiatrist <u>must</u> 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 clinical team. In the unlikely event of no response (or of an inadequate response), officials in the SEHD may be able to help.

<u>Provision of written information by the discharging hospital</u>

10.12 In addition to the pre-discharge contact recommended in paragraph 10.11, 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.

10.13 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;
- any specific risk assessment issues, 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.

10.14 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. A recommendation for conditional discharge cannot proceed without this information being available.

10.15 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

10.16 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 contact the SEHD who will consider whether the approval of Scottish Ministers can be given. It should be noted that patients cannot be compelled to take medication while on conditional discharge. However, were the patient to indicate signs of relapse of his mental state, the patient can be recalled to hospital. Examples of specific conditions of discharge are:

- address;
- compliance with medication;
- regular psychiatric and social work supervision;
- 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.

Reporting

10.17 The supervisors will be asked to complete report forms at specified intervals, initially on a monthly basis (see specimen forms at Appendices 1 and 2) 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. 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.

Right of Appeal

10.18 Patients should be reminded of their right to appeal to the Sheriff for absolute discharge after one year of conditional discharge. Patients should also be reminded of their right to approach the Mental Welfare Commission for Scotland on any aspects of their care about which they might feel aggrieved.

10.19 **Annex E covers in more detail the role of the Psychiatric Supervisor and Annex F the role of the Social Work Supervisor**.

11. CHAPTER ELEVEN - ABSOLUTE DISCHARGE

11.1 Scottish Ministers 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 1984 Act, and thus no longer presents as a result of mental disorder a serious danger to the public. In reaching this view, Scottish Ministers take account of the patient's index offence and history as well as their conduct in hospital and the community and of whether the patient's rehabilitation is felt to be complete, the exception being those restricted patients who are also life sentence prisoners. Please refer to Chapter 7 for guidance on these patients.

<u>When it might be appropriate</u>

11.2 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. Recommendations for absolute discharge should always be discussed in the first instance between the RMO and the Scottish Executive Health Department's (SEHD) Psychiatric Adviser. When a formal recommendation is submitted, this should always include 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. A report from the social work supervisor should also be provided and should provide 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 D**.

<u>How it is achieved?</u>

11.3 In most cases, an absolute discharge will be authorised by Scottish Ministers under Section 68(2) of the Mental Health (Scotland) Act 1984. Patients also have a right of appeal to the Sheriff and to the Mental Welfare Commission for Scotland, although the latter may only recommend discharge of restricted patients to Scottish Ministers (section 3(3) of 1984 Act). Where a recommendation is received for discharge from the Mental Welfare Commission for Scotland, the views of the RMO will always be sought by SEHD officials before Scottish Ministers consider the recommendation.

<u>How it is managed?</u>

11.4 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 clinical team, including the social worker following absolute discharge.

11.5 It should be noted that if Scottish Ministers direct that the restriction order ceases to have effect <u>after</u> the patient has been conditionally discharged, the direction operates as an absolute discharge by virtue of section 68(4) of the Mental Health (Scotland) Act 1984. In other words, it is different from the situation where the patient remains in hospital described at paragraph 9.2

Early Discharge Protocol for patients in secure hospital settings

11.6 In response to one of the recommendations in the Mental Welfare Commission for Scotland'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 which will complement the proper application of the established Care Programme Approach (CPA), will apply to all patients in the State Hospital who no longer, or may no longer meet the criteria for compulsory intervention under the Mental Health (Scotland) Act 1984 or the Criminal Procedure (Scotland) Act 1995 but who have complex needs and continue to pose a significant risk to public safety. **The Protocol is currently in draft form and will be issued in autumn 2002.**

12. CHAPTER TWELVE- APPEALS BY RESTRICTED PATIENTS

Introduction

12.1 This section deals with the various rights of appeal available to restricted patients under the 1984 Act (as amended). The principal right conferred on all restricted patients is an annual right of appeal to a Sheriff for discharge from detention. The appeal procedure and the applicable legal tests vary according to the provision under which the patient is detained. The 1984 Act also provides rights of appeal against:

- recall from conditional discharge;
- continuing liability to recall from conditional discharge;
- transfer from prison to hospital;
- transfer from a local hospital to the State Hospital; and
- an appeal to the Court of Session by either the Scottish Ministers or the patient against a decision of a Sheriff.

The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 ("the Ruddle Act")

12.2 The procedure for appeals contained within the 1984 Act has been significantly amended by the Mental Health (Public Safety and Appeals)(Scotland) Act 1999 ("the 1999 Act") with effect from 1 September 1999. The competence of the 1999 Act was the subject of legal challenge on the basis of the European Convention on Human Rights ("ECHR") shortly after it was enacted. In a decision in the case of *A* v. *Scottish Ministers*, the Judicial Committee of the Privy Council upheld the competence of the 1999 Act. In summary, the 1999 Act amended the 1984 Act,

- to put beyond doubt that mental disorder included personality disorder;
- by introducing a new ground to prevent a Sheriff or Scottish Ministers absolutely or conditionally discharging a patient whose mental disorder makes him or her a serious risk to the public irrespective of whether such continued detention is for the purposes of medical treatment; and
- by introducing a new form of appeal to the Court of Session against a decision of the Sheriff (as mentioned at para 12.1 above).

