

**MEMORANDUM OF PROCEDURE  
ON  
RESTRICTED PATIENTS**

**MAY 2010**

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## 1. INTRODUCTION AND EXECUTIVE SUMMARY

### Introduction

1.1 This (April 2010) Memorandum is an updated and revised version of the Memorandum which was published by the Scottish Executive in September 2005 to accompany the coming into force of the Mental Health (Care and Treatment) (Scotland) Act in October 2005; throughout the rest of this document this will be referred to as “the 2003 Act”). For a full list of terminology used throughout the Memorandum, see paragraph 1.22.

1.2 The Memorandum is an essential reference document for those who are involved with the management and care of patients subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction; that is, patients who are subject to special restrictions. It should be noted that whilst the 2003 Act in fact makes separate provision in parts for such patients<sup>1</sup>, for ease of reference within this Memorandum, all three categories of patients are together referred to as “restricted patients” unless the context otherwise requires; where the context does so require, such patients are referred to as “CORO patients”, “HD patients” and “TTD patients” respectively (see terminology at paragraph 1.22). The Memorandum also sets out information in relation to certain patients subject to other types of mental health orders, such as interim compulsion orders, assessment orders and treatment orders, in relation to whom Scottish Ministers also have a statutory role although they are not “restricted patients”.

### Legal Status of this Memorandum

1.3 The explanations which this Memorandum gives and the procedures it describes should be closely noted and observed by all those involved in the care and management of restricted patients, and other patients in relation to whom the Scottish Ministers have a statutory role, both within hospitals and in the community. It is not, however, intended as a complete instruction document or an authoritative interpretation of the law. You are therefore strongly advised to seek your own independent legal advice in respect of specific situations.

### Overview of Scottish Ministers’ Role

1.4 The 2003 Act gives the Scottish Ministers a specific statutory role in respect of restricted patients. The underlying purpose of the Scottish Ministers’ statutory role in respect of the management of restricted patients is to provide an additional layer of scrutiny as regards the long-term protection and security of the public whilst at the same time ensuring that appropriate care and treatment is delivered by the clinical team to the patient. The Scottish Ministers thus expect a multidisciplinary approach to managing restricted patients. Therefore, this revised version of the Memorandum reinforces the key role played by all members of the multi-disciplinary team, including Mental Health Officers (“MHO”s) who should be consulted and involved in the decision making process

1.5 The oversight of the Scottish Ministers means that restricted patients are overseen not only by the Responsible Medical Officer (“RMO”) but also by the Scottish Ministers and the Mental Health Tribunal for Scotland (“the Tribunal”). The main safeguards are as follows:

- (a) specifically for CORO patients: the existence of a restriction order means that the compulsion order continues without limit of time, instead of lasting only 6 months. Such patients also cannot be released from compulsion (either within a hospital or community setting) without a decision of the Tribunal after a hearing at which the

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<sup>1</sup> Part 10 of the 2003 Act covers those patients who are subject to a compulsion order with restriction order, whilst patients subject to a hospital direction or a transfer for treatment direction are provided for at Part 11. The remainder of the 2003 Act applies equally to all such patients as appropriate.

Scottish Ministers have the right to make representations;

(b) specifically for TTD patients: it is for the Scottish Ministers both to make the TTD authorising the transfer of a prisoner to hospital, and to subsequently revoke it to return the patient to prison. The Scottish Ministers also have duty to revoke a HD in certain circumstances;

(c) decisions about transfer of a restricted patient (for example between hospitals, including to lower security hospitals) and suspension of detention from hospital ("SUS") (for example for testing out in the community) are subject to scrutiny and approval of the Scottish Ministers. The Scottish Ministers may also revoke the SUS, independently of the RMO;

(d) The Scottish Ministers are required to monitor restricted patients on a continuing basis (reports from RMOs and MHOs) and refer the case to the Tribunal at appropriate intervals;

(e) CORO patients who are conditionally discharged, and thereby coming into increased contact with the community, are subject to the supervision of the Scottish Ministers in the public interest, including variation of their conditions of discharge. The Scottish Ministers also have a unique power to recall a patient to hospital from conditional discharge if necessary.

1.5 As noted above, the Scottish Ministers also have a more limited statutory role in relation to certain other patients, namely those subject to interim compulsion orders, assessment orders and treatment orders.

### **The Scottish Ministers' Policy**

1.6 Managers of restricted patients should also refer to other relevant Scottish Government literature most notably:

- Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland ([NHS MEL \(1999\) 5](#)) Scottish Executive, 1999)<sup>2</sup>
- the [2003 Act](#)<sup>3</sup> itself and all regulations and orders made under that Act;
- the Scottish Government Health Directorate [Code of Practice](#)<sup>4</sup> (made under Part 18 of the 2003 Act);
- the Mental Health Tribunal for Scotland [Rules of Procedure](#)<sup>5</sup> (SSI 2005/519, as amended by SSI 2006/171 and SSI 2008/396) (made under section 21 and Schedule 2 to the 2003 Act);
- circulars containing policy and guidance – links to these are accessible throughout the revised Memorandum.

1.7 Although the current policy on the management of mentally disordered offenders was established in January 1999 and is outlined in the document [Health, Social Work and related services for Mentally Disordered Offenders in Scotland](#)<sup>6</sup> the policy in relation to restricted patients has developed further over recent years and has been informed by the following matters.

### *Mental Welfare Commission Inquiry*

<sup>2</sup> [http://www.show.scot.nhs.uk/sehd/mels/1999\\_5.doc](http://www.show.scot.nhs.uk/sehd/mels/1999_5.doc)

<sup>3</sup> [http://www.opsi.gov.uk/legislation/scotland/acts2003/asp\\_20030013\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1)

<sup>4</sup> <http://www.scotland.gov.uk/Publications/2005/08/30105347/53499>

<sup>5</sup> [http://www.opsi.gov.uk/legislation/scotland/ssi2005/ssi\\_20050519\\_en.pdf](http://www.opsi.gov.uk/legislation/scotland/ssi2005/ssi_20050519_en.pdf)

<sup>6</sup> [http://www.show.scot.nhs.uk/sehd/mels/1999\\_5.doc](http://www.show.scot.nhs.uk/sehd/mels/1999_5.doc)

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1.8 The Mental Welfare Commission (“[MWC](#)”) inquiry report into Mr L and Mr M<sup>7</sup> helped to inform policy development and its recommendations are reflected in this revised version. Following receipt of the MWC Report, the Scottish Government invited the Risk Management Authority (“RMA”) to take forward work reviewing the risk assessment and management of restricted patients. The RMA worked closely with those professionals working with restricted patients, officials in the Scotland Government Health Directorate (“SGHD”) and the Forensic Mental Health Managed Care Network (Forensic Network) in conducting this review. The report by the RMA is available on their [website](#)<sup>8</sup>. It focuses on the way in which the system works to produce, share and use knowledge and information. The list of their recommendations together with the Scottish Government response is contained in [NHS CEL 13 \(2007\)](#)<sup>9</sup>. The RMA have worked closely with the Scottish Government in the production of this revised Memorandum of Procedure.

### *The Forensic Mental Health Managed Care Network (Forensic Network)*

1.9 The Forensic Network was established in 2003 to advise on policy and service development in respect of forensic mental health services. The Forensic Network has worked in a consultative way with clinicians, managers, service users and others to develop papers on a range of issues relevant to service delivery. Since 2003 the Forensic Network has established a series of short life working groups that have produced reports that have informed national policy and guidance. The consultation papers and comments on the papers can be viewed or downloaded from the Forensic Network [website](#)<sup>10</sup>. Policy and guidance emanating from the work of the Forensic Network has been set out in [NHS HDL \(2006\)48](#) and with regard to the Care Programme Approach (“CPA”) for Restricted Patients in [NHS CEL 13 \(2007\)](#).<sup>11</sup> More recently, May 2010, the Forensic Network produced updated guidance on the use of CPA. The full report can be accessed on the Forensic Network [website](#)

### *The Management of Offenders etc (Scotland) Act and operation of CPA*

1.10 The Management of Offenders etc (Scotland) Act 2005 (“*the 2005 Act*”) contains provisions in sections 10 and 11 which require the Scottish Prison Service, Local Authorities and the Police, as responsible authorities in the area of a local authority, to jointly establish arrangements for the assessment and management of risks posed by sex offenders subject to registration and violent offenders convicted on indictment and subject to a Probation Order or licence supervision<sup>12</sup>. In addition the legislation also provides the NHS with a statutory function as a responsible authority to establish joint arrangements for the assessment and management of risk posed by restricted patients. Specific guidance on referral and notification to MAPPA in relation to restricted patients was issued in [NHS CEL 19 \(2008\)](#)<sup>13</sup>

1.11 These arrangements will be supported by the operation of the Care Programme approach **which** is mandatory for restricted patients.<sup>14</sup> The CPA care plan forms the template for admission, through-care, discharge and aftercare arrangements and specifies individual and agency responsibilities.

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<sup>7</sup> [http://www.mwscot.org.uk/web/FILES/Publications/Mental\\_Welfare\\_Inquiry.pdf](http://www.mwscot.org.uk/web/FILES/Publications/Mental_Welfare_Inquiry.pdf)

<sup>8</sup> [www.RMAScotland.gov.uk](http://www.RMAScotland.gov.uk)

<sup>9</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2007\\_13.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2007_13.pdf)

<sup>10</sup> [www.forensicnetwork.scot.nhs.uk](http://www.forensicnetwork.scot.nhs.uk)

<sup>11</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2007\\_13.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2007_13.pdf)

<sup>12</sup> At the time of writing, provisions for violent offenders are not in force.

<sup>13</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2008\\_19.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_19.pdf)

<sup>14</sup> most notably the Mental Health (Care and Treatment) (Scotland) Act 2003, the Scottish Government Health Directorate Code of Practice, the Mental Health Tribunal for Scotland Rules of Procedure, the Community Care guidance on care plans for people with mental illness, etc

1.12 Multi Agency Public Protection Arrangements (“MAPPA”) and CPA for restricted patients have a common purpose of maximising public safety and the reduction of serious harm. Although the same underlying principles of gathering and sharing of relevant information in relation to risk apply, CPA focuses on the care and treatment likely to minimise the risk posed, whilst MAPPA focuses on multi agency management of risk. Within the MAPPA framework, the CPA process will remain the vehicle for planning a person’s care and treatment and for risk assessment and management planning. See [Chapter 5](#) for further background.

#### *Governance*

1.13 The concept of clinical governance was introduced to NHS Scotland in [Designed to Care \(SEHD 1997\)](#),<sup>15</sup> the White Paper on improving Scotland’s healthcare, with policy detailed in [MEL \(1998\) 75](#)<sup>16</sup> and updated in [MEL \(2000\) 29](#)<sup>17</sup>. It was described as corporate accountability for clinical performance. More recently, it has been described as the system for making sure that healthcare is safe and effective, that care is patient-centred and that the public are involved.

1.14 Clinical governance is intended to provide a framework for activities supporting the improvement of patient care through a commitment to high standards, reflective practice and risk management. This is achieved by ensuring that those providing services work in an environment that supports them and which places safety and quality of care at the top of the Board’s governance agenda.

1.15 Health Boards should be able to demonstrate clarity around governance arrangements and the effectiveness of risk reporting arrangements. Health Boards also have to demonstrate they are satisfied with the quality of the operation of the CPA and that there are appropriate resources in place. They will be responsible for collating statistical information on the operation of CPA, MAPPA and recording breaches of conditional discharge. It is essential that a senior manager is identified for each Health Board and that they link in with the relevant RMO in order to meet their responsibilities under MAPPA. It is recommended that an audit be carried out on the quality of the operation of CPA on an annual basis. [Annex I](#) contains a useful CPA audit tool adopted by Lanarkshire Health Board.

1.16 Risk reporting arrangements should exist that supply regular reports from clinical teams to Health Boards. The Health Board should have active and dynamic risk registers that document the consideration of risks. The associated risk management action plans should demonstrate a planned approach to minimising risk. In addition, risk assessments for individual patients or units should demonstrate considered approaches to minimising risk.

#### **Structure of the Memorandum**

1.17 The Memorandum has been structured with early chapters exploring the overarching principles in the management of restricted patients:

- Risk assessment and management;
- Care Programme Approach; and
- Multi-Agency Public Protection Arrangements.

1.18 The patient is at the centre of the considerations of, and requirements placed upon, these professionals and as such, a ‘patient journey’ is at the centre of the document. This patient journey is used as a loosely chronological model of processes and is not intended to

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<sup>15</sup> <http://www.scotland.gov.uk/library/documents1/care-00.htm>

<sup>16</sup> [http://www.show.scot.nhs.uk/sehd/mels/1998\\_75.htm](http://www.show.scot.nhs.uk/sehd/mels/1998_75.htm)

<sup>17</sup> [http://www.show.scot.nhs.uk/sehd/mels/2000\\_29final.htm](http://www.show.scot.nhs.uk/sehd/mels/2000_29final.htm)

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reflect individual patient experiences. There are links throughout the document to make navigating through the Memorandum easier. Contact details of colleagues in the casework branch are available at [Annex E](#).

1.19 There are chapters on the management of prisoners who have been transferred to the mental health system for treatment and who are then subject to special restrictions. Contact details of colleagues in Victims, Witnesses Parole & Life Sentence Division (VWPLSD) are provided at [Annex E](#).

1.20 Template forms, contact lists, a glossary ([Annex F](#)) and list of other relevant legislation ([Annex G](#)) are attached as annexes to the main document.

1.21 Examples of Risk Management Traffic Lights for all levels of Security is contained at [Annex H](#)

1.22 References to legislation or to provisions of such legislation, throughout the Memorandum are to the [2003 Act](#)<sup>18</sup> unless otherwise stated. In addition, the following terminology is used throughout this Memorandum:

**“1995 Act”** means the Criminal Procedure (Scotland) Act

**“2003 Act”** means the Mental Health (Care and Treatment) (Scotland) Act 2003

**“2005 Act”** means the Management of Offenders etc (Scotland) Act 2005;

**“CD”** means conditional discharge (by the Tribunal under section 193(7) of the 2003 Act);

**“Commission”** means the Mental Welfare Commission for Scotland (continued under section 4 of the 2003 Act);

**“CORO”** means a compulsion order (made under section 57A(2) of the 2003 Act) and a restriction order (made under section 59 of the 2003 Act);

**“CPA”** means the Care Programme Approach, see chapter 4;

**“CPN”** means Community Psychiatric Nurse, see paragraph 2.22;

**“HD”** means a hospital direction (made under section 59A of the 2003 Act);

**“MAPPAs”** means Multi Agency Public Protection Arrangements, see chapter 5;

**“Memorandum”** means the Memorandum of Procedures on Restricted Patients (DATE 2010);

**“MHO”** means a mental health officer (appointed, or deemed to be appointed, under section 32(1) of the 2003 Act), see paragraph 2.20;

**“MWC”** means the Mental Welfare Commission

**(“PMO (FP)”**) means the Scottish Government’s Principal Medical Officer (Forensic Psychiatry)

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<sup>18</sup> [http://www.opsi.gov.uk/legislation/scotland/acts2003/asp\\_20030013\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1)

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**“Restricted patients”** means patients subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction; that is, patients who are subject to special restrictions under the 2003 Act; see paragraph 1.2.;

**“RMA”** means the Risk Management Authority as established under Part 1 of the Criminal Justice (Scotland) Act 2003;

**“RMO”** means the approved medical practitioner appointed (by virtue of section 230 of the 2003 Act) to be the patient’s responsible medical officer;

**“SGHD”** means the Scottish Government Health Directorate;

**“SGJD”** means the Scottish Government Justice Directorate

**“SGLD”** means the Scottish Government Legal Directorate

**“SUS”** means suspension of detention from hospital (granted under section 224 of the 2003 Act for restricted patients), see chapter 8;

**“Tribunal”** means the Mental Health Tribunal for Scotland (established under section 21 of the 2003 Act

**“Tribunal Rules”** means The Mental Health Tribunal for Scotland (Practice and Procedure) (No.2) Rules 2005<sup>19</sup>

**“TTD”** means a transfer for treatment direction (made under section 136 of the 2003 Act);

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<sup>19</sup> SSI 2005/519, as amended by SSI 2006/171 and SSI 2008/396

## 2. ROLES AND RESPONSIBILITIES

### Role of the Scottish Ministers

**The Scottish Ministers' statutory role is to provide for the protection of the public.**

2.1 As indicated in paragraph 1.4, the underlying purpose of the Scottish Ministers' statutory role in respect of the management of restricted patients is to provide an additional layer of scrutiny as regards the long-term protection and security of the public, whilst at the same time delivering appropriate care and treatment to the patient. This statutory role, reflected in the framework of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), is one which the Scottish Parliament has given to the Scottish Ministers. The scheme of the legislation thus places on the Scottish Ministers the responsibility in the case of restricted patients to balance a patient's claim to liberty against the interests of other members of society to be safeguarded against the risks to which such liberty may give rise. In the performance of these statutory duties, the Scottish Ministers are, of course, both politically accountable to the Scottish Parliament as well as being bound by the controls that the Scotland Act 1998 places on them in their actions, of which compliance with human rights legislation is most relevant.

2.2 Under the 2003 Act the Scottish Ministers no longer have the power to conditionally discharge patients or to revoke restriction orders. These powers are now reserved to the Tribunal. However, the authority of the Scottish Ministers is still required at key points in the care of restricted patients:

Authority of the Scottish Ministers required	Section of the 2003 Act
transfer between hospitals	section 218
transfer between hospital and prison ( <i>TTD patients</i> )	section 210
cross border transfers	section 290
SUS (i.e. authorising any leave from the hospital grounds)	sections 221 and 224
variation of conditions of discharge ( <i>CORO patients</i> )	section 200(2)
recall from conditional discharge ( <i>CORO patients</i> )	section 202

All requests when the authority of Scottish Ministers' is required should be directed to the Scottish Government's Principal Medical Officer (Forensic Psychiatry) ("PMO (FP)")<sup>20</sup>, who will thereafter ensure that the appropriate action is taken within the Government. On receiving such a request from a Responsible Medical Officer ("RMO"), Scottish Ministers will consider and give authority as appropriate. The Scotland Government Health Directorate ("SGHD") officials will relay the decision of the Scottish Ministers to the RMO and designated Mental Health Officer ("MHO"). Where the Scottish Ministers do not authorise a request, the reason for this will be included.

2.3 In addition, the Scottish Ministers are responsible for making references or applications to the Tribunal following:

<sup>20</sup> See ANNEX E for contact details of the PMO (FP).

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<b>Application or Reference circumstance</b>	<b>Section of the 2003 Act</b>
a recommendation from the RMO, having consulted with the designated MHO	sections 185 (CORO patients) & 210 (HD & TTD patients)
notice from the Mental Welfare Commission	sections 186 (CORO patients) & 211 (HD & TTD patients)
a period of not more than 2 years after the date of the patient's previous reference/application or the day on which the CORO, HD or TTD is made	sections 189 (CORO patients) & 213 (HD & TTD patients)
as a result of the Scottish Ministers duty to keep CORO under review (CORO patients)	section 191

SGHD are required to refer cases to the Tribunal for consideration when the triggers above for making an application or reference occur. The Scottish Ministers are a party in references, applications and appeals involving restricted patients and will provide a Position Statement setting out their position. This Statement will reflect any concerns relating to risk.

2.4 It is important that multidisciplinary teams allow sufficient time for consideration by the Scottish Ministers of such decisions. Scottish Government officials will for their part make every effort to process requests timeously. RMOs and MHOs can assist in this by ensuring that all relevant information is provided to the SGHD to enable the Scottish Ministers or the Tribunal to make the decision.

2.5 It is very important that RMOs and MHOs do not presume that a favourable decision will result from any request to the Scottish Ministers and, in particular, they should not raise a patient's expectations unrealistically.