12.3 The 1999 Act amends the legal tests which are to be applied either by the Scottish Ministers when reviewing the appropriateness of continued detention or by the Sheriff when considering an appeal, and the order in which those tests are to be applied. This inevitably impacts on the information which will have to be addressed in medical reports required for the purpose of reviewing detainability and appeals. Accordingly, Appendix 3 sets out the type of request which a psychiatrist is likely to receive.

Preparation of Reports and Attendance at Hearing

12.4 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 often be instructed by OSSE for the substantive appeal hearing and may wish to discuss the case with individual expert witnesses prior to their giving evidence. (Appeals by non-restricted patients are handled by Central Legal Office, the legal advisers to the NHS, to whom all papers should be forwarded.)

12.5 The RMO or Hospital Records Officer must forward any papers received relating to an appeal by a restricted patient to the Scottish Executive Health Department (SEHD) officials immediately on receipt. There are actions which OSSE will have to carry out by a specified date once notified of an appeal by a restricted patient. This is important because there is no separate notification of the appeal to the SEHD.

12.6 On receipt of papers indicating an appeal, the SEHD will write to the RMO requesting a report containing their view of the patient's mental disorder and detainability. This report must consider the questions set out in the SEHD letter. (See sample at Appendix 3.) Providing the report in this form ensures that Ministers obtain all the information necessary for them to consider whether to oppose the patient's application for discharge.

12.7 In cases where Scottish Ministers intend defending an appeal the SEHD will normally instruct a second medical report on the patient from a consultant psychiatrist with appropriate experience relating to the patient's mental disorder. In cases of particular complexity, or where a divergence of psychiatric opinion seems likely, further reports may be instructed by the SEHD. The RMO's report and any second (or further) opinion will be lodged with the court by OSSE for use at the substantive hearing. It should also be noted that the SEHD Psychiatric Adviser will examine, and thereafter give an opinion as to the detainability of, the patient and that will be factored in to Scottish Ministers' decision- making process.

12.8 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 Department 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. Generally, an RMO will be expected to give oral evidence at the appeal hearing.

12.9 **An ongoing appeal should not halt or delay the normal progress of the care and treatment of a restricted patient.** An appeal does not affect the Scottish Ministers' decision making powers. The RMO should continue to report on progress and request permission for leave of absence, 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 appeal 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.

Statutory Provisions – Appeals

12.10 The following paragraphs explain in more detail the various appeal rights available to restricted patients under both criminal and civil law statutory provisions and the legal tests which Sheriffs must apply.

Criminal Law: The Criminal Procedure (Scotland) Act 1995 ("the 1995 Act")

12.11 In addition to the appeal rights provided under the 1984 Act, there is an appeal procedure within criminal law in relation to certain categories of patient. This relates to the stage of proceedings at which a restricted patient first enters the mental health system via disposal by the criminal courts under the 1995 Act.

12.12 Section 60 of the 1995 Act confers on a person the right to appeal to the High Court of Justiciary against the imposition of a Hospital Order (section 58 of the 1995 Act), Interim Hospital Order (though not a renewal thereof-section 53 of the 1995 Act), Guardianship Order (section 58 of the 1995 Act), Restriction Order (section 59 of the 1995 Act) or Hospital Direction (section 59A of the 1995 Act). Such an appeal is treated as though it were an appeal against sentence. The Appeal Court is unlikely to allow the appeal if the medical evidence warranted the imposition of the particular order appealed against.

Civil Law: Part VI of the Mental Health (Scotland) Act 1984

12.13 The 1984 Act confers upon restricted patients the following rights of appeal:-

- Section 64 - 67 of the 1984 Act – appeals against detention under a Hospital Order with a Restriction Order, a Hospital Direction or a Transfer Direction with a Restriction Direction;
- Section 71(5) of the 1984 Act – appeal against Transfer Direction made by Scottish Ministers;
- Section 66 of the 1984 Act – appeal against recall from conditional discharge and appeal against continuing liability to recall to hospital;
- Section 29 of the 1984 Act – appeal against a transfer to the State Hospital; and
- Section 66A of the 1984 Act – appeal to the Court of Session against the Sheriff's decision.

(1) Appeal Against Detention under Hospital Order / Restriction Order, Hospital Direction or Transfer Direction/Restriction Direction

12.14 This is the principal right conferred on restricted patients and affords them an annual opportunity to have a Sheriff review the appropriateness of their continued detention and to order a discharge if detention is no longer justified on the medical evidence.

12.15 Section 63(2) of the 1984 Act provides that a patient who is subject to a Hospital Order/Restriction Order, Hospital Direction or Transfer Direction/Restriction Direction may appeal to the Sheriff to order his discharge from detention. The appeal is by way of Summary Application which gives the Sheriff a wide discretion in regulating the conduct of the court proceedings.