### **Role of Officials in the Scottish Government Health Directorate (SGHD)**

2.6 The SGHD undertakes the casework on restricted patients on a day to day basis on behalf of the Scottish Ministers. The SGHD role is therefore to help ensure that the management of restricted patients provides an additional layer of scrutiny as regards the long-term protection and security of the public, whilst delivering appropriate care and treatment to the patient. At the heart of the work carried out by officials in SGHD is ensuring that patients are subject to the Care Programme Approach (CPA) and robust risk assessment and management plans are in place. These are updated/reviewed on a 6 monthly basis or prior to key rehabilitation stages or in advance of Tribunal hearings.

2.7 Officials in the SGHD concerned with restricted patients are: -

- The PMO (FP); a consultant forensic psychiatrist who is responsible for liaison with the RMO and for advising the Scottish Ministers and their administrative officials on clinical aspects in relation to restricted patients. The PMO (FP) will visit all restricted patients on an annual-18 month cycle and/or when the RMO recommends transfer involving a drop in the level of security; conditional discharge of CORO patients; revocation of the compulsion order and/or revocation of the restriction order; and where appropriate, recommending return to prison of patients under a Transfer for Treatment Direction.
- The PMO (FP) also offers access to a psychotherapy service aimed at multidisciplinary teams working with personality disordered patients. This service is designed to act as an additional support for those who may be experiencing difficulties in managing these very challenging patients. Any member of the

clinical team may make a referral to this service. The psychotherapist will make a psychodynamic formulation of the patient in order to work with the team.

- Officials in Branch 4 of Mental Health Division of the SGHD are responsible for administrative matters generally in relation to case work on restricted patients, and the preparation and submission of specific recommendations about a patient for consideration by the Scottish Ministers. Officials also prepare Position Statements reflecting risk considerations for the Mental Health Tribunal for Scotland.
- Officials in Branch 3 of Mental Health Division of the SGHD are responsible for administrative matters (e.g. suspension of detention, SUS) in relation to remand patients (see [CEL 9 \(2009\)](#)).

### **Mental Health Tribunal for Scotland**

2.8 Part 3 of the 2003 Act established a new judicial body - the Mental Health Tribunal for Scotland ("the Tribunal") – to replace the former role of the Sheriff Court as the body for dealing with the majority of mental health hearings. The primary role of the Tribunal is to consider and determine applications, references and appeals in relation to compulsory detention and treatment of those persons diagnosed as suffering from a mental disorder. Further information on the Tribunal and its role in respect of restricted patients is detailed at [Chapter 14](#).

### **The Mental Welfare Commission**

2.9 The Mental Welfare Commission for Scotland ("MWC") is an independent body first established in 1960 and continued in an extended role under Part 2 of the 2003 Act, to work to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. The MWC will give advice and guidance to patients and to service providers. It will arrange to visit people detained in hospital, including people subject to restriction orders. Whilst the Mental Welfare Commission cannot order the discharge of a restricted patient it can require the Scottish Ministers to refer a patient's case to the Mental Health Tribunal for consideration.

2.10 The Commission has a duty to monitor the operation of the 2003 Act and to [promote best practice](#) in its use<sup>21</sup>. It publishes information about the use of legislation on its website and in ad hoc reports. This includes promotion of the principles of the 2003 Act. The Commission publishes guidance on a number of topics including [consent to treatment](#)<sup>22</sup>, [carers and confidentiality](#)<sup>23</sup>, restraint and restriction of freedom and [the use of seclusion](#)<sup>24</sup>.

2.11 In addition the Commission operates a telephone advice service for service users, carers and professional staff. Further information is available on the MWC's [website](#)<sup>25</sup> or through its telephone advice service at 0131 222 6111.

### **The multi-disciplinary team**

2.12 The wide ranging variety of needs within a forensic mental health patient population mean that in order to assess, plan and deliver care, treatment, intervention and support for recovery, the teams which care for them must be multidisciplinary and multi-agency. In the

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<sup>21</sup> [http://www.mwscot.org.uk/GoodPractice/Publications/Guidance\\_documents.asp](http://www.mwscot.org.uk/GoodPractice/Publications/Guidance_documents.asp)

<sup>22</sup> <http://www.mwscot.org.uk/web/FILES/Publications/MWCCConsenttotreatment.pdf>

<sup>23</sup> [http://www.mwscot.org.uk/web/FILES/Publications/Carers\\_Confidentiality\\_web.pdf](http://www.mwscot.org.uk/web/FILES/Publications/Carers_Confidentiality_web.pdf)

<sup>24</sup> <http://www.mwscot.org.uk/web/FILES/Publications/SeclusionGuidance.pdf>

<sup>25</sup> [www.mwscot.org.uk](http://www.mwscot.org.uk)

case of restricted patients and for clarity, particular responsibilities are given to members of this team. These roles are described herein.

- The Responsible Medical Officer (RMO)
- The Mental Health Officer (MHO)
- Allocated social worker (ASW)
- The Community Psychiatric Nurse (CPN)
- Police Liaison (as described in [Chapter 5](#) : MAPPA and pre-CPA)

### **Role of the Responsible Medical Officer**

2.13 The Responsible Medical Officer (“RMO”) is an approved medical practitioner who is appointed to have the primary responsibility for the patient’s care and treatment<sup>26</sup>. The 2003 Act effectively places a responsibility on NHS Health Boards to ensure that each restricted patient has an RMO at all times, by requiring hospital managers to appoint an RMO as soon as practicable after the occurrence of what is referred to as “an appropriate act”<sup>27</sup>. The RMO is responsible for planning the patient’s care and treatment with due regard to public safety and ensuring that it is implemented within the confines of his/her responsibility for that patient and the legislative framework. The RMO must work in close co-operation with the designated MHO involving them in the decision making process<sup>28</sup> and all others within and outwith the hospital involved with the care of the patient and with the Scottish Government Health Directorate (SGHD). **A restricted patient must have an RMO at all stages of their care.**

2.14 SGHD would usually expect an RMO to be a Consultant Psychiatrist or Consultant Forensic Psychiatrist. The RMO must be an Approved Medical Practitioner<sup>29</sup>. In some circumstances, i.e. annual leave, it may be necessary for a Specialist Registrar (SpR) or Specialty Registrar years 4-6 (StR 4-6) to act as RMO, suitably supervised in the Consultant’s absence. In such cases, the Consultant or Medical Director must inform SGHD in writing prior to any period where an SpR or StR 4-6 will act as RMO. A locum Consultant who is not on the specialist register should not act as RMO.

2.15 It is the responsibility of the RMO, in consultation with the rest of the multidisciplinary team, to recommend to the PMO (FP) any action to be considered by the Scottish Ministers .

2.16 The RMO leads the contribution to Multi-Agency Public Protection Arrangements in respect of the restricted patients under his or her care<sup>30</sup>.

2.17 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 SGHD and the designated MHO immediately, and that the notifications and routine reports mentioned in the following paragraphs are submitted timeously.

#### **In hospital**

- Within 3 months of admission to hospital an admission report

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<sup>26</sup> See section 230(1) of the 2003 Act

<sup>27</sup> See section 230(4) of the 2003 Act for a definition of “an appropriate act”

<sup>28</sup> Note in particular that the 2003 Act places a statutory duty on the RMO in relevant places to consult the MHO on certain matters.

<sup>29</sup> Section 22 of the 2003 Act

<sup>30</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2008\\_19.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_19.pdf)

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

- [Annual report](#) with copy of Care Plan<sup>31</sup>
- Applications for suspension of detention from hospital (granted under section 224 of the 2003 Act for restricted patients) (“SUS”) should be included in the CPA, with the exception of those detained at the State Hospital
- A formal risk assessment and risk management plan must be in place before consideration of unescorted leave and updated/reviewed at 6 monthly intervals
- A progress report on SUS (contained within [CPA documentation](#) or [annual report](#)).

For CORO patients on Conditional Discharge (“CD”)

- Any breach of CD should trigger consideration of recall or other appropriate action by the care team and report outcome
- Monthly or 3-monthly reporting (see [RMO Supervisor Form](#)) and copied to MHO and CPN
- [Annual report](#)

Both inpatients and those CORO patients on CD

- Notification of Incidents (see [Annex B](#))
- Notification of Positive Drug tests
- CPA- [[CPA Documentation](#)] (minimum 6-monthly)
- MAPPA Notifications and Referrals at appropriate points in the patient’s care (see [Chapter 5](#)).

### **The Mental Health Officer**

2.18 An MHO is a qualified and experienced social worker who has undergone added accredited training in mental disorder and mental health law, and who has been appointed (or deemed to be appointed) as such by their local authority<sup>32</sup>. MHOs for restricted patients should also have undertaken some level of forensic MHO training. In addition to their involvement with the patient, the MHO has particular responsibilities in respect of the Named Person<sup>33</sup>. **A restricted patient must have a designated MHO at all stages of their care.** If the designated MHO changes, SGHD should be informed as soon as possible.

2.19 The designated MHO provides reports as part of the annual review process. In addition, where a patient is visiting the home of a relative or friend for the first time, a social work report **will** be required prior to the visit being authorised, usually by the MHO or an allocated social worker.

In hospital

- Explain to the patient their rights in relation to advocacy
- Explain to the patient their rights in relation to legal representation
- Explain the Tribunal process to the patient
- Explain to the patient the role of the named person and their right to receive full tribunal papers in the same way as the patient does
- Liaise with community services
- Provide report regarding home visits
- Contribute to risk assessment and risk management planning and consideration of SUS.

It would also be best practice for the MHO to:

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<sup>31</sup> See section 182(3) of the 2003 Act for CORO patients, and section 206(3) for HD / TTD patients

<sup>32</sup> See section 32(1) of the 2003 Act for duty on local authorities to appoint MHOs

<sup>33</sup> See <http://www.scotland.gov.uk/Publications/2004/10/20016/44075>

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

- Ensure that the named persons have an understanding of the reasons for the patient's detention and the events and illness which led to the order being made (subject to issues around disclosure which may require consent from the patient)
- Ensure named persons are fully aware that they will receive full Tribunal papers including a full transcript of any court hearing with details of index offence and the possible implications of this
- Support named persons to consider the sensitive nature of all the papers relating to such cases and how they may store and dispose of them with due care and attention
- Advise others of any changes relating to the named persons

### CORO patients on Conditional Discharge

- Any breach of CD should trigger consideration of recall or other appropriate action by the care team
- Monthly/3 monthly reporting ([MHO supervisor form](#)) and copied to RMO and CPN
- Annual Report

### Both inpatients and those CORO patients on CD

- Attendance at Clinical team meetings
- Attendance at CPA meetings
- Attendance at shrieval Tribunals
- Notification of Incidents (see [Annex B](#) )
- Care Programme Approach ( [CPA Documentation](#) )
- MAPPA Notifications and Referrals at appropriate points in the patient's care (see [Chapter 5](#)).

### **The allocated Social Worker**

2.20 A person subject to any kind of compulsory order may already be allocated within social services. The type of allocation will depend on the person's need, for example, mental illness, learning disability and also age in the case of older people. An allocation begins with a needs assessment and then develops into care management with appropriate resources, where necessary.

2.21 To fulfil these population needs, councils in Scotland employ social work staff with different professional qualifications such as social work, occupational therapy and nursing. Social work professionals can be located in a range of specialist teams such as older people, mental illness, learning disability and community care.

2.22 The role of the Mental Health Officer on the other hand, has a specific remit to be an independent assessor within the 2003 Act. Some councils have dedicated MHO teams which make this role much clearer. Other councils have a mixture of dedicated MHOs and social workers with an extra remit as MHOs. They may therefore rightly be involved in progressing further assessments within the restricted patients system such as home assessments before SUS or discharge. This is different from an assessment of needs which the MHO can request from their council using section 227 in the 2003 Act.

2.23 In the case of a restricted patient, a conditional discharge will probably involve a social work assessment from the relevant specialist team as described above, for appropriate resources as part of the conditions.

### **The Community Psychiatric Nurse**

2.24 The Community Psychiatric Nurse (“CPN”) has responsibility to report to the Scottish Ministers on the progress in the community of conditionally discharged CORO patients. In some cases they will have had additional forensic training and be a Forensic Community Psychiatric Nurse although this is not always the case. The CPN will be identified by the community service manager in the health board area in which the CORO patient will reside on conditional discharge following a referral from the RMO. It is essential that the CPN is identified at the earliest opportunity to enable development of relationship with the patient, participation in the risk assessment, risk management planning and involvement in the discharge planning process.

For CORO patients on Conditional Discharge

- Monthly/3 monthly reporting ([CPN supervisor form](#)) and copied to RMO and MHO
- CPA - ([CPA Documentation](#))
- Any breach of CD should trigger consideration of recall or other appropriate action by the care team.

### **The Police Role**

2.25 The Police have two key roles in relation to management of restricted patients

- Sharing information to help the responsible Health authority assess and manage risk appropriately
- To help address community safety issues when patients are moving towards spending time in the community or discharge to the community

2.26 Police engagement in the CPA process will be at the following stages, this may be at a pre-CPA meeting rather than the main CPA meeting, dependant on the input required.

- Admission – allows suitable police liaison officer from the patient’s home force to be identified and will assist with gathering of intelligence for the risk assessment process;
- When consideration for first time of escorted/unescorted SUS or in certain circumstances escorted leave within hospital grounds;
- Prior to accommodation being identified for CORO patient progressing towards CD
- When a breach of condition occurs or if a CORO patient is recalled; and
- Any other occasion when it can be demonstrated that a police officer’s presence is essential.

2.27 Police will also be key partners in MAPPA, and will be involved in the oversight of management of restricted patients via these arrangements – see [Chapter 5](#).

### 3. RISK ASSESSMENT AND MANAGEMENT

3.1 The risk of harm to others is an important concern when making decisions about the treatment care and recovery of restricted patients. Patients who present a risk to others are likely also to be vulnerable to other forms of risk, e.g. self harm, self neglect or exploitation by others<sup>34</sup>. Good clinical care must include good risk assessment and management.

3.2 Risk assessment and management is an overarching principle in the management of restricted patients; it is an ongoing and dynamic process throughout the patient journey. The risk that a patient may present can vary over time and with the patient's condition. Good clinical care should involve a multidisciplinary approach of structured risk assessment and management within the Care Programme Approach ("CPA"). The Scotland Government Health Directorate ("SGHD") expect reassessment of the risk that a patient might present at 6 monthly intervals or at appropriate points and, in particular:

- before transfer involving a drop in the level of security;
- prior to a MAPPa referral and
- prior to consideration by the Tribunal.

3.3 A balance needs to be struck; risk aversion can be detrimental to a patient's rehabilitation. A multidisciplinary approach that appropriately engages the patient and has a focus on victim safety is required for effective management of the risk patients pose to others.

**3.4 It is understood that there is inherent uncertainty in the processes of risk assessment and risk management. The goal is not to predict adverse events, nor to have overly risk-averse practice which can be counter-productive. Risk assessment is useful in identifying conditions where the risk of harm to others is increased and to inform measures to manage that risk. It is important to emphasise that risk can be reduced and managed but never eliminated.**

3.5 The fuller the risk assessment provided by the multi-disciplinary team, the speedier the response officials are able to provide to recommendations for suspension of detention from hospital (granted under section 224 of the 2003 Act for restricted patients) ("SUS"), and transfer. In addition, full risk assessment improves input to Tribunal cases. Scottish Ministers need to be satisfied that the multidisciplinary team have properly identified and evaluated any risk to the public and that sound measures have been taken to manage it.

**3.6 It is essential that each of the decision points for multidisciplinary teams, the Scottish Ministers and the Tribunal are supported by good quality risk assessments and risk management plans which are regularly updated within the CPA every 6 months and updated as circumstances change.**

3.7 The Risk Management Authority ("RMA") guidance on risk management planning<sup>35</sup> indicates that good quality risk management relies upon the following areas.

#### **Collaborative Working**

<sup>34</sup> See Royal College of Psychiatry Reports 1996 CR53. Assessment and clinical management of risk of harm to other people on Risk and 2008 CR150. Rethinking Risk to Others in Mental Health Services

<sup>35</sup> RMA Risk Management Standards and Guidelines are designed specifically for those required to prepare an RMP for offenders subject to an Order for Lifelong Restriction (OLR). However, the concepts within them may also be developed to have a wider application across offender risk management in Scotland, whether within the criminal justice system or mental health services

3.8 Risk Management for restricted patients requires a multi-disciplinary and multi-agency approach. This will require the multidisciplinary team to develop, communicate, implement and review the measures adopted to manage risk. With the introduction of MAPPA for restricted patients, the police are an integral part of the process. There may be separate risk assessments undertaken by Criminal Justice agencies with regard to the patient. Teams should be aware of these, their meaning and impact on communication of risk between agencies.

3.9 Formal assessment of risk should take place at a number of stages in the patient's progress and will be reviewed and updated as circumstances change. It is therefore important that all relevant information on a patient is shared with the Mental Health Officer, as well as other members of the multidisciplinary team on a need-to-know basis. All restricted patients must be managed via the CPA<sup>36</sup>. The dissemination of information may be broadened to include external agencies such as local authority housing departments, care providers and the police. Equally, the CPA process may offer opportunities for gathering additional information, e.g. local police intelligence at pre-CPA meetings. The introduction of Multi Agency Public Protection Arrangements ("MAPPA") for restricted patients reinforces the requirement for multi-agency information sharing. Decisions on how and when to share information outside of the CPA and MAPPA meetings, and who with, will be taken on a case-by-case basis and should take account of patient confidentiality considerations.

### **Risk Assessment**

3.10 The treatment plan for a restricted patient will necessarily include measures to manage the risk that the patient poses to others. The foundation of risk management planning is risk assessment. A 'risk assessment document' as a contributor to the planning process under CPA is recommended<sup>37</sup>. Risk assessment informs management planning, which in turn informs subsequent assessment and planning in a continuous and dynamic process.

3.11 Risk assessment will demonstrate:

- a thorough review of the available information;
- personal and family history;
- criminal history and history of violence;
- substance misuse;
- psychiatric history;
- assessment of personality; and
- other relevant risk factors (e.g. sex offender risk factors).
- the use of appropriate **risk assessment tools** for the case in hand; to assist in:
  - the application of **structured professional judgement** to help identify relevant risk and protective factors; and to provide a framework for
  - a **formulation of risk** that includes the nature, severity, imminence, frequency and likelihood of re-offending; and
  - an examination of a number of **possible future scenarios** that risk management strategies will seek to avert, or in the case of 'best-case' scenarios; support.

3.12 In order that the risk assessment may contribute to the treatment plan for the patient, it is not recommended that multidisciplinary teams undertake a solely statistical (or actuarial) assessment but attempt to place the risk the patient presents in context using Structured Professional Judgement. However, use of appropriate protocols or assessment tools (e.g.

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<sup>36</sup> More details available in CEL 13 (2007)

<sup>37</sup>

suitable for mentally disordered offenders, sexual offenders or violent offenders) may contribute to the risk assessment and can be useful in framing the risk assessment in a systematic way. The RMA has evaluated the commonly used risk assessment tools for general offending, risk of violence and risk of sexual violence. This evaluation is published in [Risk Assessment Tools Evaluation Directory](#) (RMA 2007)<sup>38</sup>

- 3.13 Risk Assessment should be clearly indicated and should clearly document:
- the likely impact of the harm posed by the patient;
  - an indication of those to whom the patient poses a risk of harm;
  - all relevant risk factors;
  - active protective factors; and
  - early warning signs and relapse indicators.

3.14 Risk assessment will be a continuous process in the implementation and review of the plan as implemented through the CPA.

### **CPA and risk management**

3.15 In response to the risk assessment, the multidisciplinary team will document preventive actions and contingency actions (traffic light section) in the documentation for CPA, alongside mental health considerations that may or may not be linked to the risk to others. The plan will outline clear lines of accountability and responsibility and timeframes for delivery.

- 3.16 The CPA treatment plan will set out risk management strategies to:
- address the identified risk factors; and
  - support and enhance protective factors.

- 3.17 The contingency action plan (traffic light section) will set out planned responses to:
- the appearance of early warning signs;
  - the weakening or breakdown of protective factors; and
  - the weakening or breakdown of the risk management strategies set out in the treatment plan.

### **Risk Management Strategies**

3.18 The multidisciplinary team must ensure that they don't over-rely on one type of strategy in their plan to manage risk. The RMA in their [Standards and Guidelines](#)<sup>39</sup> suggest that a risk management plan should map multi-layered risk management strategies to each identified risk factor *and* to each active protective factor. This ensures that multiple strategies, delivered by multiple means, are applied to address each identified risk and protective factor.

3.19 The [CPA Documentation](#) must set out the arrangements for the supervision and monitoring of the patient, must detail the treatments or interventions to be carried out and must address victim safety planning.

- 3.20 Risk management strategies will represent the principles of effective practice and each strategy should be:
- sufficient to manage the risk posed;
  - appropriate to the patient and the patient's situation;
  - relevant to the risk factor(s);

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<sup>38</sup> <http://www.rmascotland.gov.uk/ViewFile.aspx?id=280>

<sup>39</sup> <http://www.rmascotland.gov.uk/ViewFile.aspx?id=264>

- evidence-based; and
- the least restrictive necessary.

**Accommodation**

3.21 The multidisciplinary team should ensure that appropriate accommodation is identified for patients in both secure and community settings. However, it is perhaps most important in the community setting. Suitable housing should be identified prior to discharge of a patient into the community.

3.22 Identified accommodation must be subject to an evaluation of the risk posed by the patient; and those risks posed to the patient. Police and other agencies should be involved in assessing the suitability of identified accommodation.

3.23 For those restricted patients who are sexual offenders, multidisciplinary teams should refer to the National Accommodation Strategy for Sexual Offenders and its associated guidance.

3.23 At the stage of planning conditional discharge and once accommodation has been identified and vetted by the police, a MAPPA referral should be made.

**Responding To Change**

3.24 To ensure the continuing suitability of the plan, and the ability to respond timeously and effectively to any material change in the risk that the patient presents, the multidisciplinary team should engage in ongoing assessment and evaluation of the risk management strategies implemented and review the patient's progress.

3.25 Revisions of the strategies must be recorded in the CPA documentation and communicated to the appropriate parties in a timely manner.

## 4 CARE PROGRAMME APPROACH

### **Background to CPA**

4.1 The Care Programme Approach (“CPA”) was developed originally for use at local level in Scotland for people with severe and enduring mental illness in 1996 via Scottish Office Circular SWSG 16/9. Unlike in England, where CPA was mandatory, this circular simply recommended CPA for use in Scotland.

4.2 In 2006, the Forensic Network was asked to carry out a survey of current practice in respect of implementation of the CPA across forensic services in Scotland. Their remit was to review and revise the CPA Guidance to ensure that the protection of the public was at the core of the decision making in respect of restricted patients’ rehabilitation in light of the new Management of Offenders etc (Scotland) Act 2005 (“the 2005 Act”) and the introduction of Multi-Agency Public Protection Arrangements (“MAPPA”), and to establish joint arrangements for effective risk management. The Network subsequently developed proposals and recommendations for future action on behalf of the Scottish Government publishing a Report on their Review of CPA Guidance for Restricted Patients in Scotland in December 2006<sup>40</sup>. The Scottish Government, taking account of the responses to the consultation exercise, accepted and endorsed the recommendations made in the consultation report. The guidance with respect to the key components of the CPA as outlined in section 8 of the CPA Consultation Report was adopted by the Scottish Ministers as policy<sup>41</sup>. A prominent feature of enhanced CPA is ensuring consistency across Scotland.

4.3 The proposals for CPA were developed in the context of the new duties on NHS Boards established under the 2005 Act which gives a statutory basis for the MAPPA. By complying with the recommendations in the CPA Consultation Report, NHS Boards will be able to meet many of their obligations under MAPPA in those cases where they are the responsible authority.

4.4 The CPA has been adopted as the mechanism for regular review for all patients subject to Compulsion Order with Restriction Order (CORO), Hospital Direction (HD), Transfer for Treatment Direction (“TTD”) and Interim Compulsion Order (ICO). Under [Delivering for Mental Health](#)<sup>42</sup> and the MAPPA guidance all restricted patients from 30 April 2008 must be being managed under the new CPA arrangements.

4.5 In May 2010, the Forensic Network produced updated guidance on the use of CPA. The full report can be accessed on the Forensic Network [website](#). The updated guidance incorporates child protection, protection of adults at risk of harm, risk factors relating to driving, [suspension of detention forms](#), [risk management traffic lights good practice guidance](#) (with examples), identifying new information within objectives and new [CPA documentation](#) including a template for [pre-CPA](#) discussion.

### **Purpose and aims of CPA**

4.6 The purpose and aims of CPA today are:

- to ensure that patients with a mental disorder associated with complex health and social care needs receive on-going care support and supervision throughout their detention in hospital and rehabilitation into the community

<sup>40</sup> <http://www.forensicnetwork.scot.nhs.uk/publications.html>

<sup>41</sup> More details available in CEL 13 (2007)

<sup>42</sup> <http://www.scotland.gov.uk/Publications/2006/11/30164829/0>

- to ensure structured support for those most in need, or most at risk to themselves or others
- to ensure that there is effective multi disciplinary agency collaboration
- to ensure that patients and their families and carers are involved as far as possible with care planning decisions and arrangements
- to enable systematic arrangements for the assessment and management of health and social care needs
- to ensure the appointment of a lead care co-ordinator to monitor and co-ordinate care arrangements
- to ensure that the policy is compatible across Scotland.

### **Implementing CPA**

4.7 The Scottish Government [CEL 13 \(2007\)](#)<sup>43</sup> provides guidance on the implementation of CPA, the roles of individuals and templates of the documentation which supports the CPA process:

- CPA is the appropriate tool for all restricted patients
- an initial CPA meeting should be held approximately 4 – 10 weeks after admission to hospital and a review meeting should be held at a frequency of at least every 6 months.
- more frequent meetings will be necessary at transitional points and where there are changes in circumstances which need to be considered particularly those that influence risk.

### **CPA Documentation**

4.8 As outlined in Chapter 3, the updated CPA documentation will be used to record risk assessment, multi-disciplinary reports and management plans as well as the ongoing care and treatment of the patient. The traffic lights system is an integral part of the CPA documentation and clearly highlights risks, relapse signs and crisis planning. Examples of Risk Management traffic lights for all levels of security, including in the community, is contained in [Annex H](#)

4.9 The CPA documentation will also be used in place of the previous Memorandum's Annex B3 to provide the risk management information necessary to support requests for escorted and unescorted suspension of detention "SUS". For more details see [Chapter 8](#) and the [SUS plan](#) template.

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<sup>43</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2007\\_13.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2007_13.pdf)

## 5 MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS

5.1 Multi-Agency Public Protection Arrangements (“MAPPA”) and Care Programme Approach (“CPA”) for restricted patients have a common purpose of maximising public safety and the reduction of the risk of serious harm. Although the same underlying principles of gathering information apply, CPA focuses on the care and treatment likely to minimise the risk posed, whilst MAPPA focuses on multi agency management of risk. Within the MAPPA framework, the CPA process will remain the vehicle for planning a person's care and treatment and for risk assessment and management planning.

5.2 The underlying concept of MAPPA is to provide systems and processes for relevant agencies to share information about individuals who represent a risk to the community. Where appropriate, the agencies will cooperate to put together plans to assess and manage these risks. It is important to emphasise that the remit of the Multi-Agency Public Protection Panel (“MAPPP”) is scrutiny of risk assessment, information sharing and risk management plans and **not** an opportunity to have a case conference<sup>44</sup>.

5.3 As indicated in [CEL\(2007\)7](#)<sup>45</sup>, as part of their responsibilities under the 2005 Act, Health Boards have to be able to demonstrate the effective establishment and implementation of the arrangements between Agencies for the management of offenders who are subject to MAPPA arrangements. Each Health Board (and the State Hospitals Board for Scotland) should therefore have identified a senior manager responsible for providing:

- the assurances on the quality of the operation of CPA; and
- the statistical information required for the MAPPA coordinator.

5.4 The Guidance note on the extension of the 2005 Act to restricted patients ([CEL 19 \(2008\)](#)) provided guidance on the immediate actions to be taken by Health Boards in relation to restricted patients, and explained both how restricted patients would be assessed and managed within the MAPPA framework as well as the ongoing responsibilities of Health Boards and patient care teams under the 2005 Act.

5.5 It should be noted that by complying with the Guidance for Forensic Services circulated in October 2007 ([CEL 13\(2007\)](#)), and by the use of the CPA detailed in that CEL, Health Boards will be able to meet many of their obligations under MAPPA. As indicated in Annex C of CEL 13 (2007), CPA is to be adopted as the mechanism for regular review of all restricted (CORO, HD and TTD) patients; Annex B of that CEL also provides a Governance checklist in respect of the quality of clinical services provided to patients by their services and clinicians.

5.6 There are **three levels of management** in the MAPPA model:

<b>Level 1</b>	Ordinary Risk Management
<b>Level 2</b>	Local Inter-Agency Risk Management
<b>Level 3</b>	Multi-Agency Public Protection Panel (MAPPP)

5.7 **The management of restricted patients, including those on conditional discharge, will normally be at Level 1 or 2.** A MAPPA level can normally only be

<sup>44</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2008\\_19.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_19.pdf)

<sup>45</sup> Implementation of the Multi-Agency Public Protection Arrangements (MAPPA) in Relation to Registered Sex Offenders required by sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005

allocated by the MAPPA Group when a patient is being considered for unescorted ground parole, suspension of detention from hospital (granted under section 224 of the Mental Health (Care and Treatment) (Scotland) Act for restricted patients) ( "SUS") or conditional discharge.

5.8 The MAPPA coordinator must be **notified** immediately following admission to hospital of a restricted patient. The Local MAPPA co-ordinator should also be **notified** when a restricted patient is transferred between hospitals or returned to prison. The [MAPPA Notification Form](#) must be used.

5.9 There are 3 key stages at which a MAPPA referral must take place, using the [MAPPA Referral Form](#) :

- when the patient is being considered for unescorted ground parole or unescorted SUS for the first time – following scrutiny of the risk assessment and management plans MAPPA will indicate whether or not they are content with the plans. Once agreement is reached the Responsible Medical Officer ("RMO") should submit the request for SUS to the Scottish Ministers in the usual way;
- when suitable accommodation has been identified in the community as part of the planning for conditional discharge – SUS may continue as usual whilst this process is underway; and
- when the RMO is considering recommending the revocation of the compulsion order or the revocation of the restriction order.

5.10 However, there may be occasions involving transfer or escorted SUS from the State Hospital when the risk is considered to be high. In these exceptional cases a referral to MAPPA level 2 may be appropriate. However, a police view should be sought before a decision is made to make a MAPPA 2 referral. Other examples of possible MAPPA 2 referrals:

- if a patient is already on unescorted SUS or unescorted ground leave and the care team considers the risk presented by the patient might be best managed at MAPPA Level 2 or above; or
- if a patient is on conditional discharge and the clinical team and others involved through the CPA process consider the risk presented by the patient might be best managed at MAPPA Level 2 or above.

5.11 The RMO leads the contribution to MAPPA in respect of restricted patients under his or her care. The RMO is responsible for making patient Notification and/or Referrals to the local MAPPA co-ordinator at appropriate points and copying these documents to the Scotland Government Health Directorate ("SGHD"). Further details of the MAPPA processes are contained in [CEL 19 \(2008\)](#)<sup>46</sup> and in the following chapters relating to SUS, conditional discharge and revocation of the compulsion order or restriction order.

5.12 The Scottish Ministers will reflect in their Position Statement for submission to the Tribunal the following information - A MAPPA meeting was held on [date]. MAPPA level is [state level]. The MAPPA group support the recommendation by the RMO for unescorted SUS.

5.13 For those Tribunals considering conditional discharge, revocation of the compulsion order or revocation of the restriction order **SGHD** will contact the relevant MAPPA co-ordinator to request that a Minutes Executive Summary be prepared for lodging at the Tribunal (which in turn will be copied to the patient and other parties).

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<sup>46</sup> [http://www.sehd.scot.nhs.uk/mels/CEL2008\\_19.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_19.pdf)

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

5.14 The table below is the proforma of statistic collected on restricted patients.

<b>RESTRICTED PATIENTS (RP'S):</b>	<b>NUMBER</b>
<b>a) Number of RP'S:</b>	
i) Living in your area on 31 <sup>st</sup> March 09:	
ii) During the reporting year:	
<b>b) Number of RP's per order:</b>	
i) CORO:	
ii) HD:	
iii) TTD:	
<b>c) Number within hospital/community<sup>47</sup>:</b>	
i) State Hospital:	
ii) Other hospital no unescorted SUS (SUS):	
iii) Other hospital with unescorted SUS:	
iv) Community (Conditional Discharge):	
<b>d) Number managed by category between 1 April 2008 and 31 March 2009:<sup>48</sup></b>	
Level 1 – ordinary agency risk management:	
Level 2 – through inter agency risk:	
Level 3 – MAPPAs, (critical few):	
<b>e) Number of RPs convicted of a further crime of sexual harm or non sexual violence<sup>49</sup>:</b>	
i) MAPPAs Level 1:	
ii) MAPPAs Level 2:	
iii) MAPPAs 3:	
<b>f) No of RPs on SUS:</b>	
i) who did not escape/abscond or offend:	
ii) who escape/absconded:	
iii) who escaped/absconded and then offended:	
iv) where escapes/absconson resulted in withdrawal of SUS:	
<b>g) No. of RPs on Conditional Discharge:</b>	
i) who did not breach conditions, not recalled or did not offend:	
ii) who breached conditions (resulting in letter from the Scottish Government). <sup>50</sup>	
iii) recalled by the Scottish Ministers due to breaching conditions:	
iv) recalled by the Scottish Ministers for other reasons:	

<sup>47</sup> The lowest level within the reporting year should be reported, ie how many restricted patients have been in the community.

<sup>48</sup> As per footnote 1.

<sup>49</sup> The highest level that a patient has been at within the reporting year should be reported.

<sup>50</sup> As per footnote 1.

## SUMMARY OF PATIENT JOURNEY (CHAPTERS 6-14)

### ADMISSION [\[CHAPTER 6\]](#)

- Predisposal orders
- Post disposal orders and directions
- Transfers from outside Scotland

### MANAGEMENT IN HOSPITAL [\[CHAPTER 7\]](#)

- Admission/three month report
- Annual reports
- Mental state and appropriate detention

### SUSPENSIONS OF DETENTION [\[CHAPTER 8\]](#)

- |                            |                        |
|----------------------------|------------------------|
| • Application and feedback | • Grounds leave/access |
| • Types of SUS             | • Emergency SUS        |
| • Programme of planned SUS | • Change in RMO        |

### TRANSFERS [\[CHAPTER 9\]](#)

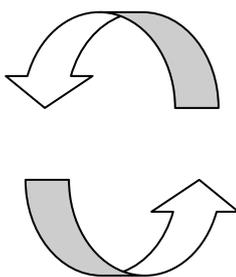
- Transfer to another ward within the same hospital
- Transfer to another hospital with equivalent level of security
- Transfer to another hospital involving a reduction in the level of security
- Transfer to the State Hospital from conditions of lower security
- Transfer to Scotland
- Transfer from Scotland

### PLANNING FOR CONDITIONAL DISCHARGE [\[CHAPTER 10\]](#)

- Appropriate Conditional Discharge
- Information for the Tribunal
- Pre-discharge procedures
- Information to the supervisors
- Conditions of discharge

### MANAGEMENT WHILST ON CONDITIONAL DISCHARGE [\[CHAPTER 11\]](#)

- Reporting requirements
- Role of supervisors
- Liaison with other professionals
- Changes in location or supervisors
- Breach of conditions
- Concern about patient's condition



### TRANSFERRED PRISONERS [\[CHAPTER 13\]](#)

- Transfers between hospital and prison
- Release on licence
- SUS

### TRIBUNAL [\[CHAPTER 14\]](#)

- Applications by patient or named person
- Review of CORO
- Review of HD or TTD
- References by Scottish Ministers
- Hearings
- Appeals to the Tribunal by patient or named person
- Appeals from Tribunal to the Sheriff Principal by a variety of parties
- Appeals from Tribunal to the Court of Session by a variety of parties
- Reports and attendance
- Excessive security

### END OF SPECIAL RESTRICTIONS [\[CHAPTER 12\]](#)

- **CORO patients:** either revocation of the compulsion order (which simultaneously revokes the restriction order) or revocation of the restriction order (in which case patient drops down to Part 9 of the 2003 Act)
- **HD patients:** revocation of the hospital direction, or earlier release of the prisoner from their term of imprisonment [\[CHAPTER 13\]](#)
- **TTD patients:** revocation of the transfer for treatment direction, or earlier release of the prisoner from their term of imprisonment [\[CHAPTER 13\]](#)

## 6 ADMISSION

6.1 Mentally disordered offenders may be diverted into the mental health system from the criminal justice system at various points of the court process. This includes at the pre-trial stage, during trial, at the post-conviction but pre-sentence stage, at the sentencing stage and after sentencing.

- **Pre-disposal orders:** for assessment and treatment of offenders
- **Disposal / sentence by court:** a person may, due to their mental disorder, be ordered by the court to be detained in hospital to receive medical treatment for their mental disorder in lieu of receiving a prison sentence
- **Post-sentence:** a prisoner serving a term of imprisonment may also be transferred from prison to hospital via a transfer for treatment direction

6.2 The relevant orders are divided into pre-disposal, sentence and post-disposal under the Criminal Procedure (Scotland) Act 1995 (“the 1995 Act”) which for reference are: -

### Pre-disposal

Description of order	Legislation
An <b>assessment order</b> - a pre-disposal order made by the court authorising hospital detention for up to 28 days so that the patient’s mental condition may be assessed. Compulsory treatment may also be given in certain circumstances (see e.g., sections 52D(6)(c) and 242(5) (b). The order may be renewed once only for 7 days.	section 52B-J of the 1995 Act
A <b>treatment order</b> - a pre-disposal order made by the court authorising hospital detention for treatment of a person’s mental disorder. Compulsory treatment may be given. The order ceases at the end of the period for which the person is on remand or is committed, unless earlier terminated by the court.	section 52K-S of the 1995 Act
An <b>interim compulsion order</b> - a pre-disposal order made by the court authorising hospital detention for 12 weeks (but can be renewed regularly for up to one year) so that the court can gather further evidence on whether the forensic criteria apply. Compulsory treatment may be given.	section 53 or 57(2)(bb) of the 1995 Act

6.3 A person detained in custody whilst awaiting trial or sentence may be transferred to a hospital by order of the Court for assessment or treatment<sup>51</sup>. Alternatively, a person may be detained in hospital whilst awaiting sentence under an interim compulsion order. Such patients are not restricted patients.

6.4 However, the Scottish Ministers do have a statutory role in relation to remand patients which role at this stage is two-fold:

- applications / notifications – the Scottish Ministers may themselves apply for either an assessment order or a treatment order where it appears to them that the person has a mental disorder, and they will otherwise be notified of an application for such

<sup>51</sup> under sections 52D, 52M, 53 and 57(2)(bb) of the 2003 Act

an order where a prosecutor applies for one or where the court makes such an order of its own volition. Similarly, the Scottish Ministers will be notified where the court has imposed an interim compulsion order. Once the Court disposes of that person's case, or if proceedings are dropped, the relevant order lapses. (The Court ultimately may make a compulsion order with or without a restriction order under the 1995 Act, or it may ultimately impose a penal sentence instead);

- **SUS**- suspension of detention from hospital (granted under section 224 of the Mental Health (Care and Treatment) (Scotland) Act for restricted patients), – the Scottish Ministers' consent is required for any SUS for remand patients. for remand patients will be the exception rather than the rule, due to the high level of supervision that is recommended for such patients. (see [Chapter 8](#) for further information).

6.5 The hospital authorities should include the Scotland Government Health Directorate ("SGHD") in their notification system when any such patients are admitted to hospital and when their cases are disposed of by the Court (or proceedings are dropped).