12.16 The patient may appeal to the Sheriff between 6 and 12 months from the date on which the Order restricting his discharge was made, and thereafter once in any 12 month period (hence "annual" appeal right).

(a) Patients Subject to Hospital Order/Restriction Order

12.17 Appeals by patients subject to a Hospital Order/Restriction Order are regulated by section 64 of the 1984 Act. The 1999 Act, mentioned above, has significantly amended the tests which a Sheriff must apply when considering an application for discharge. Each of the legal tests is now described. This is the approach the Sheriff will adopt in the appeal and is one witnesses will be asked to mirror in their reports.

12.18 In terms of section 64(A1) of the 1984 Act (inserted by the 1999 Act), a Sheriff must first decide whether, at the time of the appeal hearing, the patient is suffering from a mental disorder within the meaning of the 1984 Act. (Reference should be made to section 1 of the

1984 Act for the definition of "mental disorder".) Where the Sheriff finds that the patient does suffer from a mental disorder within the meaning of the 1984 Act he must consider its effect. If the effect is such that there is a risk of serious harm to the public, the patient should be detained in hospital, whether for medical treatment or not, and the Sheriff **must** refuse the appeal. (This is known as the "serious harm" test). That will be the end of the appeal. It is not necessary at that stage for the Sheriff to consider questions of treatability.

12.19 It is for the Scottish Ministers to establish whether the patient represents a risk of serious harm. This will be done by reference to the medical evidence. Consequently, expert witnesses may be asked to comment on the sort of risk which they consider any given patient presents. The question of whether that risk is a "serious" one within the meaning of the Act is a legal one for the Sheriff to resolve but the Sheriff will base his decision on the medical evidence. It is therefore helpful for expert witnesses to set out in their reports, with examples if possible, the kinds of offences which they consider a patient may commit if discharged. The witnesses' opinions are sought on the "balance of probabilities" – in other words what is more likely to happen than not.

12.20 Where the Sheriff finds that the "serious harm" test has not been established, he must go on to consider the tests contained within section 64(1) of the 1984 Act

12.21 The provisions in section 64 have been discussed and their meaning authoritatively decided in some recent court cases. Most significantly, the House of Lords analysed section 64 in the case *Reid* v *Secretary of State for Scotland* The result is that section 64 as amended by the 1999 Act should be applied by Sheriffs as follows (this is important as it informs the sorts of questions which the Sheriff will have to determine by reference to the medical evidence and accordingly the type of information you will be expected to provide) :

- Does the patient suffer from a mental disorder within the meaning of the 1984 Act, as amended by the 1999 Act; if not, the patient should be discharged;
- Identify the nature and degree of the mental disorder. If the patient is either a psychopath or suffers from mental impairment which is not severe (i.e. the two "special" cases appearing in section 17(1)(a)(i) and (ii) of the 1984 Act) consider whether medical treatment is likely to alleviate or prevent a deterioration of the condition. If treatment is not likely to do so, the patient should be discharged; if treatment is likely to do so, *or if the patient is suffering from any other kind of mental disorder*, go on to consider the following;
- In the light of all the circumstances, consider the appropriateness of the patient being detained in hospital for medical treatment (the circumstances can include the health and safety of the patient and the safety of other persons); if the Sheriff is *not* satisfied that the detention is "appropriate" the patient should be discharged (and the Sheriff should then go on to consider whether conditional discharge is appropriate); If he *is* satisfied that it is appropriate for the patient to continue to be detained, he should go on to consider the following ;
- Is it *necessary* for the health or safety of the patient or for the protection of others that the patient should be detained for treatment. If yes, the patient continues to be detained, if no, consider whether the patient should be conditionally discharged.

12.22 It is important to note that a Sheriff must be satisfied that detention is *both* appropriate *and* necessary by reference to the nature and degree of the mental disorder. If detention is

appropriate (in the sense of desirable) but not necessary then the patient will be entitled to be discharged either absolutely or conditionally.

Effect of Absolute or Conditional Discharge

12.23 Where the Sheriff has made an Order for the absolute or conditional discharge of the patient, the authority for detention continues under the original Order until:

- The expiry of the time for lodging an appeal in the Court of Session, where no appeal is lodged (an appeal must be lodged within 14 days of the Sheriff's Order of absolute or conditional discharge); or

- Scottish Ministers give notice to the Court of Session and the managers of the hospital concerned that they do not intend to seek an Order continuing the effect of the original Order ("an extension order"); or

- the Court of Session refuses the Scottish Ministers' request for an extension order; or

- the recall of an extension order or expiry of its effect.

12.24 On the occurrence of any of those events, the patient will be entitled to be discharged from hospital with immediate effect. In the case of an Order for conditional discharge, the Sheriff may, in terms of section 64(7) of the 1984 Act, defer the Order to enable appropriate practical arrangements to be made.