**6.6 The have produced a protocol with Scottish Court Service (SCS) and are notified by the courts of all new pre-disposal orders and any subsequent changes to their status.**

6.7 In general terms, an accused person who is detained in hospital while awaiting trial should be subject, at least initially, to a high level of supervision. The patient should not be allowed to leave the ward or place of supervised occupation without an escort. In some cases this level of supervision will require to be maintained throughout the remanded person's stay in hospital. In other cases, where, for example, the previous history of the accused is well known, or where his mental condition improves, the Responsible Medical Officer ("RMO") may think it appropriate to allow some relaxation in supervision (see [CEL 9 \(2009\)](#)).

6.8 Where a patient detained under a predisposal order<sup>52</sup> has recovered from their mental disorder in advance of their anticipated court appearance, it will be appropriate for the RMO and Mental Health Officer to submit a report to the court who will decide whether or not it is appropriate to return the patient to custody or release them. The Scottish Ministers have no statutory role in this process.

6.9 There is no automatic provision for the continued detention in hospital of a patient subject to a predisposal order<sup>53</sup> where the order ceases to have effect because the proceedings have been dropped or the person has been acquitted. In such circumstances, civil detention procedures should, where necessary, be effected<sup>54</sup>.

The Scottish Ministers cannot transfer patients on remand or Interim Compulsion Orders between hospitals and this can only be achieved by referral back to the court to change the hospital named on the order.

**Disposal / sentence by court - orders and directions**

Description of Order	Legislative reference
A <b>compulsion order</b> made by the court at the time of disposal following <b>conviction</b> or acceptance of a guilty plea.	section 57A of the 1995 Act

<sup>52</sup> ibid

<sup>53</sup> ibid

<sup>54</sup> under sections 36, 44 or 63 of the 2003 Act

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<p><b>A compulsion order and restriction order</b> made by the court following 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</p>	<p>section 57(2) (a) and (b) of the 1995 Act</p>
<p>A <b>restriction order</b> made by the court at the time of disposal and is added to a compulsion order (under section 57A). It means that the measures specified in the compulsion order will be without limit of time.</p>	<p>section 59 of the 1995 Act</p>
<p>A <b>hospital direction</b> made in addition to a prison sentence. It allows the person to be detained in hospital for treatment of their mental disorder and then transferred back to prison to complete their sentence once detention in hospital is no longer required.</p>	<p>section 59A of the 1995 Act following a conviction on indictment under the 1995 Act</p>

6.10 As noted above, a person may, due to their mental disorder, be ordered by the court at sentencing to be detained in hospital to receive medical treatment for their mental disorder in lieu of receiving a prison sentence.

*CORO – section 57A & 59 (either direct or via section 57(2)(a) & (b)) of the Criminal Procedure (Scotland) Act 1995 Act*

6.11 There are two disposals that the court can now give at sentencing that bring patients under the supervision of the Scottish Ministers: a restriction order with compulsion order (CORO) and a hospital direction (HD)<sup>55</sup>:

a)The court may firstly impose a compulsion order under the 1995 Act instead of a prison sentence, where the offender meets the relevant criteria. In receiving such a mental health disposal, the patient may additionally be made subject to a restriction order, in which case the special restrictions which will apply to the patient are those contained in Part 10 of the Mental Health (Care and Treatment) (Scotland) Act ("the 2003 Act") (CORO patients), without limit of time. A CORO may be imposed directly by the court under section 57A with section 59 where the offender is convicted of an offence punishable by imprisonment (where the sentence is not fixed by law), or where the case is remitted to the High Court for sentencing.

b)Alternatively, the court may make an order under section 57(2)(a) and (b) of the 1995 Act that a CORO should be made where the offender has been either acquitted on the grounds of his insanity at the time of the act, or has been found to be insane in bar of trial.

6.12 CORO patients are also subject to the various further statutory safeguards arising from the Scottish Ministers' role in relation to their management and care, as summarised in paragraph 1.4 above.

*Hospital direction – section 59A of the 1995 Act*

6.13 Alternatively, a hospital direction, which is a hybrid order of hospital disposal with prison sentence, may instead be imposed by the court. A hospital direction will be used where the person has a mental disorder which meets the criteria for admission to hospital, but either the mental disorder and the offence are not closely linked or the offender is likely to remain a risk to the public even after appropriate treatment of the mental disorder.

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<sup>55</sup> Orders previously imposed under the Criminal Procedure (Scotland) Act 1975 and the 1995 Act prior to the introduction of the 2003 Act were automatically transferred over to the corresponding provisions under the 1995 Act as at 5 October 2005 – see Mental Health (Care and Treatment) (Scotland) Act 2003 (Transitional and Savings Provisions) Order 2005, SSI 2005/452

6.14 With the imposition of a hospital direction, Part 11 of the 2003 Act will apply during the lifetime of the offender’s prison sentence, unless earlier revoked. HD patients are also subject to the various further statutory safeguards arising from Scottish Ministers’ role in relation to their management and care, as summarised in paragraph 1.4 above.

*Order for Lifelong Restriction*

6.15 Part 1 of the Criminal Justice (Scotland) Act 2003 provides for the establishment of the Risk Management Association and, from June 2006, for a new High Court disposal for high risk violent and sexual offenders, the Order for Lifelong Restriction (“OLR”). The OLR is not a mental health order [but may sit alongside one]; rather it is designed to ensure that offenders are not released into the community until they have served an adequate period in custody to meet the requirements of punishment and thereafter do not present an unacceptable risk to public safety.

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

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

6.17 The deciding factor between these two would be whether the offender’s risk is “directly or in significant part linked to a mental disorder likely to benefit from treatment<sup>56</sup>” – if it is, then the mental health disposal would be more appropriate than the OLR. If, however, the offender is suffering from a mental disorder not directly linked to their offending and requires detention in hospital for treatment, an OLR and a Hospital Direction may be applied. For further information on the interaction between OLRs and CORO/TTD patients see [Chapter 7](#).

**Post disposal / sentence directions or transfers**

Description of direction or transfer	Legislative reference
A <b>transfer for treatment direction</b> – an order made by Scottish Ministers which allows the transfer of a prisoner to hospital for treatment of a mental disorder.	Section 136 of the 2003 Act
<b>Transfer to Scotland of detained patients</b> from another jurisdiction – reception into Scotland of such patients	SSI 2005/467, made under section 290 of the 2003 Act

*Transfer for treatment directions – section 136 of the 2003 Act*

6.18 As noted above, prisoners serving a term of imprisonment may also be transferred from prison to hospital via a transfer for treatment direction, in which case Part 11 of the 2003 Act will again apply during the lifetime of the offender’s prison sentence, unless earlier revoked. TTD patients are again also subject to the various further statutory safeguards arising from Scottish Ministers’ role in relation to their management and care, as summarised in paragraph 1.4 above.

*Transfers from outwith Scotland*

6.19 Restricted patients may be accepted on transfer from other UK jurisdictions with which there are reciprocal legislative arrangements (i.e. England, Wales and Northern

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<sup>56</sup> Criminal Justice (Scotland) Act 2003

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

Ireland). 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. Once received into Scotland, such patients will be treated as Scottish patients and detained under the equivalent provision in the 1995 or 2003 Acts. The laws from their original jurisdiction will cease to apply.

6.20 Patients from outwith the UK may also be transferred to Scotland via the Repatriation of Prisoners Act 1984, which requires the Scottish Ministers to issue a warrant. In terms of that Act the foreign provision contained in the warrant will have the same effect as a Scottish detention or court order.

6.21 No patient may be received into Scotland (whether restricted or unrestricted) from outwith Scotland without the consent of the Scottish Ministers<sup>57</sup>. Therefore, the Scottish Government Health Directorate (SGHD) carries out a series of checks, including as to whether the patient is detainable under the legislation currently applying, for all patients in respect of whom a transfer to Scotland is proposed, before arrangements can be made for the transfer.

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<sup>57</sup> Section 290(4) of the Mental Health (Care and Treatment) (Scotland) Act 2003, and regulation 24(2) of SSI 2005/467 made under s290.

## 7 MANAGEMENT IN HOSPITAL

### Admission/Three Month report

7.1 The Scottish Ministers require a report to be provided on each restricted patient admitted to hospital (whether from court or on transfer from prison or another hospital) within 3 months of admission<sup>58</sup>. A copy of the Part 9 Care Plan should accompany this report. For restricted patients admitted to the State Hospital, an admission history is routinely provided after the patient has been in hospital for 6 weeks. This may form part of the patient's 3-month report following admission, provided that there is a brief update on the patient's current mental state.

### Annual reports

7.2 The Responsible Medical Officer ("RMO") is required to prepare and submit a report on each restricted patient annually on the anniversary of the date they received their hospital disposal or were admitted to hospital under a transfer for treatment direction<sup>59</sup>. A copy of the most recent CPA documentation (which includes the Part 9 Care Plan) should accompany this report. The report must contain the information outlined in section 183(3) or section 207(3) of the Mental Health (Care and Treatment) (Scotland) Act ("the 2003 Act"), in addition to any particulars which Scottish Ministers may require. A template is offered [here](#).

7.3 The RMO must, in the 2 month period ending with the anniversary of the date on which the order was made, examine the patient, consult with the designated Mental Health Officer ("MHO") and, as soon as practicable thereafter, prepare and submit a report to the Scottish Ministers.

7.4 The annual report should be accompanied by form **CORO1** for those patients on a compulsion order and restriction order or form **HD1** for those patients subject to a hospital direction or transfer for treatment direction. In preparing reports, the RMO is expected to take into account the views of the multidisciplinary team caring for the patient including psychology, and in particular the views of the designated MHO. However, the RMO must take responsibility for all reports to the SGHD on a restricted patient, with the exception of reports prepared by the MHO or psychologists. Annual or 3 month reports not prepared by the RMO must be countersigned by the RMO to indicate agreement with the opinion given.

7.5 The importance of this reporting mechanism for the Scottish Ministers is twofold. Firstly, in terms of the Scottish Ministers' overarching interest in ensuring that the legislation is being complied with by those upon whom a statutory duty is placed under the Act. Secondly, however, the Scottish Ministers also have a more direct interest in that the report then enables them to perform their own separate statutory duties in relation to the restricted patient, in accordance with Part 10 of the 2003 Act. Accordingly, SGHD routinely writes to RMOs to remind them of their statutory duty to review a patient's CORO, HD or TTD in the 2 month period prior to the relevant anniversary date. Accordingly, within that letter, SGHD will routinely:

- remind RMOs that any failure by an RMO to carry out the mandatory annual review and/or to provide the report to Scottish Ministers, as required under the 2003 Act, is a breach of a statutory duty by that RMO; and

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<sup>58</sup> Note that separate timescales for reporting apply to patients transferred to a hospital from outwith Scotland – see SSI 2005/467 (Part III) in that regard and Chapter 9 of this Memorandum.

<sup>59</sup> Under sections 182(2) and 183(2) of the 2003 Act for compulsion order/restriction order patients, and section 206(2) and 207(2) for those patients subject to a transfer for treatment direction or hospital direction

- highlight that any such failure by the RMO has the consequence of preventing the intended operation of the remainder of the review process, and thereby the Scottish Ministers' role in that process; and that the Scottish Ministers take very seriously their statutory responsibilities in respect of restricted patients, and particularly those who are living in the community.

### **State Hospital intermediate review reports**

7.6 While there is no statutory requirement for such reports to be provided to the Scottish Ministers, it is considered good practice for an RMO to copy these reports, as they relate to restricted patients, to the PMO(FP) and the designated MHO.

### **Content of reports**

7.7 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 whether (by reference to the criteria set out in the 2003 Act) the patient is detainable under the mental health legislation at the time of making the report. (Psychiatrists will be familiar with these tests and they are set out in, for example, section 182(3)(b) of the 2003 Act.) A Part 9 care plan is required as part of the report at annual review. Each report must also contain the patient's CHI number.

### **Guidance on reporting on restricted patient's mental state and appropriate detention**

#### *CORO patients*

7.8 When preparing a report on a CORO patient to the Scottish Ministers, the RMO must meet the requirements of section 182(3) of the 2003 Act. Those requirements are:

- (a) to carry out a medical examination of the patient (or make an arrangement for an approved medical practitioner to carry out such an examination);
- (b) to consider whether the criteria outlined in sections 182(3)(b) and s182(4) (paragraph 7.11 are met in relation to the patient; and
- (c) and to consult with the Mental Health Officer.

7.9 The criteria outlined in sections 182(3)(b) and (4) which must be considered by the RMO in conducting the review and preparing the report to the Scottish Ministers are whether:

1. the patient has a mental disorder;
2. medical treatment which would be likely to –
  - (i) prevent the mental disorder worsening; or
  - (ii) alleviate any of the symptoms or effects of the disorder,is available for the patient;
3. if the patient were not provided with such medical treatment there would be a significant risk –
  - (i) to the health, safety and welfare of the patient; or
  - (ii) to the safety of any other person;
4. as a result of the CORO patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment (the "detention in hospital" test);

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

5. it continues to be necessary for the CORO patient to be subject to the compulsion order (the “necessity for a compulsion order” test); and

6. it continues to be necessary for the CORO patient to be subject to the restriction order (even if not requiring detention in hospital) (the “necessity for a restriction order test”).

These factors are statutory criteria, so they must all be applied.

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

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

7.11 The RMO must then go on to consider whether each of the 5 other criteria are met. It is important that reasons are given in the [report](#) for the conclusion reached in respect of each of the tests.

7.12 It should be noted in relation to a restriction order that the “risk of serious harm requiring detention in hospital” test is a quite separate test from the “necessity for a restriction order” test. A recommendation for revocation of a restriction order will only be appropriate where the RMO is satisfied that *both* tests are not met. In other words, even if the RMO considers that the restricted patient does not meet the test of “risk of serious harm requiring detention in hospital (whether or not for medical treatment)”, the RMO **must** separately go on to consider whether or not otherwise, or in any case, the restriction order “continues to be necessary”. In relation to that latter test of whether or not the restriction order “continues to be necessary”, Scottish Ministers’ view is that those applying the statutory test must have regard both to:

1. the original criteria which the court considered when imposing the restriction order, i.e. having regard to:

- (i) the nature of the index offence,
- (ii) the antecedents of the patient, and
- (iii) the risk that the patient would commit further offences if at large;

2. whether it is necessary for the protection of the public from serious harm for the patient to be subject to the restriction order;

and

3. the nature and effect of the restriction order on the patient's present circumstances\*.

(\*With particular regard to the statutory overseeing role afforded to the Scottish Ministers under the 2003 Act; the decision making role of the Tribunal; the involvement of MAPPA in assessing risk; and the fact that without the restriction order, the compulsion order becomes time limited). See the [necessity for restriction order](#) test guidance attached to the RMO annual report template.

7.13 This approach was approved by the Court of Session on 11 February 2009 in the case of JK [<http://www.scotcourts.gov.uk/opinions/2009CSIH9.html>]. Therefore, any recommendation for the revocation of a restriction order must address both the original

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

criteria for imposing the restriction order and its nature and effect on the patient's current circumstances, and give reasons why these considerations no longer apply.

### *HD and TTD patients*

7.14 When preparing a report on a HD or TTD patient to the Scottish Ministers, the RMO must meet the requirements of section 206(3) of the 2003 Act. Those requirements are similar to those in relation to a CORO patient, namely:

- (a) to carry out a medical examination of the patient (or make an arrangement for an approved medical practitioner to carry out such an examination);
- (b) to consider whether certain criteria are met in relation to the patient; and
- (c) to consult with the Mental Health Officer. Note that for HD and TTD patients the RMO must also consult with such other persons as the RMO considers appropriate.

7.15 Again, the criteria which require to be considered in relation to a HD patient or TTD patient, which are set out at section 206(4) are similar to those in section 182(4) for CORO patients as outlined at paragraph 7.9 above.

7.16 The RMO must then go on to consider whether:

- as a result of the HD patient or TTD patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment (the "detention in hospital" test); and
- it continues to be necessary for the HD patient or TTD patient to be subject to the direction in question (the "necessity for the direction" test).

7.17 If the patient is a TTD patient, in considering whether or not the TTD remains necessary, the RMO should also consider whether the patient should be returned to the prison establishment. The Scottish Ministers are not required to revoke the TTD and so 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. However, different considerations may apply when considering the environment into which the patient might be transferred.

7.18 As noted at paragraph 7.5 above, provision of these reports is a main route through which the SGHD obtains current information on a restricted patient. It is therefore vital that the RMO ensures that all relevant information on the patient is provided, and timeously. This should include any information that might provide further background detail on a patient that was not previously available or has become clearer or more detailed with time.

7.19 Of Course, the RMO may at any time provide information to SGHD on a patient and must in any case provide reports on any serious incidents which affect a patient at the time of their occurrence, which should always be copied to the designated MHO. If, in the interval between annual reports, the RMO considers that the patient's mental condition has changed in such a way that the Scottish Ministers should be informed, they should take the initiative in making any additional report or recommendation that they consider appropriate. In assessing proposals regarding restricted patients, the SGHD looks for evidence of both appropriate risk assessment and effective risk management. See [Chapter 3](#) for details. This will enable Scottish Ministers to consider what action, if any, needs to be taken in the light of the RMO's and designated MHO's current view on the patient.

7.20 Where there are any other unusual factor, for example, if the hospital receives information about any form of application to the Mental Health Tribunal, appeal to the Courts or further charges brought against the patient, the RMO should notified the SGHD and the designated MHO at once.

### **Order for Lifelong Restriction**

7.21 As outlined in [Chapter 6](#), the introduction, in June 2006, of the Order for Lifelong Restriction (“OLR”) equipped courts with a new provision for the sentencing and treatment of violent and sexual offenders who pose a continuing danger to the public. As a form of life sentence, an OLR can only be imposed by the High Court. But it differs from a life sentence or a long determinate sentence because of the crucial element of risk assessment which is undertaken prior to sentence being passed. Where the Fiscal believes that there may be grounds for the making of an OLR, e.g. as a result of the person’s offending history, the Crown will make an application to the Court at the time of conviction for a Risk Assessment Order (“RAO”). The RAO is the mechanism by which a person is assessed for an OLR. If the application for the RAO granted, it allows up to 90 days for an accredited assessor to prepare a Risk Assessment Report.

7.22 An OLR or a RAO can, in certain circumstances sit alongside, a mental health order. These are:

- an Interim Compulsion Order patient who is subject to a RAO;
- an OLR and a Hospital Direction (HD);
- an OLR and a transfer for treatment direction (TTD); or
- a CORO patient who is also subject to a RAO.

In such cases, the RMO must be aware of the interaction between the OLR/RAO and mental health orders and any additional responsibilities placed on him, particularly in relation to updating of risk management plans and the role of the Risk Management Authority (“RMA”).

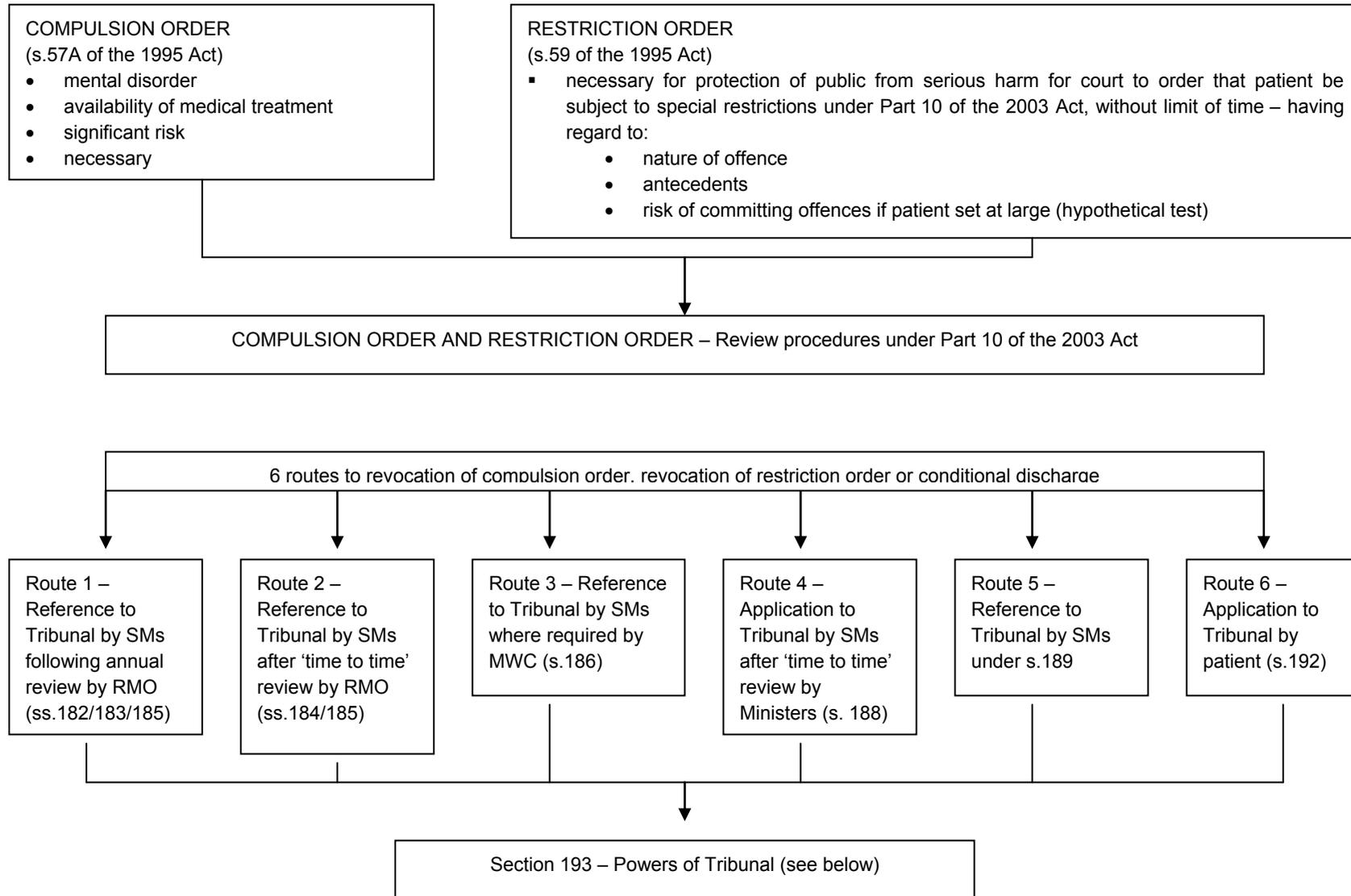
### *Risk Management Plans and the Risk Management Authority (“RMA”)*

7.23 Within 9 months of an Order for Lifelong Restriction (“OLR”) being granted, a risk management plan requires to be prepared by the “lead authority” and approved by the RMA. In normal practice the RMA would expect the risk management plan to be submitted to them no later than 7 months after the OLR takes effect to allow time for them to review the plan and suggest any alterations prior to the statutory 9 month deadline. Once a risk management plan is in place it can be amended as many times as necessary to take account of changes in the person’s circumstances. However, each amendment must be approved by the RMA. An annual progress report must also be submitted to the RMA on the anniversary of the making of the OLR.

7.24 In the case of the first three scenarios mentioned in Paragraph 7.22 above, the Health Board would be classed as the “lead authority” and therefore the preparation of the risk management plan may come under the responsibility of the RMO. In the fourth scenario the “lead authority” will be the prison in which the person was first detained, however it is likely that the RMO will be asked to input into the risk management plan and will need to be involved in subsequent updates and annual progress reports.

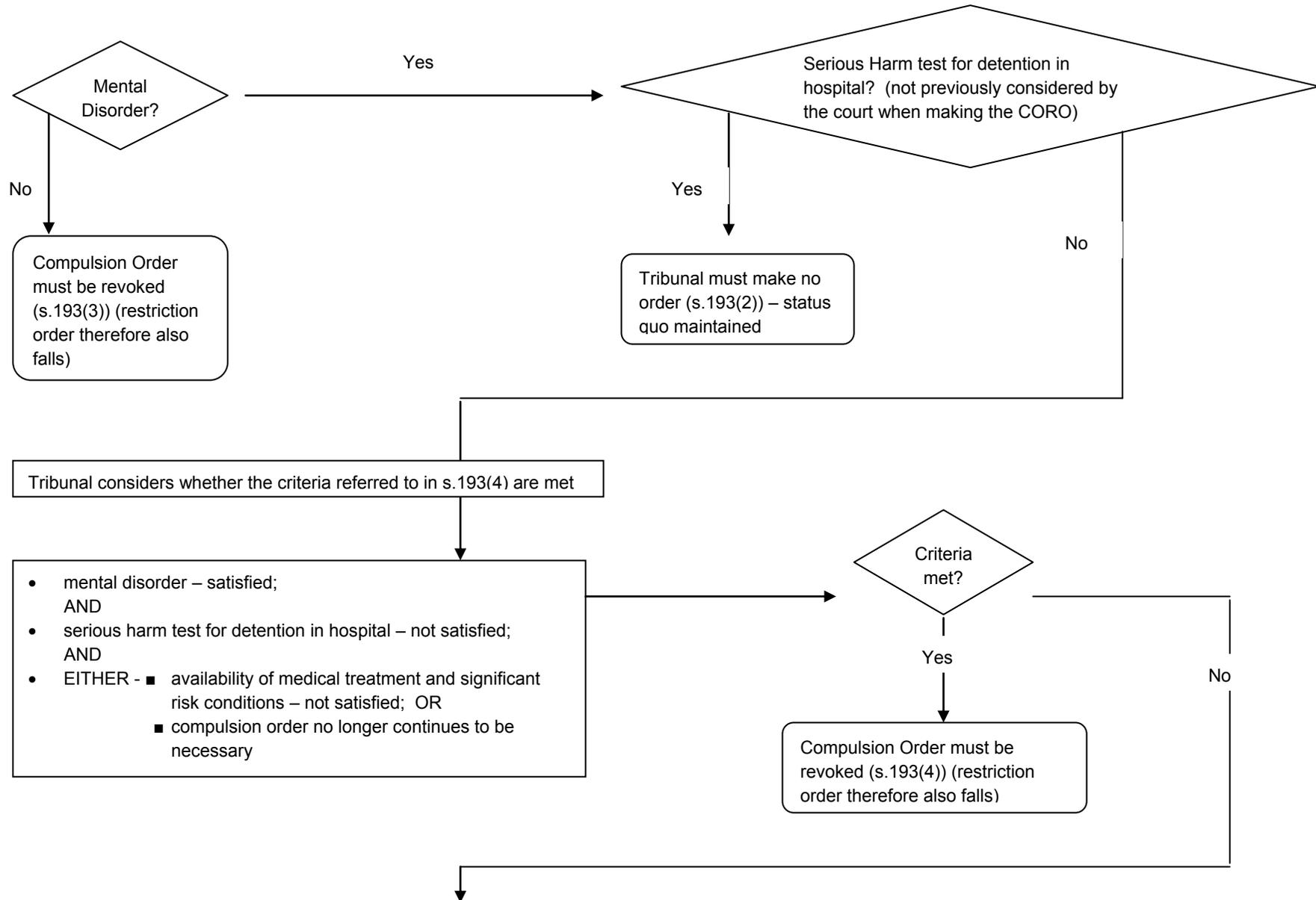
7.25 For further information and advice about OLRs and RAOs contact the RMA.

## Compulsion Order and Restriction Order

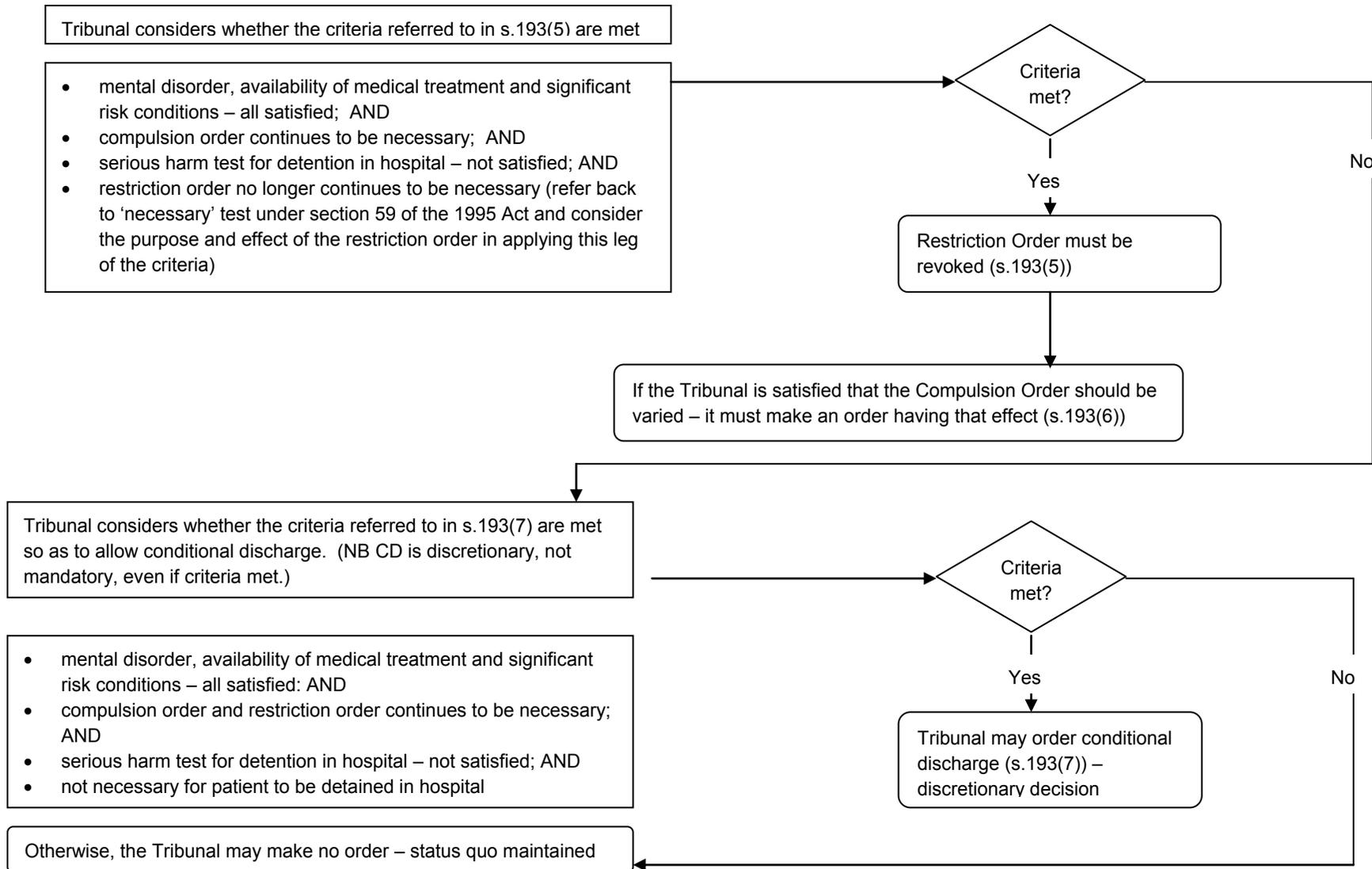


MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

SECTION 193 – Powers of Tribunal



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## 8 SUSPENSION OF DETENTION (SUS)

8.1 This Chapter deals principally with the suspension of detention from hospital (granted under section 224 of the Mental Health (Care and Treatment) (Scotland) Act 2003 for restricted patients), (“SUS”) for restricted patients; different rules apply as regards SUS for remand patients and you are referred to paragraphs 8.48 to 8.52 that highlight those differences.

8.2 SUS means very simply that detention within hospital is suspended. Liability to detention is, however, maintained as are any other measures authorised under the order or direction in question. **A certificate authorising SUS will be required for all occasions when the patient leaves the hospital.** Under the Mental Health (Care and Treatment) (Scotland) Act (“the 2003 Act”), The Responsible Medical Officer (“RMO”) needs the Scottish Ministers’ consent before granting any SUS from hospital for a restricted patient. The Scottish Ministers’ consent is also a statutory requirement for any SUS from an interim compulsion order, treatment or assessment order (see paragraphs 8.48 to 8.52). It should be noted that leave in the grounds of the hospital, either escorted or unescorted, does not require permission from the Scottish Ministers and can be granted at the discretion of the RMO. The only exception to this being the Orchard Clinic (see paragraph 8.18).

### **Scottish Ministers’ approach to SUS**

8.3 The Scottish Ministers recognise that SUS, which serves a definable purpose, is well thought-out and carefully and sensitively executed, has an important part to play in the treatment and rehabilitation of restricted patients. Suspensions of detention provide information for the assessment of risk and help RMOs and the Scottish Ministers in determining when, and under what conditions, moves within the hospital system can safely be made. Suspensions of detention can also provide valuable information to all parties, including the Tribunal, when considering discharge into the community.

8.4 Clinical teams should plan SUS in the context of the [Care Programme Approach](#) (“CPA”) and in response to a needs assessment and a risk assessment (including risk of harm to others and respect the fears of victims and others who may have been affected by the patient’s offending behaviour). An example is given within the templates “[Suspension of Detention Plan](#)” Also to sustain public confidence in the arrangements as a whole, MAPPA should be applied at the required stages as detailed in paragraphs 8.18 and 8.19 below and [Chapter 5](#). SUS can be requested exceptionally outwith the CPA process by letter to the Scottish Government providing feedback if appropriate on previous SUS.

### **Legislation**

8.5 Section 224 of the 2003 Act sets out procedures for suspension of detention from hospital (“SUS”) for patients who are on a compulsion order and restriction order, a hospital direction, a transfer for treatment direction, treatment order or an interim compulsion order. Where a patient is subject to any of these orders, the RMO may grant a SUS certificate for up to 3 months provided that:

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

8.6 Section 221 of the 2003 Act separately sets out similar procedures for SUS from an assessment order, to which again the consent of the Scottish Ministers is required. However, as assessment orders only last 28 days, the 3 month suspension period above is not relevant.

### **Reporting**

8.7 There is also a requirement for the RMO to report back to the Scotland Government Health Directorate (“SGHD”) (for CORO, HD and TTD patients) not later than 3 months after consent to SUS is given or prior to any further requests for SUS are made to the Scottish Ministers; whichever is the earlier. This feedback can form:

- a part of a statutory report;
- an update of the Care Programme Approach documentation; or
- a further request for SUS.

**SUS can be revoked at any point by the RMO or the Scottish Ministers when satisfied that it is in the interests of the patient or for the protection of any other person (see paragraphs 8.37 to 8.42).**

### **Types of SUS**

8.8 In general, the SGHD will consider SUS 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.

The SUS can be granted either on an escorted or unescorted basis depending on the individual’s circumstances, level of risk, etc. It may also be made subject to other conditions.

### **Timing of Requests**

8.9 The Scottish Ministers’ responsibilities require that proper consideration be given to each SUS request, that any risk to the public has been properly identified and evaluated, and that sound measures have been taken to guard against it. As a general rule, the longer or more unusual the freedoms sought, then the more advance notice the SGHD requires to consider the request. **It is important that, where possible, the SGHD is given at least three weeks notice of a request for SUS.** This may be longer in the case of requests for unescorted SUS for transferred life sentence prisoners as the Scottish Ministers take these decisions personally (see paragraph 8.35). Separate arrangements are in place to deal with emergency requests for SUS (see paragraphs 8.31-8.33 below).

8.10 Given that the Scottish Ministers’ consent is a statutory pre-requirement for any SUS granted by an RMO, the RMO should not make final arrangements for the SUS to take place until the Scottish Ministers’ consent has been received. Care should also be taken not to raise the patient’s expectations. It is appreciated that it is very upsetting for a patient (and where involved, the patient’s family) when a SUS planned by the multidisciplinary team is not approved by the SGHD due to lack of time for full consideration of the request, or any other reason; this situation should therefore be avoided.

### **Escorted SUS**

#### *How to make an application*

8.11 Permission for SUS **from the State Hospital** is sought by submitting an appropriately completed “Patient Outing Application Form” to the Scottish Government’s PMO (FP). Each application should inform whether the use of handcuffs has been considered necessary and, if so, the reasons for this and the arrangements for their use.

Suspensions of detention from the State Hospital should adhere strictly to that described within the 'Patient Outing Application Form'. Only in an emergency situation is any deviation from the details contained in the form appropriate. If deviation has been necessary this should be reported to the SGHD.

8.12 For patients in **medium secure units and other psychiatric hospitals**, requests should be made in writing to the PMO (FP) detailing the purpose, duration, frequency and escorting arrangements and should be accompanied by the following information:

- a recent risk assessment and risk management plan ; or
- up-to-date CPA documentation (which include elements of risk assessment and a risk management plan); and
- where SUS is being considered for the first time to the home of a patient's family member or friend, an up-to-date social work report on the property (completed by the Mental Health Officer ("MHO") or allocated social worker).

#### *Series of events*

8.13 Where it is intended that the patient make a series of similar events over a known time span (such as a series of hospital appointments, pre-transfer visits, rehabilitation programme including, for instance, attendance at college), a single detailed request may be submitted for the planned SUS.

8.14 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 SUS would be subject to the patient's mental state being stable on the day.

8.15 The RMO should inform the SGHD immediately should any change occur which affects the basis on which the Scottish Ministers' consent has been given for a SUS.

8.16 For many patients the level of risk will remain unchanged when the patient receives escorted SUS and only change when unescorted SUS or leave within the grounds of the hospital is approved. However it must be recognised that a small number of patients may also present an increased risk to the public (e.g. through absconding) while on escorted leave. It is therefore essential that the risk management plan is reviewed before **any** request for escorted SUS is made to the Scottish Ministers. Examples of risk management traffic lights which address absconding risk is contained in [Annex H](#).

8.17 In exceptional circumstances where the risk is considered to be high and escorted SUS is being considered it may be appropriate for the RMO to make a MAPPA referral (see [Chapter 5](#)). However this should be discussed with the police link in the first instance.

### **Unescorted SUS**

#### *New Requirements involving MAPPA*

8.18 When a restricted patient is **first** being considered for any **unescorted** SUS, including unescorted leave within the hospital grounds, the multidisciplinary team **must** initiate a [MAPPA referral](#). Note, however, that unescorted leave within the secure perimeter of the State Hospital or Rowanbank Medium Secure Unit would **not** normally be expected to trigger such a referral. In the case of patients in the Orchard Clinic Medium Secure Unit, leave in the grounds of the Royal Edinburgh Hospital is classed as SUS (either escorted or unescorted) and consent should be sought from the PMO (FP) using the appropriate guidelines.

8.19 The RMO should assign a provisional MAPPA Level to the patient, complete the MAPPA referral [form](#) and submit to the local Co-ordinator with a copy to SGHD. A MAPPA Group meeting will be arranged within 20 working days to review the patient's risk assessment and management plans. A copy of the minutes of the meeting will be sent to SGHD. **No requests for unescorted SUS will be considered by SGHD until the MAPPA referral process has been completed**

*How to make an application*

8.20 Requests for unescorted SUS **from the State Hospital** are rare. However, in cases where this is considered appropriate, permission is sought by submitting an appropriately completed "Patient Outing Application Form" to the PMO (FP). It should be accompanied by an up-to-date risk assessment and risk management plan or CPA documentation. Suspensions of detention from the State Hospital should adhere strictly to that described within the 'Patient Outing Application Form'. Only in an emergency situation is any deviation from the details contained in the form appropriate. If deviation has been necessary this should be reported to the SGHD. The Community Discharge Group at the State Hospital should see and agree plans involving direct discharge from the State Hospital.

8.21 For patients in **medium secure units and other psychiatric hospitals**, requests should be made in writing to the PMO (FP) detailing the purpose, duration and frequency and should be accompanied by the following information:

- a recent risk assessment and risk management plan ; or
- up-to-date [CPA documentation](#) (which include elements of risk assessment and a risk management plan) along with [SUS plan](#);
- and, where SUS is being considered for the first time to the home of a patient's family member or friend, an up-to-date social work report on the property (usually completed by the MHO).

8.22 The RMO should inform the SGHD immediately should any change occur which affects the basis on which the Scottish Ministers' consent has been given for a SUS.