(b) Patients Subject to Hospital Direction or Transfer Direction/Restriction Direction

12.25 Appeals by patients subject to a Hospital Direction or a Transfer Direction/Restriction Direction are regulated by section 65 read in conjunction with section 64 of the 1984 Act. The Sheriff must, in the first instance, consider the same legal tests contained in section 64 as apply to patients subject to a Hospital Order/Restriction Order (see above). However, the Sheriff does not have power to discharge patients subject to a Hospital or Restriction Direction

12.26 In terms of section 65, the Sheriff must first decide whether, if the patient had been subject to a Restriction Order, he or she would have been entitled to either absolute or conditional discharge. If the Sheriff concludes that neither would have been appropriate he will refuse the appeal by the patient.

12.27 If the Sheriff decides that *absolute* discharge would have been appropriate he must notify the Scottish Ministers accordingly. In these circumstances the Scottish Ministers are *obliged* to return the patient to any prison or other institution in which the patient might have been detained had it not been for the imposition of a Hospital Direction or Transfer Direction/Restriction Direction.

12.28 Where the Sheriff decides that *conditional* discharge would have been appropriate, he must notify Scottish Ministers accordingly. However, the Sheriff may nevertheless recommend to Scottish Ministers that the patient should continue to be detained in hospital. In these circumstances, Scottish Ministers have a discretion. They may order the patient's return to prison or other appropriate institution *or* they may decide that the patient should

continue to be detained in hospital. This decision will take account of both the available medical evidence and any recommendation made by the Sheriff

(2) Appeal Against Transfer Direction under Section 71(5) of the 1984 Act

12.29 Where a person who is serving a sentence of imprisonment is transferred by Scottish Ministers in terms of section 71(1) of the 1984 Act to detention in a hospital (a "Transfer Direction"), the patient may, in terms of section 71(5) of the 1984 Act appeal to a Sheriff within one month of his transfer to cancel the Transfer Direction. (These patients may also subsequently appeal against detention in the normal way under section 64 of the 1984 Act within the timeframes set out in that section).

12.30 The Sheriff *must* cancel the Transfer Direction if he is not satisfied that the grounds for an application for admission under Part V of the 1994 Act have been established i.e. in effect that the admission criteria in section 17 of the 1984 Act are not satisfied. Where the Sheriff cancels the Transfer Direction, Scottish Ministers are *obliged* to return the patient to any prison or other institution in which he or she might have been detained had it not been for the Transfer Direction (this will generally be the prison from which the patient was initially transferred). In these circumstances, Scottish Ministers will normally rely on the medical evidence of the two doctors who concluded that the initial transfer to hospital was appropriate under section 71(1).

(3) Appeal Against (a) Recall from Conditional Discharge and (b) Continuing Liability to Conditional Discharge

(a) Recall from Conditional Discharge

12.31 A patient may be conditionally discharged at any time by Scottish Ministers (section 68(2)) or by a Sheriff after hearing an appeal against detention. In either case, Scottish Ministers may, at any time while the Restriction Order is in force, recall the patient to hospital from conditional discharge (section 68(3)).

12.32 A patient who is recalled from conditional discharge by Scottish Ministers may appeal to the Sheriff against such recall within one month of the day on which he is returned to hospital.

12.33 The Sheriff *must* refuse the appeal if satisfied that, at the time of the Hearing, the "serious harm test" (as explained at paragraphs 12.18 – 12.20 above) is established. As previously discussed, matters of treatability are not relevant where the Sheriff is satisfied that the patient poses a risk of serious harm to the public flowing from his or her mental disorder.

12.34 If the Sheriff is not satisfied as to the existence of serious harm, he must then go on to consider the tests referred to in section 64(1) and (2) of the 1984 Act. These are summarised in paragraph 12.21 above.

12.35 Where the Sheriff absolutely discharges the patient after hearing an appeal against recall from conditional discharge, the patient remains liable to be detained in terms of the original Order until the occurrence of any of the events set out in section 64(4A) of the 1984 Act. These are summarised at paragraph 12.23 above

(b) Patients Subject to Hospital Direction and Transfer Direction/Restriction Direction

12.36 Patients subject to the Hospital Directions and Transfer Direction/Restriction Directions may not be conditionally discharged back to Prison. If a patient relapses while in Prison, he may be transferred to hospital of new under section 71 of the 1984 Act.

(c) Appeal Against Continuing Liability to Conditional Discharge

12.37 A conditionally discharged patient who has not been recalled to hospital may appeal against continuing liability to be recalled in terms of section 66(2) of the 1984 Act.

12.38 The patient may appeal within the period of 12-24 months from the date on which he was conditionally discharged and thereafter once in any subsequent 2 year period.

12.39 The Sheriff is required to discharge the patient absolutely if he is satisfied as to the tests set out in section 64(1) of the 1984 Act. Where the Sheriff directs the absolute discharge of the patient, the patient remains liable to recall until the occurrence of any of the events set out in section 64(4A) are established (which were summarised in paragraph 11.23 above).

12.40 If the Sheriff decides to continue the conditional discharge he may vary the existing conditions or impose new ones.