*Programme of SUS*

8.23 While, "one-off" requests can be necessary, **the Scottish Ministers would usually expect requests for unescorted SUS to be made in the form of a graduated programme over a number of weeks/months**. Such phased programmes should relate to the overall care and treatment plan and should set personal objectives for the patient. The request to the PMO (FP) should explain the part this suspension will play in the patient's overall rehabilitation plan. Once consent is given, the programme of unescorted SUS should develop according to the patient's progress, mental state and behaviour, and any significant changes resulting in an alteration to the agreed plan should be notified to SGHD.

*Overnight SUS*

8.24 At the point where the RMO and clinical team are seeking accommodation for a patient in the community, the risk assessment and management plan must be updated and the police invited to a pre-CPA meeting to discuss possible accommodation options. Once the accommodation has been identified and the plan is to progress the patient towards conditional discharge a further MAPPA referral should be made. The RMO must complete the MAPPA referral [form](#) and submit it to the local Co-ordinator with a copy to SGHD. A MAPPA Group meeting will be arranged within 20 working days. The patient's SUS programme may continue in the meantime.

8.25 Permission may be given for a patient to spend overnight SUS at the home of a family member or at accommodation identified as part of a package of care in the

community. Such SUS usually forms part of the latter stages of a patient's rehabilitation programme and is a key factor in assessing a patient's suitability for a return to the community. The maximum number of overnights permitted in any one week is four. A patient would be expected to gradually increase the number of overnights spent at his/her accommodation over a period of at least four months, e.g. one overnight the first month, two the second month and so on, until the maximum number is reached.

8.26 In cases where the Tribunal order conditional discharge and Scottish Ministers do not oppose conditional discharge it will be open to the RMO to seek unescorted SUS to cover the period up until advised by the Scottish Government of the conditional discharge taking effect

#### **Change in RMO and reviewing current SUS not involving transfer**

8.27 When there is a change in the RMO for the patient, the new RMO must review as soon as practicable the current SUS plan for the patient and confirm they are content for the level of SUS previously agreed to continue.

#### **Change in RMO and reviewing current SUS following transfer**

8.28 Consent to escorted or unescorted SUS does not automatically move with the patient if they are subsequently transferred. The new RMO must consider whether or not they wish to adopt the same plan for SUS as before and if they are content to keep the current permissions they must write to SGHD. However, in cases where the transfer has been from high security to medium or low security a fuller consideration is required. In these cases the existing SUS should be revoked and a new application for SUS should be submitted by the RMO, following consultation with the patient's designated MHO, together with an updated risk assessment reflecting the changed circumstances. There may also be a requirement for a MAPPA referral if there is considered to be a significant change to the patient's level of risk following transfer or if the patient has moved to a new MAPPA area.

#### **SUS for compassionate reasons**

8.29 SUS for compassionate reasons will be given serious consideration by the SGHD. It should be noted that such a request is more likely to be considered acceptable if efforts have been made to ensure a low profile, particularly, for example, where the media are already aware of the patient's background.

8.30 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, together with their escort, 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.

#### **SUS for cases of emergency**

8.31 Telephone requests by the patient's RMO or the duty RMO may be made in compassionate or emergency circumstances which necessitate urgent SUS (for example, to a hospital for treatment of a serious physical ailment). In these cases, the RMO or duty RMO must contact the PMO (FP) or a SGHD official to obtain the necessary approval. Prior consent for urgent clinical appointments may be sought however a written or oral update must be provided after each event.

8.32 The PMO (FP) and officials may be contacted at any time including out of office hours. **Out of hours contact details** are circulated separately to Health Boards. These details should not be posted on notice boards or incorporated within CPA documentation. Where exceptionally no contact can be made with an official, a message may be left with the Security Guards at Victoria Quay by dialling the main Scottish Government 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

8.33 Where permission is not obtained in advance of urgent leave (such as an emergency visit to hospital), a telephone report must be made to the SGHD by the RMO as soon as possible thereafter, followed by a formal report including details of why prior contact was not possible.

#### **Attending Tribunal hearings**

8.34 Where the case involves an appeal to the Tribunal, the patient would be allowed to attend unless this would be inappropriate. The Tribunal Rules, for example, make provision for a curator ad litem to be appointed to represent the patient's interest in certain circumstances in the proceedings before the Tribunal, including subject to: the health provisions outlined in the Rules of Procedure<sup>60</sup>; or where the patient has been excluded from all, or part, of the hearing<sup>61</sup>. Where the hearing is taking place outwith the hospital, a request must be made for SUS.

#### **SUS for life sentence prisoners**

8.35 Scottish Ministers personally approve all requests for SUS for transferred life sentence prisoners. It is, therefore, helpful to draw up a programme of freedoms for a period of time for which approval can be sought in advance; one-off requests for life sentence prisoners should be avoided. Prior to submitting a request, it is often helpful for the multidisciplinary team at the hospital, the designated MHO, the PMO (FP) and Scottish Government Health and Justice Directorate officials to meet when rehabilitation has progressed to unescorted SUS. 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. The SUS plan should also be incorporated for transferred prisoners receiving SUS.

#### **SUS for sex offenders**

8.36 Section 96 of the Sexual Offences Act 2003 provides a power to make regulations requiring those who are responsible for an offender while they are in detention to notify other relevant authorities of their release or transfer to another institution. The main change affecting mentally disordered offenders will be the requirement on hospital managers to inform the police when a patient is transferred to another hospital, discharged from hospital and in cases where the patient is to be released from detention for a period of 3 days or more. Guidance on the operation of the regulations will be issued as soon as practicable after they come into force.

#### **Revocation of a certificate authorising SUS**

8.37 A SUS certificate can be revoked by the patient's RMO or Scottish Ministers if either is satisfied that it is necessary to do so in the interests of the patient or for the protection of any other person.

8.38 Revocation of a SUS certificate SUS3a<sup>62</sup> (using form SUS3b<sup>63</sup> by the RMO or SUS3c<sup>64</sup> by the Scottish Ministers) authorises the immediate conveyance of the patient back to hospital by the staff of the hospital and/or the police.

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<sup>60</sup> rule 55(1) of the Tribunal Rules of Procedure

<sup>61</sup> Rules 68(1) or 69(1) of the Tribunal Rules of Procedure

<sup>62</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/mha-Forms/sus1adec2008>

<sup>63</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/SUS3bv6>

<sup>64</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/SUS3cv6>

8.39 As soon as is practicable after the revocation of the certificate in respect of a restricted patient or one subject to an interim compulsion order, the RMO or the Scottish Ministers (as the case may be) must notify:

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

8.40 Where the revocation is of a SUS of an assessment order, then the RMO or the Scottish Ministers need notify only the persons listed at the first three bullet points above.

8.41 **The RMO must make the SGHD aware if any SUS is terminated or if an adverse incident has taken place during the SUS.** When an event has been cancelled the reasons for this should be made known and whether it is planned that the event will take place at a later date.

8.42 There is no provision within the legislation for RMOs to "suspend" SUS, i.e. **where SUS is no longer considered appropriate the RMO must formally revoke the measures by completion of form [SUS3b](#)**. It is possible however if the patient consents to remaining in hospital and confirms this in writing for the SUS not to be revoked. If SUS is subsequently considered appropriate once more, then a fresh application must be made and the Scottish Ministers' consent obtained anew.

### **Absconding while on SUS**

8.43 A patient will be treated as having absconded (and so is liable to be taken into custody and returned to hospital<sup>65</sup>) if he absconds from the charge of an authorised person in terms of section 224(7)(a) of the 2003 Act whilst out on a period of SUS. Where the patient is on unescorted SUS, an abscond also includes failure to return from a period of SUS by the specified time.

8.44 In these circumstances, the SUS certificate will not require to be revoked for the accompanying nurse to have the power to return the patient to hospital. Any abscond must be reported to SGHD officials immediately.

### **Short Cross Border Visits – Scotland to England, Wales or Northern Ireland**

8.45 Restricted patients may have escorted SUS to England, Wales or Northern Ireland for short periods. RMOs should submit the SUS request in the usual way outlining the duration, location and reason for the visit along with the most recent risk assessment and management plan. Officials in SGHD will liaise with officials in the Ministry of Justice or Northern Ireland Office to ensure they are content for the visit to proceed.

### **Similar arrangements exist for restricted patients in England and Wales and Northern Ireland to visit Scotland.**

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<sup>65</sup> Application of the absconding provisions in Part 20 of the 2003 Act.

8.46 The leave of absence provisions in the Mental Health Act 1983 will apply to enable patients in England and Wales to visit Scotland, whilst the Mental Health (Northern Ireland) Order 1986 makes provision as regards leave of absence for Northern Irish patients.

**Inappropriate use of SUS**

8.47 It should be noted that SUS is not an appropriate mechanism for any longer term stays in a hospital other than the one in which the patient is currently detained, either within Scotland or outwith Scotland. Reference is made to the alternatives provided by the permanent transfer provisions between hospitals: for hospitals within Scotland, found in Part 12 of the 2003 Act; and for any transfers to hospitals outwith Scotland, the Cross-Border Transfer Regulations made under section 290 of the 2003 Act (see [Chapter 9](#)).

**Pre-disposal cases (AOs, TOs & ICOs,-) court appearances & urgent clinical outings**

8.48 As noted at paragraph 8.1 above, this chapter is principally aimed at setting down the procedures for SUS for restricted patients, and pre-disposal remand patients are in a different position as regards SUS.

8.49 As with restricted patients, those who are subject to a pre-disposal order may only be granted SUS by their RMO with the consent of the Scottish Ministers. However, for remand patients, due to the high level of supervision that is recommended in respect of such patients whilst awaiting disposal of their case, the Scottish Ministers view is that SUS should be the exception rather than the rule.

8.50 Consent may be obtained in advance for court appearances and urgent clinical outings for patients awaiting final disposal. Although not a statutory requirement, SGHD will consult with the Procurator Fiscal in relation to all requests for SUS (except urgent clinical or court requests) to ensure that the Scottish Ministers have all the relevant information to hand in considering such requests. Further details, including the agreed procedure for RMOs seeking the necessary statutory consent for any SUS for patients subject to an assessment order, a treatment order or an interim compulsion order, may be found in [CEL 9 \(2009\)](#).

8.51 If the RMO considers that the patient is not well enough to attend court, the RMO should inform the court of this; if SUS had been granted for that purpose then it should be revoked.

8.52 A written/oral update must be provided to SGHD after each event.

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
**9 TRANSFERS**

9.1 This Chapter deals principally with transfers of restricted patients; different rules apply as regards transfers for remand patients and you are referred to the discrete paragraphs 9. 49 to 9.51 below that highlights those differences.

9.2 All transfers of restricted patients must have the Scottish Ministers' approval under section 218(3) (in addition to securing the consent of the hospital managers in the receiving hospital), whether to higher, lower or equivalent levels of security. The patient and their named person must normally be given 7 days notice of the transfer<sup>66</sup>. However, where this is not possible, transfer may still take place in urgent cases and notification completed afterwards<sup>67</sup>. No notification is required if the patient consents to transfer<sup>68</sup>.

9.3 Transfer of a restricted patient's care from one Responsible Medical Officer ("RMO") to another or from one location to another should be considered via the normal Care Programme Approach procedures (see [Chapter 4](#)) and in response to needs assessment and risk assessment (including the risk of harm to others). When a patient transfers to another hospital the sending RMO must notify the local MAPPA Co-ordinator using the appropriate [form](#). Where a transfer involves a reduction in the level of security, the new RMO should give consideration to whether a MAPPA referral is required at the point of transfer or whether this can wait until the first consideration of unescorted ground parole or suspension of detention from hospital (granted under section 224 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Act for restricted patients) ("SUS").

9.4 Specific guidance is given in this chapter regarding the following types of transfer:

- Transfer to another ward within the same hospital;
- Transfer to another hospital with equivalent level of security;
- Transfer to another hospital involving a reduction in the level of security;
- Transfer to the State Hospital from conditions of lower security;
- Transfer to Scotland; and
- Transfer from Scotland.

9.5 There are other types of transfer that 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 transfer from hospital back to prison of a TTD patient. Further advice is available from the Scotland Government Health Directorate ("SGHD") officials and guidance on transfer back to prison is detailed in [Chapter 13](#).

**9.6 The RMO should contact SGHD officials for specific advice about any planned transfers.**

**Transfer to another ward within the same hospital**

9.7 Ward to ward transfers are at the discretion of the RMO, who should inform the SGHD and the designated Mental Health Officer ("MHO") when such a transfer takes place. However, **where a patient is moving from a locked to an unlocked ward the RMO should consult with SGHD and the PMO (FP) prior to transfer taking place.** The RMO should write to the Scottish Government's Principal Medical Officer (Forensic Psychiatry) ("the PMO (FP)") with details of:

- the reason for the transfer,
- the new ward and RMO (if appropriate) and

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<sup>66</sup> Section 218(4) of the 2003 Act.

<sup>67</sup> Section 218(5) of the 2003 Act.

<sup>68</sup> Section 218(7) of the 2003 Act.

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

- the initial care plan following transfer.

The PMO (FP) will consider whether it is necessary to arrange a visit to the patient to discuss with the RMO and clinical team.

### **Transfer to another hospital with equivalent level of security**

9.8 Transfers to a different hospital, even one with the same level of security, require Scottish Ministers' approval and this is given on their behalf by SGHD officials, in consultation with the PMO (FP). These transfers will take place for any number of reasons such as developments in a patient's care or rehabilitation, to move the patient closer to family and friends or hospital closure,. When the primary reason for transfer is to allow the patient to be closer to family and friends, a supporting report from the designated MHO and other involved social workers must be provided.

#### *Pre-transfer matters*

9.9 The RMO, after consulting with the designated MHO, should write to the PMO (FP) with details of:

- the reason for the transfer;
- the receiving hospital and RMO;
- evidence that the receiving RMO has agreed to accept the patient;
- that the designated MHO will remain or transfer that role; and
- the initial care plan following transfer.

The PMO (FP) will consider whether it is necessary to arrange a visit to the patient, RMO and designated MHO prior to giving consideration to the request for transfer.

9.10 Multidisciplinary teams should consider pre-transfer visits by the patient to the receiving hospital. SGHD approval must be sought for these through the normal SUS procedure for restricted patients. Where a number of pre-transfer visits are considered appropriate, a block request may be submitted. Further details are available in [Chapter 8](#).

9.11 Once the SGHD, in consultation with the PMO (FP), 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. Officials will then issue a letter to the Medical Directors and RMOs of both hospitals. This letter must remain with the patient's medical records as the formal record of the transfer. The current RMO must send notification of the change in address to the MAPPA co-ordinator using the notification [form](#). The SGHD will notify the Mental Welfare Commission of the patient's transfer.

#### *Post-transfer matters*

9.12 Following transfer, **the new RMO must write to the PMO (FP) to confirm their view on the appropriateness of continuing the same level of SUS the patient was receiving prior to transfer** (see paragraph 9.17). Any approval given previously for SUS does not transfer with the patient. If the patient was receiving extensive SUS and the transfer does not involve a drop in the level of security it is important that the patient is not adversely affected by an undue delay in consideration by the RMO and multi-disciplinary team.

### **Transfer to another hospital involving a reduction in the level of security**

9.13 Transfer involving a reduction in the level of security, e.g. from the State Hospital or from a medium secure unit to a local hospital, again requires the consent of Scottish Ministers. **In this case, the personal approval of the Scottish Ministers will be sought.** SGHD officials will not seek the agreement of Ministers until all arrangements are agreed, pre-transfer visits have taken place and a bed is available in the receiving facility. In some circumstances however, officials can seek an "in principle" decision on transfer from Ministers, subject to a bed becoming available at the receiving facility. This decision "in

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

principle” holds for up to six months and is contingent on the patient’s stable mental state, a lack of any incident during the intervening pre-transfer period, successful pre-transfer visits and a pre-transfer CPA taking place. In these cases, an update from the RMO prior to transfer proceeding should be given to the SGHD. The final transfer should not take place until the SGHD has given consent in writing.

9.14 This type of transfer might be appropriate when a patient is no longer assessed as requiring either special security or detention in conditions of medium security. 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 be appropriate to return the patient to conditions of lesser security.

9.15 The procedures outlined at paragraphs 9.9 to 9.11 above should be applied to a transfer to another hospital involving a reduction in the level of security.

9.16 In such cases, the PMO (FP) will generally always arrange a visit to assess the patient along with the RMO and the designated MHO before the recommendation for transfer is put before the Scottish Ministers.

9.17 It is also important to be aware that any approval given previously for SUS does not transfer with the patient to the new hospital a hospital closing,

### **Appeal against transfer to a hospital other than the State Hospital**

9.18 Under section 219 of the Mental Health (Care and Treatment) (Scotland) Act (“the 2003 Act”), a patient or their named person may appeal to the Tribunal against the patient’s proposed or actual transfer from the date of receipt of notice of transfer up to 28 days after the actual date of transfer. For the patient’s named person this extends to 28 days after their receipt of written notice of transfer.

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

### **Transfer from conditions of lower security to the State Hospital**

9.20 Transfers to the State Hospital from conditions of lower security require the Scottish Ministers’ approval and this is given on their behalf by SGHD officials, in consultation with the PMO (FP). In certain circumstances, it may be necessary for the multidisciplinary team in a local or medium secure unit to consider transferring a patient to the State Hospital e.g. on account of his dangerous, violent or criminal propensities.

9.21 When considering such a transfer, reference should be made to section 102(1) of the National Health Service (Scotland) Act 1978 which reflects the same statutory test which was set out in the right of appeal at section 220(6) of the 2003 Act, namely that the patient requires to be detained in hospital under conditions of special security, and that those conditions of special security can be provided only in a state hospital. For further guidance see section 102(1) of the National Health Service (Scotland) Act 1978 which reflects the same statutory test, i.e. on account of the patient’s “dangerous, violent or criminal propensities”. This was subsequently found in sS29 (4) of the Repatriation of Prisoners Act 1984 Act and this may also be used as the ‘test’<sup>69</sup> at an appeal hearing.

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<sup>69</sup> Section 102(1) of the 1978 Act and section 29(4) of the 1984 refer to patients requiring treatment under conditions of special security on account of their “dangerous, violent or criminal propensities”. Nb you need to delete that sentence ,and replace it with the last sentence in 9.21 I have deleted “Details of.....act” but can’t cut and paste the sentence in.

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9.22 The RMO, after consulting with the designated MHO, should write to the PMO (FP) with details of:

- the reason for the transfer;
- the receiving RMO;
- evidence that the RMO has agreed to accept the patient; and
- that the designated MHO will remain or transfer that role.

9.23 The proposed transfer must have the agreement of the receiving RMO and the managers of the State Hospital before permission is sought from the Scottish Ministers. SGHD officials appreciate that, by its nature, a transfer to the State Hospital may need to be **effected urgently**, and are willing to accept telephone and fax contact from the RMO where immediate permission is required<sup>70</sup>.

9.24 The RMO should again notify in writing the patient, their named person and their designated MHO of the transfer 7 days in advance, where possible. Where urgent transfer is required or where it is felt that to inform the patient prior to transfer may lead to a further deterioration in their behaviour, this notification should again be made “after the fact”.

9.25 The SGHD will notify the Mental Welfare Commission of the patient’s transfer.

### **Appeal against transfer to the State Hospital**

9.26 Under section 220 of the 2003 Act, a patient or their named person may appeal to the Tribunal against the Scottish Ministers’ decision to transfer them to the State Hospital (or against the actual transfer if it has already taken place). They may appeal from the date of receipt of notice of transfer (where given) up to a period of 12 weeks after the date of transfer. For the patient’s named person this extends to 12 weeks after receipt of written notice of transfer.

### **Transfer to Scotland**

9.27 Transfer to a hospital in Scotland from elsewhere in the UK may be appropriate for a number of reasons, for example for a restricted patient who is Scottish or who has close family ties in Scotland. Any transfer of a patient to Scotland can only take place if the Scottish Ministers have given their consent<sup>71</sup>. While the legislation permits such a transfer, there are some particular issues to be addressed before it may be approved. The requirements which must be complied with for the reception of any patient into Scotland are laid down in Part III of the Cross-Border Regulations (SSI 2005/467). It should be noted that a patient may only be transferred if they would be legally detainable under equivalent Scottish legislation.

#### *Pre-transfer matters*

9.28 Immediately the receiving hospital is contacted about the transfer and before agreeing to it, the RMO approached must contact the SGHD 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 outwith Scotland directly to a hospital in Scotland. **It is also not possible to transfer a patient on remand or who has not yet received a final disposal** (see paragraph 9.51 in that regard). SGHD officials will liaise with the Ministry of Justice, Northern Ireland Office or government of other country of origin and will seek background information on the patient including:

- diagnosis and whether detainable;
- index offence and criminal history;
- police reports;

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<sup>70</sup> Reference to information required in the case of an emergency admission to TSH need to fill in the reference

<sup>71</sup> See regulation 24(2) of SSI 2005/467 made under s290 of the 2003 Act.

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

- 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).

9.29 SGHD officials will also require a copy of the receiving RMO's assessment of the patient including their view on whether the patient is detainable.

9.30 It should be noted that a patient may only be transferred if they would be legally detainable under equivalent Scottish legislation. SGHD officials will seek the views of the solicitors in the Scottish Government Legal Directorate about whether the patient would be legally detainable under Scottish legislation. If this is not the case, the patient cannot be transferred.

**9.31 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.**

9.32 If pre-transfer visits are required, these should not take place before determination of whether the patient is detainable under Scottish legislation has been completed. Thereafter, it is the responsibility of the sending hospital to arrange any visits with the receiving hospital. Pre-transfer, short-term, cross-border visits would be effected under the regulations relevant leave of absence provisions under the legislation in the jurisdiction in which the patient is detained relating to short term, cross border visits.

9.33 Once SGHD officials, acting on behalf of Scottish Ministers, and having consulted the PMO (FP), agree that the patient may be accepted for transfer, they will notify the receiving RMO and the Ministry of Justice/Northern Ireland Office/country of origin. **The receiving RMO should liaise with the patient's present hospital to arrange the transfer. The RMO will also need to contact the relevant Scottish local authority to ensure that a designated MHO is appointed for the patient and must ensure the necessary paperwork is received when the patient transfers.** A warrant will be required.

### *Post-transfer matters*

9.34 Once a patient has been received in Scotland, they become treated as if their detention in hospital had been authorised under the relevant provision of the 2003 Act or the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act") Put simply, they become a Scottish detained patient and cease to be detained in the sending jurisdiction. Again, reference should be made to Part III of the Cross-Border Transfers Regulations (SSI 2005/467), which imposes various requirements on RMOs and MHOs following any transfer. This includes that an assessment of the patient be carried out by the RMO within 7 days of their reception with resulting notification requirements, the preparation of a care plan, and thereafter, after 3 months, an admission report will be required on the patient with annual reports thereafter. The SGHD and the local authority should be informed when the patient has been transferred.

### **Transfer out of Scotland**

9.35 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 that can cater specifically for their special needs and/or give them treatment that 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 will be returned to Northern Ireland when they no longer require such conditions.

9.36 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.

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It is also necessary for SGHD 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.

### *Pre-transfer matters*

**9.37 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 SGHD who may be able to provide some assistance through liaison with officials in the receiving country.

9.38 The requirements of the Cross-Border Transfer Regulations (SSI 2005/467) must again be complied with, Part II applies to transfers out of Scotland. In particular, it is for Scottish Ministers to effect the transfer of any patient out of Scotland, by means of a warrant for removal. In considering transfer requests involving a drop in the level of security, Scottish Ministers will need the same type of information as described above at paragraph 9.13.

9.39 The Scottish Ministers are required to have regard to a number of factors (listed in regulation 8(2) of SSI 2005/467) in deciding whether to authorise the removal of a patient from Scotland. These are: the best interests of the patient, the existence in the place to which a patient is to go after removal of arrangements which will secure appropriate treatment, any wish or preference of patient and any risk to the safety of any person. Therefore, in order to allow them to make that decision, The SGHD will also require the following information from the RMO:

- 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.

9.40 On receipt of the transfer request and supporting information, the PMO (FP) may 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 SGHD to discuss any matters of concern and ensure that the arrangements proceed smoothly. Pre-transfer visits should be given serious consideration by the care teams. If arranged, they will require approval as set out in the chapter on [SUS](#).

9.41 The SGHD 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 from the Scottish Ministers.

9.42 Thereafter, if the transfer is to conditions of lesser security, the SGHD officials will prepare a case for the 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 the Scottish Ministers' agreement to the transfer. Where the transfer is to a hospital with the same level of security this can be approved on behalf of the Scottish Ministers by SGHD officials in consultation with PMO (FP).

9.43 SGHD Officials will let the RMO and designated MHO know when the transfer is agreed. Officials will continue to liaise with the RMO and the Ministry of Justice, Northern Ireland Office or country of origin to ensure provision of a transfer warrant for the patient at the appropriate time. 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.

9.44 Where the Scottish Ministers agree to the removal of a patient from Scotland, they shall give written notice to:

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- the patient;
- the patient's named person;
- the designated Mental Health Officer; and
- the Mental Welfare Commission.

9.45 In a case where removal is to a place in the UK, this notice will be given at least 7 days before the proposed removal date, and this period extends to 28 days where the removal is to a place outwith the UK. Where the patient consents to transfer or where urgent transfer is required, the Scottish Ministers may waive the need for prior notice. However, they must inform the Mental Welfare Commission of their decision to waive notice and the reasons for this decision.

### *Post-transfer matters - appeals against transfer to another jurisdiction*

9.46 Where notice is given by the Scottish Ministers of their intention to transfer a restricted patient from Scotland, the patient may, during the period between the day on which the notice is given and the patient's removal from Scotland, appeal to the Tribunal against the proposed removal<sup>72</sup>. On receipt of such an appeal, the Tribunal may make or refuse to make an order that the proposed removal shall not take place. The patient must not be moved before the expiry of the appeal period. Similarly, the patient must not be moved after an appeal has been lodged, as the effect of the warrant for transfer is suspended pending determination of the appeal<sup>73</sup>, meaning that there is no authority under the warrant to transfer the patient.

9.47 Should the Tribunal refuse the application, the patient may appeal this decision to the Court of Session<sup>74</sup>. Where on appeal, the Tribunal has refused to make an order that the proposed removal shall not take place, the proposed removal shall again not take place within 21 days of the decision, except where the patient consents in writing to the removal. This is to allow time for that further appeal from the Tribunal to the Court of Session to be lodged. The Court of Session is the final court of appeal.

9.48 Once transferred, the patient ceases to be subject to the Scottish legislation (the 2003 Act and the 1995 Act) and is instead detained under the legislation of the receiving jurisdiction. As a result, once transferred, the patient has no right of appeal back to the Tribunal against the transfer.

### **Pre-disposal cases (AOs, TOs & ICOs,)**

9.49 As noted at paragraph 8.1, this chapter is principally aimed at setting down the procedures for the transfer of restricted patients. It should be noted that pre-disposal patients are in a *different statutory position* as regards transfers, either between hospitals or between jurisdictions.

9.50 As far as inter-Scottish hospital transfers are concerned, for remand patients and interim compulsion order patients:

- an assessment order or treatment order will specify the hospital in which the patient is to be detained. There is then a window of 7 days in which if, "by reason of emergency or other circumstances", it is not reasonably practicable for the patient to be admitted to the specified hospital, then either the Scottish Ministers or the court may direct that the patient be admitted to the hospital specified in the direction; if such a direction is given, the original court order is then treated as though it had specified the hospital named in that direction. **Once admitted to the specified**

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<sup>72</sup> SSI 2005/467, regulation 13

<sup>73</sup> SSI 2005/467, regulation 11

<sup>74</sup> under section 322 of the 2003 Act (see regulation 15 of SSI 2005/467)

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hospital, the patient **cannot** be transferred to another hospital without going back to court to have the AO or TO amended;

- an interim compulsion order (“IOC”) will also specify the hospital in which the patient is to be detained. Again, there is then a window of 7 days in which if, “by reason of emergency or other circumstances”, it is not reasonably practicable for the patient to be admitted to the specified hospital, then either the Scottish Ministers or the court may direct that the patient be admitted to the hospital specified in the direction; if such a direction is given, again the court order becomes treated as though it had originally specified the hospital named in the direction. It is emphasised that, although ICOs may last up to 12 months, there is no equivalent provision to section 218 of the 2003 Act to enable hospital managers to transfer those subject to an ICO to another hospital. **Therefore once admitted to hospital, patients subject to an ICO cannot be transferred to another hospital without going back to court to have the ICO amended**, and it should be noted that the statutory authority to detain the patient continues to be for the hospital specified in the court order.

9.51 In relation to cross border transfers, there is no statutory power to transfer remand patients, either from Scotland to another jurisdiction or into Scotland from another jurisdiction. This is on the basis that they are still subject to ongoing criminal proceedings within their existing jurisdiction and therefore transfer to another jurisdiction is not appropriate.

## 10 PLANNING FOR CONDITIONAL DISCHARGE (CORO PATIENTS ONLY)

10.1 This Chapter (and Chapter 11 which follows) applies to CORO patients only as there is no possibility of a patient subject to a transfer for treatment direction or Hospital Direction being conditionally discharged from hospital under the Mental Health (Care and Treatment) (Scotland) Act ("the 2003").

10.2 The Tribunal is empowered to order the conditional discharge of a CORO patient who no longer requires to be detained in hospital for treatment or for the protection of others from harm but in respect of whom the continuation of a restriction order is still deemed to be necessary. A patient granted conditional discharge will therefore remain subject to the CORO, and so subject to Part 10 of the 2003 Act, which means that the Scottish Ministers' supervisory role continues. When the Tribunal first grants conditional discharge, it may impose such conditions as it sees fit (for variation of conditions see paragraph 10.27). See the Compulsion Order and Restriction Order [flowchart](#).

10.3 Multidisciplinary teams should make any plans for Conditional Discharge via the normal Care Programme Approach ("CPA") procedures and in response to needs assessment and risk assessment (including the risk of harm to others). See information provided in [Chapter 3](#).

10.4 In general, a CORO patient's discharge from hospital is subject to certain conditions set by the Tribunal, the exception being those restricted patients who are also life sentence prisoners. The conditions usually imposed are those of residence at a stated address, supervision by a Responsible Medical Officer ("RMO") and designated Mental Health Officer ("MHO"). However, additional conditions may be recommended either for the protection of the public or of the patient.

10.5 Under the 2003 Act, Scottish Ministers may vary these conditions at any time, and Scottish Ministers have power to do so if they consider variation is necessary.

10.6 The purpose of formal supervision resulting from conditional discharge, and the restriction order remaining in place throughout that discharge, is to protect the public from harm in two ways:

- by assisting the CORO patient's successful reintegration into the community after what may have been a long period of detention in hospital under conditions of security; and
- by closely monitoring the CORO 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.

10.7 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 otherwise imposed by continuation of the restriction order. It is important to stress the need for the multidisciplinary team to work closely together, and with the community team, to ensure that effective and thorough pre-discharge planning takes place through the CPA and that each agency is aware of its respective procedures and protocols. Prior to accommodation being confirmed to the patient, the police's views should be sought on the proposed accommodation.

10.8 Once a CORO patient has reached the stage of overnight suspension of detention from hospital (granted under section 224 of the 2003 Act for restricted patients) ("SUS") to accommodation where it is anticipated they will ultimately reside on conditional discharge, a

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MAPPA referral should be made by the RMO on the appropriate [form](#). The consideration by the MAPPA will help inform the Scottish Ministers' Position Statement to the Tribunal following a recommendation by the RMO for conditional discharge.

### **When Conditional Discharge may be appropriate**

10.9 On admission of a CORO patient to hospital, the RMO will, together with the rest of the multidisciplinary clinical team and the designated MHO, 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 that resulted in the patient's detention and, as the mental disorder is treated, 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.

10.10 In some cases, this period of assessment and treatment may take several years. Only when the CORO patient's condition has so improved that the level of risk to the public is reduced to the extent that detention within hospital is no longer considered necessary, should the RMO, after consulting with the designated MHO, recommend the patient's conditional discharge. The PMO (FP) would usually assess the patient when plans for discharge are well underway and flag up to the RMO and designated MHO any issues which may need to be addressed.

10.11 When the RMO considers it appropriate, he should make a recommendation to the Scottish Ministers who will automatically refer the case to the Tribunal. If the Tribunal are satisfied a conditional discharge order should be made, it can then go on to consider making a deferred conditional discharge order. The conditional discharge may be deferred when the patient has been fully tested out and conditional discharge is considered appropriate but the full care package is not yet in place. **It will be for the Tribunal to determine the sufficiency of evidence in each case.**

10.12 The clinical team in the detaining hospital and the designated MHO will begin preparations for a CORO 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 MHO supervisor (usually the designated MHO) and a supervising RMO.

10.13 Where a nursing home is proposed as accommodation, the Scotland Government Health Directorate ("SGHD") will consult the Care Commission following notification of the care home name and address.

10.14 The supervisors should ensure that the CORO patient has adequate support and monitoring to make a successful transition to life in the community. They should ensure that the CPA is adopted and which is mandatory for all restricted patients. The CPA care plan forms the basis for admission, through-care, discharge and aftercare arrangements and specifies individual and agency responsibilities. Examples of risk management traffic lights within the community are contained at [Annex H](#). The arrangements for future contact with the CORO 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**

10.15 As outlined above, the clinical team in the detaining hospital must consider a number of issues when making preparations for a CORO patient's conditional discharge. However, prior to identifying such things as suitable accommodation, employment or other daytime occupation, the multidisciplinary team must consider where they intend to discharge the patient. In some exceptional cases there may be reasons why the patient should be

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discharged out of the area in which the hospital is located and, in such cases, the multidisciplinary team must make a thorough assessment of all of the factors involved. These might include:

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

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

### **Identification of Accommodation**

10.17 A carefully thought out programme of SUS will also form part of the essential pre-discharge procedures. Prior to accommodation being identified the police should be invited to a pre-CPA to share information about the prospective accommodation and for any police intelligence about the area to be shared with the clinical team. Overnight stays in the patient's identified accommodation are a key part of the programme and will enable the clinical team to appropriately assess how well the CORO patient is adapting to their new lifestyle. It is expected that a CORO patient will complete at least 4 months of overnight stays, building from one night per week to the maximum of four nights per week on monthly increments prior to conditional discharge taking place.

### **Supervising Team**

10.18 As soon as the prospective RMO, MHO and CPN supervisor are known, they should discuss the CORO patient's after-care and supervision arrangements, with each other and the referring team. A CPA meeting should be arranged at least three months prior to the proposed discharge date, and a MAPPa referral should be made using the standard referral [form](#) once accommodation has been identified.

10.19 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.

10.20 The multidisciplinary team should consider, where appropriate, including representatives from the housing association or local council housing department in the planning process. The team should also ensure that copies of the minutes of each CPA meeting and the [CPA documentation](#) are sent to the PMO (FP) for information. The police role is outlined in [Chapter 2](#).

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10.21 In the case where the CORO patient is being discharged to a different team in the community, the RMO, MHO and the Community Psychiatric Nurse (“CPN”) supervisors must visit the hospital at least once to meet the patient before discharge. In addition, the new RMO supervisor should peruse all the patient’s notes and make their own assessment and take part in at least one multidisciplinary case conference. By doing so, they will be able to discuss the case with the outgoing RMO and the staff of all disciplines who know the patient. On this visit contact must also be made with the MHO supervisor if they are transferring the case to another social worker. If it should happen that the RMO supervisor is not invited by the discharging hospital to take part in pre-discharge discussions and preparations, the RMO supervisor should ask, in the first place directly, for a suitable contact with the hospital multidisciplinary team. In the unlikely event of no response (or of an inadequate response), officials in the SGHD may be able to help.

### **Provision of written information by the discharging hospital**

10.22 In addition to pre-discharge contact, it is essential that the RMO, MHO and CPN supervisors, should receive, as early as possible before discharge, detailed written information about the patient which can be retained for reference.

10.23 Discharging hospitals are advised that the full package of information provided to the supervisors for retention should be based on the [CPA documentation](#)<sup>75</sup>, and must cover the following aspects of the CORO patient’s 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;
- forensic history including its relationship to illness and other problem areas and a detailed note of the index offence (if the patient is a sex offender, it should refer to his statutory requirement to register with the police following discharge);
- summary of progress in hospital;
- a report on present home circumstances;
- **a risk assessment and risk management plan**, including any warning signs which might indicate a relapse of his mental state or a repetition of offending behaviour together with the time lapse in which this could occur; and
- supervision and after-care arrangements that the hospital considers both appropriate and inappropriate in the particular case.

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

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

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

### **Variation of Conditions of Discharge**

10.27 when conditional discharge is first granted, the conditions of discharge are set by the Tribunal. These may be varied, if necessary, from time to time by the Scottish Ministers. If

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supervisors wish to recommend a change in any of the formal conditions of discharge they must consult with the Scottish Ministers who may vary the conditions , e.g. the patient's address,.

### EXAMPLES OF SPECIFIC CONDITIONS OF DISCHARGE

- address; and access to this address for the clinical team
- compliance with medication
- compliance with agreed structured activities
- regular psychiatric and MHO contact
- regular contact with CPN and/or care workers
- compliance with any exclusion zone or excluded contacts
- compliance with conditions of abstinence from drugs and/or abstinence from or limits on alcohol and associated testing
- psychological interventions

10.28 This list is by no means exhaustive. Conditions are designed to meet the needs and manage the risks posed by individual CORO patients. A patient may appeal to the Tribunal against any variation in their conditions made by the Scottish Ministers.

#### **Right of Appeal**

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

10.30 Where the Tribunal orders conditional discharge, the order does not come into effect until 21 days after the patient requested or was informed of the decision. The RMO may request that the Scottish Ministers grant unescorted SUS to cover the period until the conditional discharge order takes effect. Where the Scottish Ministers do not oppose conditional discharge, they may grant up to 7 nights of SUS – Rule 2 of the Mental Health (Period for Appeals) (Scotland) (No 2) Regulations 2005 SSI 2005/441 refers.

## 11 MANAGEMENT WHILST ON CONDITIONAL DISCHARGE (CORO PATIENTS ONLY)

11.1 This chapter is for the guidance of:

- Responsible Medical Officer (“RMO”) supervisors; consultant psychiatrists who take on the role of RMO supervisor to a CORO patient who, having been made subject to conditions of discharge, is conditionally discharged from hospital by the Tribunal under section 193(7) of the Mental Health (Care and Treatment) (Scotland) Act (“the 2003 Act”).
- Community Psychiatric Nurses (“CPNs”), who become involved with the supervision of such patients.
- Mental Health Officer (“MHO”) supervisors; mental health officers who have responsibility to supervise and report to the Scottish Ministers on the progress in the community of such patients.

11.2 The chapter covers the responsibilities of those involved with the CORO 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. Those aspects of the work which may not be familiar are described and examples are given of procedures and practices which have been found, over the years, to be most effective.

11.3 At any time, there are around 50 CORO patients on conditional discharge and under supervision in the community.

### **Reports to the Scottish Ministers**

11.4 In addition to the [RMO supervisor](#) and [MHO supervisor](#), the [CPN Supervisor](#) will also be asked to provide reports on a CORO patient’s progress in the community. CPNs often form a key part of the multidisciplinary team and have a good knowledge of the patient. All supervisors will be asked to complete report forms at specified intervals, initially on a monthly basis. **All of the supervisors should provide copies of the reports that they send to the PMO (FP) to each other.**

11.5 In some cases, the Scottish Ministers may ask for more frequent reports in the initial period after discharge. This would be made clear at the beginning of supervision.

11.6 Supervisors should naturally take the initiative in contacting [SGHD](#) quickly should the patient be involved in any unusual or serious incidents and/or should the patient’s mental condition deteriorate sufficiently to give cause for concern. When completing reports supervisors should consider the following, although not exhaustive, list of issues:

- any change in mental state;
- any concerning behaviour;
- failure to attend appointments with supervisors or other members of the multidisciplinary team;
- non-compliance with medication or proposed change to medication;
- abuse of drugs/alcohol;
- any change of address; and
- any changes to the level of supervision/support or other aspects of the care plan.