(4) Appeal Against Transfer to the State Hospital

12.41 Section 29 of the 1984 Act ("transfer of patients") applies to restricted patients by operation of Part II of Schedule 2 to the 1984 Act. In terms of section 29(4), a patient who is transferred to the State Hospital from a "local" hospital may, within 28 days of the date of transfer, appeal to a Sheriff against the transfer

12.42 The Sheriff must order the return of the patient to the hospital from which he was transferred unless he is satisfied that the patient, on account of his dangerous, violent or criminal propensities, requires treatment under conditions of special security and cannot suitably be cared for in a hospital other than in the State Hospital.

(5) Appeal to the Court of Session against the Sheriff's Decision

12.43 The 1999 Act introduced a new form of appeal to the Court of Session against a decision of a Sheriff under section 64 or 66, or a notification or recommendation by the Sheriff under section 65. This form of appeal is therefore available to all categories of restricted patients.

12.44 Both the patient and Scottish Ministers may appeal to the Court of Session against a decision of the Sheriff. The appeal must be lodged within 14 days of the Sheriff's decision.

12.45 Pending resolution of that appeal, and where the Sheriff has ordered discharge of the patient, Scottish Ministers may ask the Court of Session to grant authority to continue to detain the patient. Where such an Order is made, it continues authority to detain the patient until expiry of the time within which a further appeal could be lodged in the House of Lords, or where such an appeal is lodged, until that appeal is determined.

13. CHAPTER THIRTEEN - DISCLOSURE OF INFORMATION

13.1 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.

13.2 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 legislation is the Data Protection Act 1998 which 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.

13.3 The principal new areas covered by the legislation are:

- the Data Protection Registrar becomes the Data 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.

13.4 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.

Release of information to patient

13.5 Restricted patients, whether in or outwith 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 multi-disciplinary team caring for them in order to facilitate their care.

13.6 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

13.7 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.

13.8 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.

A new code of practice is to be published in early 2003. It will contain eight key principles outlining how patient identifiable information should be handled. The code has been produced following a recommendation from The Confidentiality and Security Advisory Group for Scotland (CSAGS), whose report “Protecting Patient Confidentiality: Final Report” was published in April 2002.

13.9 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.

13.10 In reaching a decision, all relevant circumstances should be taken into account including advice from the multi-disciplinary 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.

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

<u>Discharge of restricted patients</u>

13.12 The SEHD no longer routinely informs the police when a restricted patient is discharged from hospital. However, the SEHD has to balance patient confidentiality against the wider public safety. Where there are clear implications for public safety in any particular case the SEHD will liase with clinicians to seek the consent of the patient to inform the police about the patient’s discharge. Where this is not forthcoming, Scottish Ministers will take a decision on whether it is necessary to breach patient confidentiality.

14. CHAPTER FOURTEEN - OTHER RELEVANT ACTS

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

14.1 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.

Sex Offenders Act 1997

14.2 A patient will be identifiable as a sex offender under the Sex Offenders Act 1997 from a comparison of his offence(s) with those listed in Schedule 1 to the 1997 Act. The 1997 Act came into effect on 1 September 1997.

14.3 The 1997 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.

14.4 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.

14.5 Where it is not clear whether a patient is required to register under the 1997 Act, legal advice should be sought by the patient. The RMO should advise the patient about this.

14.6 Registration involves notifying the patient of their obligations under the 1997 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. Recent changes to the 1997 Act allow Scottish Ministers to make regulations requiring those responsible for an offender to notify the police when discharging someone who is subject to the 1997 Act.

14.7 NHS MEL (1997) 48 and Police Circulars Nos. 9/2000 and 6/2001 provide full guidance on the implementation of the Act, as amended.

Sex Offender Order

14.8 Sex Offender Orders (SOOs) came into force on 1 December 1998 under section 20 of the Crime and Disorder Act 1998. The decision to apply for a SOO lies with the police. It

can be used against anyone with a previous conviction for an offence listed in Schedule 1 of the Sex Offenders Act 1997. A SOO is a new 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 Sex Offenders Act 1997 while they are in effect.

Schedule 1 Offenders and Sex Offenders

14.9 It should be noted that offenders who have to register under the Sex Offenders Act 1997 are only a particular subset of those who might be considered to be sex offenders and to present a risk to women or children. The offences covered by the Sex Offenders Act 1997 are not intended as an exhaustive list of sex offences. 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.

14.10 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.

14.11 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.

14.12 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

14.13 The Crime and Punishment (Scotland) Act 1997, Section 48 inserts new sections 19A and 19B in the Criminal Procedure (Scotland) Act 1995. These sections confer new 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 hospital 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

14.14 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.

14.15 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.

14.16 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 clinical 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

14.17 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

14.18 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 14.13.

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
Mrs R A Toal	0131 244 2510
Miss F Currie	0131 244 2459 (Surnames A - L)
Mrs J McNeill	0131 244 1818 (Surnames M - Z)
Mrs J Craigie	0131 244 2457 (Surnames A - L)
Mrs N Brown	0131 244 2546 (Surnames M - Z)
Mr J Brown	0131 244 2192
Dr J Loudon	0131 244 2805

Outwith Office Hours

2. Outwith office hours (of 5pm to 8.30am) and on weekends and public holidays immediate contact should be made with one of the following:

Dr M Sturrock	01505 843068	Pager No - 07699 763083
Mrs R A Toal	0131 621 0564	Pager No - 07666 724044
Miss F Currie	0131 665 8199	Pager No - 07699 751181
Mrs J McNeill	01383 873042	Pager No - 07699 757752
Mr J Brown	0131 445 5955	Pager No - 07699 708951
Mrs F Tyrrell	0131 334 2197	Pager No - 07663 766405

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.

4. This notice should **NOT** be placed on Notice Boards.

The Scottish Executive Health Department
St Andrew's House
July 2002

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 DANGER 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 ON RESTRICTED PATIENT 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 1984 Act as amended by the 1999 Act. **See also Annex B2 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 in grounds, unescorted leave etc and how they are used;
patient's relations with family and friends outwith 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 1984 Act, as amended by the 1999 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 care team of information previously known about the patient.

ANNEX B2

RISK MANAGEMENT

1. The Scottish Executive Health Department (SEHD) is responsible for assessing and managing the risk presented by each restricted patient on behalf of Scottish Ministers. 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. In preparing reports for the SEHD it is important therefore that the RMO should address the issues below and provide the SEHD with the relevant information to help them to assess the patient's risk.

2. The RMO should consider and report on:

- whether the patient is detainable under the 1984 and the 1999 Acts and if so for what reasons;
- the level of security which the patient requires;
- the current understanding of the factors relating to the index offence and the previous dangerous behaviour;
- what change, if any, has taken place in respect of these factors;
- 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 care team.

3. 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 care team.

4. 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.

5. 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

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 leave of absence;
- 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;
- details of pre-transfer visits, if necessary, and the patient's reactions and behaviour on these;
- details of the initial treatment and care plans for the patient in the 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 C

INFORMATION REQUIRED FOR SCOTTISH MINISTERS – CONDITIONAL DISCHARGE

1. Details which should be provided include:

- 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. (The Mental Health (Public Safety and Appeals) Act 1999 refers);
- a copy of the minutes of the Care Programme Approach or pre-discharge care team meeting convened prior to conditional discharge (CD). This should include details of who will be responsible for the patient's psychiatric and social work supervision in the community and if appropriate Community Psychiatric Nurse (CPN);
- 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 outwith 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?

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.

ANNEX D

INFORMATION REQUIRED FOR SCOTTISH MINISTERS – 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 any proposed Absolute Discharge.
- what is the clinical 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. 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.

4. 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.

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

ANNEX E

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 the special restrictions set out in section 62 of the Mental Health (Scotland) Act 1984 (a restricted patient), is conditionally discharged from hospital by either Scottish Ministers or by the Sheriff on Appeal under section 68(2) or 64(2) respectively of the 1984 Act. They may also be of value to other clinical staff, such as community psychiatric nurses, 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 40 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 situation of danger to the patient or to others should be averted 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. A warrant for the conditional discharge of a restricted patient usually specifies that the patient "shall subject himself to the supervision of such persons as Scottish Ministers may approve for this purpose". This form of words allows the supervising psychiatrist, in any particular case, to determine the appropriate manner and frequency of psychiatric supervision and treatment. The minimum frequency of contact is determined by the interval at which Scottish Ministers requests reports on the patient's progress but 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 paragraphs 26 to 30 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, community psychiatric nurse and hostel staff. It will normally be expected that this is placed in the context of a multi-disciplinary 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 Carepathway Framework for Mentally Disordered Offenders should be applied.

7. Scottish Ministers recognise that many supervising psychiatrists have had infrequent 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 care teams and discuss care plans and related issues. RMOs 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.

10. Important elements in effective supervision are 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 client 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 a reversion to potentially dangerous behaviour. 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 of medication is stopped. The supervision of medication after a patient's 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 should be one of the subjects 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 multi-disciplinary 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 community psychiatric nurses have been involved in the after-care and supervision of restricted patients, they have proved themselves 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. The consent to treatment provisions in Part X of the Mental Health Act 1984 do not apply to conditionally discharged patients. The supervising psychiatrist has no specific legal authority to require a conditionally discharged patient to take medication against his will. However, where medication is prescribed to relieve mental disorder which, if untreated in the community, would be likely to lead to the patient becoming a danger to himself or others, the patient's co-operation with such medication can be regarded as a condition of his discharge. If, therefore, the patient refuses medication against the supervising psychiatrist's advice, he may be liable to be recalled to hospital as a detained patient. Sometimes Scottish Ministers decide to make co-operation with medication recommended by the supervising psychiatrist a condition specified on the warrant of discharge. Generally, however, this is unnecessary since it adds nothing to the powers either of the supervising psychiatrist or Scottish Ministers, but Scottish Ministers would be prepared to consider imposing a condition requiring compliance with medication if the supervising psychiatrist felt that it would be helpful in setting boundaries for the management of a particular patient.

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 F.**

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 community psychiatric nurse.

17. It is recommended that the social work supervisor's first meeting takes place at the supervisor's office with further meetings taking place in the patient's home as well as 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 Care Programme Approach (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 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. Reports are submitted to the SEHD whether the patient was discharged by authority of Scottish Ministers or by the Sheriff on appeal. 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. If a report is not received at the required time, a reminder is sent.

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 patient's current mental condition, including any changes since the last report and the apparent reasons for those changes. The report should cover the subject of medication, where appropriate. Reference should be made to any notable improvements or achievements by the patient. If the supervising psychiatrist 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 plans for the patient's continued rehabilitation which will have been agreed by the supervising psychiatrist and the social work supervisor in consultation with professional staff who may be involved.

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 responsible medical officer at the hospital from which the patient was discharged (if the responsible medical officer 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 outwith 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 responsible medical officer. All hospitals will expect and welcome such approaches.

ACTION IN THE EVENT OF CONCERN ABOUT THE PATIENT'S CONDITION

35. If a supervising psychiatrist is concerned about a conditionally discharged patient's mental state or behaviour, the concern should first be discussed with the other professionals involved in the case, particularly the social work supervisor.

36. If the supervising psychiatrist 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. Whether or not such action is taken, and even if the social work supervisor does not share the supervising psychiatrist's concern, the supervising psychiatrist should report to the SEHD at once so that consideration should be given to the patient's formal recall to hospital.

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 contact numbers can be found at Annex A1.**

Recall to Hospital

38. It is not possible to specify all the circumstances in which Scottish Ministers may decide to exercise their powers under section 68(3) of the 1984 Act 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.

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. 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.

40. In cases where it seems that admission is necessary to protect the public from possible harm following a deterioration in the patient's mental disorder, the supervising psychiatrist may recommend that the patient be formally recalled to a hospital. Scottish Ministers would normally be prepared to act on such a recommendation.

41. Whether Scottish Ministers decide to recall a patient depends largely on the degree of danger which the particular patient might present in relation to a 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.

42. 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.

43. 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 may point to a need for a longer period of compulsory detention in hospital. The patient has the right of appeal to the Sheriff within one month of formal recall.

Absconding patients

44. 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.

45. 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

46. 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.

47. 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.

48. 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 1984 Act until he nears the end of his prison sentence. Scottish Ministers may decide to authorise the patient's absolute discharge, so ending his liability to detention under the 1984 Act; 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

49. 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.

50. 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 any proposed Absolute Discharge. When Scottish Ministers agree 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.

51. The Sheriff on appeal has the power to hear the case of a conditionally discharged patient and either to direct a variation in the conditions attaching to discharge or to direct absolute discharge.

ANNEX F

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) 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, a situation of danger to the patient or to others can be averted 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 will 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 best assured, in the long run, 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. It is good practice for the first meeting to take place at the social work office with further meetings taking place in the patient's home as well as the supervisor's office 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.

DISCLOSURE OF INFORMATION

14. This is covered briefly in Chapter 13 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 disclosure 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 34-37 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. 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 or the Sheriff on appeal. If a report is not received at the required time, a reminder is sent.

26. After a period 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 supervisor should, in consultation with the supervising psychiatrist, consider whether a recommendation should be put forward to the Psychiatric Advisor for the patient's absolute discharge (see paragraphs 43 to 45 below). If, however, the patient continues to require formal 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 patient's current circumstances including accommodation, employment, training, major relationships and other interests and spare time activities, any changes since the previous report and the reasons for those changes. Reference should be made to any notable improvements or achievements by the patient. 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 CONCERN ABOUT THE PATIENT'S CONDITION

32. 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.

33. 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.**

Recall to hospital

34. It is not possible to specify all the circumstances in which Scottish Ministers may decide to exercise their powers under section 68(3) of the Mental Health (Scotland) Act 1984 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 should 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.

35. 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. 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.

36. Where recall is considered to be necessary by Scottish Ministers 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 the patient at the time of recall 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.

37. 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 Sheriff under section 66(1) of the 1984 Act within one month of recall.

Absconding patients

38. 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.

39. 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

40. 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.)

41. 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.

42. 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 1984 Act until he is near the end of his prison sentence. At that stage, Scottish Ministers will decide, on the medical recommendation, whether to authorise the patient's absolute discharge under the Act, 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

43. 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.

44. 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 any proposed Absolute Discharge. Scottish Ministers will wish to see evidence of a prolonged period of stability in the community which has been tested by a variety of normal pressures or experiences and it is unlikely that he will be satisfied after periods shorter than those mentioned earlier. However, 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 Scottish Ministers. The Psychiatric Adviser will then assess the patient and, if he/she is agrees with the recommendation, a submission will be put forward to Scottish Ministers.

45. When Scottish Ministers 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.

ANNEX G

PATIENT'S GUIDE TO TRANSFER DIRECTION WITH RESTRICTION DIRECTION

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

2. If you are in this category, you are a restricted patient and cannot be transferred or given leave of absence 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 direction and restriction direction fall.

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

8. If you are granted early release, the transfer direction and restriction direction fall.

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. You may appeal to the Sheriff against this continuing detention in hospital.

ANNEX H

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 8539
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 I

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

Title	Reference	Date
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)	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
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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

Title	Reference	Date
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

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
Public Health Division
Room 3E.04
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. Length of time since 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 E 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 **2002**

APPENDIX 2

SOCIAL WORK SUPERVISOR'S REPORT

<u>MEDICAL RESTRICTED</u>

To: Scottish Executive Health Department
Public Health Division
Room 3E.04
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. Length of time since 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 F 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 **2002**

APPENDIX 3

SAMPLE LETTER FROM DEPARTMENT SEEKING REPORT ON PATIENT FOR APPEAL

Name
Address

Dear

(PATIENT AND DOB): RESTRICTED PATIENT

(Patient) is subject to detention in (hospital) by virtue of section (legislation). He has appealed to the Sheriff in terms of section 64 of the Mental Health (Scotland) Act 1984, as amended by the Mental Health (Safety) (Scotland) Act 1999, against his detention. (Patient)'s Responsible Medical Officer is (psychiatrist).

Your opinion is requested to help enable the Department to form a view in relation to the appeal and for any Proof Hearing which may take place in due course. You may be aware that the 1999 Act was the subject of legal challenge in the Court of Session. Its lawfulness in terms of Article 5 of the European Convention of Human Rights was upheld. This decision was subsequently appealed to the Privy Council and was again upheld. A report is sought to address the altered tests contained within the 1984 Act as amended.

Background

I would be grateful if you would give details of the index offence and the circumstances surrounding it. Your report should also include full details of the patient's history (including previous convictions and admissions); diagnosis on admission; treatment and medication at the hospital and progress therein, including any incidents which may have occurred. If there have been any changes in his medication, or rate of progress then you should highlight these.

Diagnosis

Please confirm your present diagnosis to include whether you consider that (patient) is suffering from a mental disorder. In doing so you should have regard to the definition of mental disorder in section 1(2) of the 1984 Act which has been amended to include personality disorder. In particular you should indicate whether any mental disorder which you have diagnosed is:

1. A mental illness; or

2. A persistent disorder manifested only be abnormally aggressive or seriously irresponsible conduct, where medical treatment is likely to alleviate or prevent a deterioration of the patient's condition; or

3. A mental handicap comprising mental impairment (where medical treatment is likely to alleviate or prevent a deterioration of the patient's condition); or

4. Severe mental impairment.

Risk: What is the effect of that disorder?

If you are of the view that (patient) is suffering from a mental disorder, please consider the effect of that disorder. Is the effect of it such that it is necessary, in order to protect the public from serious harm, that the patient continues to be detained in a hospital, whether for medical treatment or not?

This will involve an assessment of the likelihood of (patient) re-offending and the likely nature of any such re-offending. You should explain the means, tests or factors used to arrive at your assessment. If you feel you cannot make an assessment of risk, you should explain the reason why you do not think that this point can be adequately dealt with (e.g. lack of background information). What will amount to serious harm will vary from case to case; you should take into account all relevant circumstances, including whether, if the appeal is successful, ** will be returned to the community.

If you are of the view that the effect of the disorder necessitates detention in hospital (whether for treatment or not) to protect the public from serious harm, the legislation does not require anything more to be established. However, on the basis that there may be divergence of psychiatric opinion on the presence of serious harm, it is necessary that you go on to deal with these further points.

Appropriateness, Safety and Treatability

If the disorder which you have diagnosed falls within the meaning of section 1(2) of the 1984 Act as described above under "diagnosis", please go on to assess these further matters:

1. Is that mental disorder of a nature and degree which makes it appropriate for the patient to receive medical treatment in the hospital?; and

2. Is it necessary for the health and safety of that person or for the protection of others that he should receive such treatment?; and

3. The treatment cannot be provided unless the person is detained under the Act.

You will be familiar with these tests, as they are the admission criteria contained in section 17 of the 1984 Act. If you are of the view that it is not necessary that (patient) be detained for treatment, is it necessary that he remain liable to be recalled to hospital? In considering the appropriateness of conditional discharge (CD) you should identify the sort of package which should be in place.

You should also identify whether (a) you support conditional discharge now having been satisfied that everything is in place and sufficient testing has taken place to assess risk, (b) whether CD is appropriate now and only the practical arrangements remain to be put in place (deferred CD). This option assumes that sufficient testing/assessment of risk in the community has been satisfactorily demonstrated and that it is merely the practical

requirements of discharge, such as accommodation, which require to be put in place. or (c) it is not appropriate now but may be some time in the future for instance to allow further work or testing to be carried out. An indication of likely timescales in this scenario would be helpful.

Your opinion on all of the above matters should be given on the balance of probabilities. In other words, unless you are sure, you should consider the questions “is it more likely than not?” and give your opinion on that basis.

I thank you in advance for your assistance in this matter and look forward to receiving your report. It would be helpful if this could be returned to me by (deadline), along with a copy of your CV.

If you wish to discuss any of these details please contact either Rosie Toal on 0131 244 2510 or Greg Thomson (Solicitor) on 0131 244 7973.

Yours sincerely

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