### *Changes to Reporting intervals*

11.7 **After a period of at least 12 months in the community**, when a conditionally discharged CORO patient has settled down and is maintaining a steady pattern of life, **the RMO, CPN or MHO supervisor may consider it appropriate to submit reports to the SGHD at longer intervals**, reflecting a belief that the patient can manage well with

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supervision. The RMO, MHO and/or CPN supervisor may write to the Scottish Government's Principal Medical Officer (Forensic Psychiatry) ("the PMO (FP)") recommending that his or her reports be made at three monthly intervals (the maximum interval permissible). It would normally be expected that all supervisors in a patient's case would be reporting at the same intervals. In circumstances where it was felt appropriate for one or more supervisor to report at a different interval, the reasons for this must be clearly outlined in a letter to the PMO (FP).

11.8 Besides reporting to the Scottish Ministers on a regular basis, the RMO, MHO and CPN supervisor should keep in touch with each other (and other social care agents in the community) about the patient and copy their reports to each other. In addition to supplying the more frequent reports mentioned earlier, the RMO, in consultation with the MHO, will be required to provide an annual report on the patient's condition and progress. The patient will remain on the [Care Programme Approach](#) ("CPA") and subject to MAPPA for the duration of their conditional discharge.

11.9 Conditions of discharge must be stringently adhered to by the patient and monitored closely by the supervising team. Where there is a breach of any of the conditions of discharge, this will automatically trigger a formal consideration of whether recall is appropriate via a CPA meeting<sup>76</sup>. If recall is not considered to be appropriate, the justification for not recalling the patient and what steps the team are taking to monitor the patient following the breach must be clearly set out and reported to officials in SGHD immediately. The RMO must advise the appropriate senior manager at the Health Board of any breaches in conditional discharge in order that they can fulfil their responsibilities in relation to the collation of statistical information in respect of the operation of CPA for inclusion in the MAPPA Annual Report. A formal breach of conditional discharge is counted for MAPPA recording purposes as one where the SGHD has written directly to the patient copied to the managers of the Health Board, RMO, MHO and CPN.

11.10 Supervisors should also report to the SGHD any concerns regarding any aspect of management of the patient, irrespective of whether a report is due. After the completion of initial summary data, the report itself should convey sufficient information to enable the Scottish Ministers to consider whether the patient may remain in the community or whether, for the protection of the public, steps should be taken to return him to hospital. The report should include a detailed account of the issues outlined, as well as any other issues which supervisors feel may be of relevance.

### **Post-Discharge Contact with the Discharging Hospital**

11.11 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 RMO supervisor needing further background information about a patient or to discuss the patient's behaviour should make direct contact with the previous RMO. All hospitals will expect and welcome such approaches.

### **The Role of the Supervisors**

11.12 It is the Scottish Ministers' aim that, by means of conditional discharge of a CORO patient, any risk should be minimised by effective supervision, by appropriate support in the community or by recall to hospital if need be. It is recognised that this places great reliance on the personal skills and dedication of individual supervisors (i.e. RMO, CPN and MHO 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

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<sup>76</sup> Dependant on what has been decided by the multidisciplinary team as part of their contingency plan

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intervention. This is underpinned by good risk assessment prior to the CORO patient leaving hospital.

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

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

11.15 Important elements in effective supervision include the development of a close relationship with the patient and partnership working between the RMO, CPN and MHO supervisors. The frequency of supervision should be such as to detect any deterioration in the CORO patient's mental health or behaviour at an early stage. It is understood that the professional/patient relationship may be made more difficult by the fear or resentment of a conditionally discharged patient of being "policed" by the supervisors.

### **RMO Supervisor**

11.16 The RMO supervisor, in any case, is ultimately responsible for all matters relating to the mental health of the CORO 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.

11.17 The RMO supervisor will be expected to indicate prior to discharge the appropriate manner and frequency of psychiatric supervision and treatment, in any particular case. The minimum frequency of contact is determined by the interval which the Tribunal directs that reports on the patient's progress should be made to the Scottish Ministers. However there will, of course, be many cases in which the RMO supervisor considers more frequent contact appropriate. A [template](#) for reports to the Scottish Ministers is offered.

11.18 The RMO supervisor should be prepared to be directly involved in the treatment and rehabilitation of the CORO 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 RMO supervisor should also be prepared to work with other professionals involved in the patient's care, including the MHO supervisor and possibly the general practitioner, CPN and other support staff. This is placed in the context of a multidisciplinary team and [CPA](#). In addition, the principles of the Integrated Care Pathway Framework for Mentally Disordered Offenders<sup>77</sup> should be applied (see [NHS HDL \(2001\) 9](#)).

11.19 The Scottish Ministers recognise that many RMO supervisors have had little or no experience of restricted patients and the legislation and procedures entailed. However, there is a great deal of support available from various sources. Scottish Government Health Directorate (SGHD) officials and the PMO (FP) can provide information about an individual case or advice on any aspect of supervision, including the legal framework. [RMO's can also obtain independent legal advice from solicitors based at the Central Legal Office who provide advice to Health Boards.]

11.20 While requests for change in status and reports require to be made in writing, telephone contact for discussion and updating is encouraged and SGHD officials and the PMO(FP) will make themselves available, where possible, to meet multidisciplinary teams and discuss care plans and related issues. RMOs are encouraged to use this resource.

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<sup>77</sup> [http://www.show.scot.nhs.uk/sehd/mels/2001\\_9/mdo-00.htm](http://www.show.scot.nhs.uk/sehd/mels/2001_9/mdo-00.htm)

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11.21 Hospital-based RMOs may choose to supervise their own CORO 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 RMO supervisor 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 MHO 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 RMO supervisor. Whenever such a handover occurs, the change of RMO should be notified to the SGHD and the supervising MHO and the hospital-based RMO should ensure that the new RMO and the MHO supervisor are given all necessary information on the patient, through a CPA meeting.

11.22 Should the CORO patient's mental health deteriorate, the RMO supervisor 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 paragraphs 11.55 – 11.62 below). Any decision to admit the CORO patient for short-term treatment on a voluntary basis will generally be taken with the knowledge of, and often in consultation with, the MHO and CPN supervisors as part of the regular review process. In all cases he should be advised when the patient is admitted or discharged in these circumstances.

11.23 If the CORO patient will be taking medication, the RMO supervisor should inform the general practitioner and the MHO 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 MHO 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 MHO 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.

### **MHO supervisor**

11.24 A MHO supervisor may have many difficult decisions to make when working with a conditionally discharged CORO 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 decisions about such proposed changes 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 MHO supervisor making a special report to the SGHD for example in the case of change of address or holidays.

11.25 A sound knowledge of the case and the establishment of a close working relationship with the patient are essential if the MHO supervisor is to be able to spot warning signs before dangerous behaviour occurs. If the patient is in close contact with, or living with, friends or relatives the MHO supervisor should also see them regularly, sometimes separately from the patient.

11.26 It is recommended that meetings with the patient 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 MHO supervisor judges appropriate. These are considered to be minimum periods. Sometimes the SGHD will request that more frequent meetings take place. Generally, individual supervisors will consider more frequent meetings appropriate, particularly for the initial period of the first year during which the patient settles down to life in the community. Meetings may take place at the supervisor's office, in the patient's home or other venues. The MHO supervisor's visits to the "home territory" should be in accordance with good practice and local risk management protocols. A [template](#) for reports to Scottish Ministers is offered.

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11.27 The MHO supervisor will provide practical support to the patient in his everyday life, especially in matters relating to accommodation, relationships and employment. As well as the importance of a close and informed relationship between the MHO supervisor and the patient, the most valuable element in successful supervision is liaison with other professionals involved in the case. This is placed in the context of a multidisciplinary team and [CPA](#).

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

11.29 The RMO supervisor should inform the MHO supervisor of the nature of any medication, its effects on the patient's condition and behaviour and any possible side-effects. The RMO should also inform the MHO 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 MHO, whilst not primarily concerned with the patient's mental health during his or her regular contact with the CORO patient, may identify indicators of medication difficulties (and, possibly, indicators of other problems arising) which are helpful to the psychiatrist.

11.30 Should the MHO supervisor become aware of an incident or detect a deterioration in the CORO patient's mental health or behaviour, he should immediately alert the RMO and CPN supervisors to any concerns and discuss appropriate action. It may be 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. The MHO supervisor should also contact officials in SGHD by telephone to advise them of the situation and the steps that are being taken. This should be followed up by a full report in writing, which may form part of the regular supervisor report.

### **CPN Supervisor**

11.31 Where CPNs have been involved in the after-care and supervision of CORO patients, they have proved extremely helpful. The CPN supervisor has a key role in monitoring the mental health of the CORO patient, including the regular assessment of the patient's condition and the monitoring and administration of medication.

11.32 The CPN, like the MHO, provides practical support to the patient in his everyday life. Depending on the arrangements in a particular local area, the CPN may be the key worker in the necessary liaison between all those involved with a CORO patient in the community, having contact with those providing accommodation, employers or day care staff, relations, general medical practitioners and the RMO and MHO supervisors.

11.33 The minimum frequency of contact is determined by the interval which the Tribunal directs that reports on the patient's progress should be made to the Scottish Ministers. However there will, of course, be many cases in which the CPN supervisor considers more frequent contact appropriate. A [template](#) for reports to the Scottish Ministers is offered.

11.34 The CPN supervisor should also be prepared to work closely with other professionals involved in the patient's care, including the RMO and MHO supervisors and possibly the general practitioner and other support staff. This is placed in the context of a multidisciplinary team and [CPA](#).

11.35 Should the CPN supervisor become aware of an incident or detect a deterioration in the CORO patient's mental health or behaviour, he should immediately alert the RMO and MHO supervisors to his concerns and discuss appropriate action. It may be necessary to

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arrange for the patient to receive additional out-patient treatment or to be admitted to hospital for treatment either voluntarily or by recall. The CPN supervisor should also contact officials in SGHD by telephone to advise them of the situation and the steps that are being taken. This should be followed up by a full report in writing, which may form part of the regular supervisor report.

### **Medication**

11.36 For many conditionally discharged CORO patients, continuation of medication is crucial to avoid a relapse and the attendant possibility of increased risk. It is important, therefore, that the RMO, MHO and CPN supervisors are fully informed of the CORO patient's medical history, including details of current medication and what is known of its effects, side-effects and the effect on the patient's condition and behaviour if medication is stopped. The patient's general practitioner and, where appropriate, other support staff will also need to have basic information about medication.

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

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

### **Sharing Of Information**

11.39 This is covered briefly in [Annex A](#) of this Memorandum. Except where medical information is concerned, it will usually be the MHO supervisor who has to make decisions. Those to whom it may be appropriate to disclose information about a CORO 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.

11.40 Decisions about sharing of information should be taken by the MHO 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 CORO 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 CORO 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 other professionals**

11.41 Supported accommodation projects, hostels, centres providing day care and other community settings are likely to have several members of staff involved with the patient on a day-to-day basis. The work of other clinical personnel involved with the patient, such as psychiatric nurses or psychologists, should be under the general direction of the RMO supervisor who should consult them periodically about the patient's progress.

11.42 Whichever supervisor is designated the key worker in liaison between those involved in the CORO patient's care, should discuss with them the broad approach to the patient's

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care and invite them to contact him or her if there is any cause for concern about the patient's condition or behaviour. Attendance at regular CPA meetings will also offer those involved in the care of the patient to discuss progress and any concerns.

11.43 All conditionally discharged CORO 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 RMO supervisor, MHO and CPN supervisor. The RMO supervisor 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 RMO supervisor and to provide the general practitioner with a point of contact in the event of any concern about the patient's mental condition. It is understood that in some circumstances, the general practitioner may appropriately be an active participant in the CPA and should, at least, receive copies of the CPA minutes.

11.44 The 'traffic light' section of the [CPA documentation](#) should be produced such that it may be shared with all those who may have contact with the patient. In particular, it should share important contingency information and as well as health and social care arrangements this section should be stored in the patient's ViSOR record.

### **Changes in address**

11.45 If the CORO patient wishes to change his address or to be away from the address for more than a short absence, and the MHO supervisor agrees that the new accommodation proposed is suitable, the RMO supervisor or MHO supervisor MUST write to the PMO (FP) to seek agreement to the change. (Although, in an emergency the MHO supervisor may have to agree to a change of address without prior reference to the SGHD in which case he should contact the PMO (FP) 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 whole of the supervising team should be kept informed. The MAPPA coordinator should also be notified of such a change.

### **Change in Supervisors**

11.46 When a RMO, MHO or CPN 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 the patient and other supervisors know whom to contact. If absences are to be for longer than two months, the Medical Director of the NHS Board/Chief Social Work Officer of the Local Authority and SGHD should be informed. When changes in 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.

11.47 It is important that the SGHD are notified as soon as possible of any change of RMO, MHO or CPN supervisor. The supervising RMO, MHO or CPN should also be informed of any impending change of other supervisors.

### **Patient Holidays**

11.48 A conditionally discharged CORO patient is not precluded by his status from having holidays away from home. However, the patient should always discuss plans for such holidays with his supervisors so that the suitability of the arrangements can be considered, and the PMO (FP) should be informed.

11.49 During the first six months after discharge, for absences from home of two weeks or more, the MHO 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.

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11.50 The RMO and CPN supervisors 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.

11.51 Holidays abroad do not allow any form of supervision to continue and should be considered very carefully. Any proposals for a CORO patient to leave the country should be put to the PMO (FP) for approval. These proposals 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 SGHD officials for their observations. However, it is worth noting that a request for a CORO patient to go abroad would not normally be considered until they had been on conditional discharge for at least a year.

### **Action in the Event of a Breach of Conditions or Concern about a Patient**

11.52 Conditions of discharge must be stringently adhered to by the CORO patient and monitored closely by the supervising team. **In the event of a breach of any of the conditions of discharge, this should trigger automatically formal consideration of whether recall is appropriate.** This should be carried out as part of the CPA processes. If recall is not considered to be appropriate, the justification for not recalling the patient and what steps the team are taking to monitor the patient following the breach must be clearly set out and reported to officials in SGHD immediately.

11.53 If a RMO supervisor is concerned about a conditionally discharged CORO patient's mental state or behaviour or has reason to fear for the safety of the patient or of others, he may decide to take immediate local action to admit the patient to hospital for a short period with the patient's consent. Similarly, if the MHO or CPN supervisor has reason to fear for the safety of the patient or of others, he should contact the RMO supervisor immediately to consider such an action. Supervisors with such concerns should report to the SGHD at once.

11.54 Telephone discussion in such circumstances is welcomed by the PMO (FP) or officials in the SGHD. In normal office hours an officer should be contacted at the Scottish Government Health Directorate, St Andrew's House, Regent Road, Edinburgh EH1 3DG. Officials may also be contacted out of office hours, if required. (See [Annex E](#).)

### **Recall to Hospital**

11.55 Under section 202 of the 2003 Act, the Scottish Ministers have the power to recall a CORO patient from conditional discharge where they are satisfied that it is necessary for the patient to be detained in hospital. In practice, a formal warrant of recall is issued by SGHD officials following a recommendation from the RMO supervisor and consultation with the PMO (FP). In cases of urgency, the warrant can be faxed to the RMO. **Formal recall cannot take place without a warrant issued by the Scottish Ministers.** It is not possible to specify all the circumstances in which the Scottish Ministers may decide to exercise their powers to recall to hospital a conditionally discharged CORO patient, but in considering the recall of a patient they will always have regard to the safety of the public. Accordingly, a report to the SGHD must always be made in a case in which:

- there appears to be an actual or potential risk to the public;
- contact with the patient is lost or the patient is unwilling to co-operate with supervision;
- the patient's behaviour or condition suggest a need for further in-patient treatment in hospital;
- the patient is charged with or convicted of an offence;
- the patient breaches any of the conditions of discharge; or
- the patient takes illicit drugs.

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11.56 Consideration of a case for recall will take into account any steps taken locally to remove the CORO patient from the situation in which he presents a danger. Where the RMO supervisor decides not to formally recall the patient, they should provide a brief report to the SGHD outlining the reasons for their decision. They should always try to discuss the situation with the MHO and CPN supervisors and in any case copy the report to them.

11.57 The Scottish Ministers have no objection to a conditionally discharged CORO patient being admitted to a hospital, informally for a short period of observation or treatment. The SGHD 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 informally.

11.58 This is partly because such a patient will not be "detained" in that hospital, and partly as it raises questions of whether the patient does in fact require a further period of detention back in hospital. The Scottish Ministers would therefore 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 RMO supervisor is encouraged to discuss such cases with the PMO (FP), and a decision is reached after consultation with the doctor(s) concerned and with the MHO supervisor.

11.59 Where a conditionally discharged CORO patient is admitted to hospital informally, the RMO supervisor should consider whether the patient is able to consent to treatment. The RMO should also consider whether, if the patient chose to discharge themselves, they would allow them to do so. If they would not, the RMO supervisor should give consideration to formal recall (so that the patient is formally detained once again, with the statutory protections that this brings) to prevent any possibility of breaching the patient's rights under the European Convention on Human Rights [HL v UK (Bournemouth) 5 October 2004, with reference to article 5 ECHR]. Where there is any doubt about the appropriateness of continued informal admission, the RMO supervisor is encouraged to contact the PMO (FP) for further advice.

11.60 Whether the Scottish Ministers decide to recall a CORO patient depends largely on the degree of danger which the particular patient might present in relation to his mental disorder. Where the patient has a history 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, the 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 SGHD and a decision is reached after consultation with the doctor(s) concerned and with the MHO and CPN supervisors.

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

11.62 After recall, a CORO patient is once again detained as a restricted patient in pursuance of the legal authority which was operating immediately before the conditional

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discharge. In some cases the RMO supervisor may be able to recommend the patient's further discharge after only a short while, but in other cases what has been learned about him in the community or slow response to treatment may point to a need for a longer period of compulsory detention in hospital. The CORO patient, or the patient's named person, has the right of appeal to the Tribunal within 28 days of formal recall.

### **Absconding patients**

11.63 On occasion, a conditionally discharged CORO patient might leave the approved address without approval and break off contact with both supervisors. In such cases, the MHO supervisor should report to the SGHD 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 SGHD may decide to monitor the situation whilst taking no immediate action, perhaps until patient's whereabouts are known.

11.64 However, if necessary, the Scottish Ministers will issue a warrant for the recall of the patient for breaching conditions of discharge, thus providing the police with the statutory powers to bring the patient into custody and return the patient to hospital.

11.65 The MAPPA coordinator and the police should also be informed that the patient's whereabouts are unknown. The patient may be reported as a 'missing person'. Police involvement in finding the patient may be based on concern for the patient's own safety.

11.66 If a conditionally discharged CORO patient is suspected of having left his approved address to go abroad the 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 [Annex C](#).

### **Further offending**

11.67 Where a CORO patient has committed a criminal offence whilst on conditional discharge, if the patient is in custody and he is no danger to himself, the Scottish Ministers will usually await the outcome of the prosecution. In that event, the criminal 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 the Scottish Ministers have in mind to recall the patient at once to hospital.

11.68 If a conditionally discharged CORO 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.

11.69 If a conditionally discharged CORO patient is convicted of a further offence and the court imposes a new sentence of imprisonment, the Scottish Ministers often reserves judgement on the patient's restricted status until towards the end of his prison sentence. The Scottish Ministers will make a reference to the Tribunal and based on the medical recommendation, will recommend either revocation of the compulsion order, the continuation the conditional discharge, or the recall to hospital on release from prison. This 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.

## 12 END OF SPECIAL RESTRICTIONS

12.1 For CORO patients, the Tribunal can order:

- revocation of a compulsion order; or
- revocation of a restriction order,

which has the effect of ending the special restrictions which the continuation of the restriction order had authorised and patient is absolutely discharged. In the case of revocation of a compulsion order, the restriction order automatically fall, it and cannot stand alone. See further details in [Chapter 14](#) on Tribunals.

12.2 There are also other times when the statutory responsibilities of the Scottish Ministers in respect of certain patients under the mental health legislation automatically come to an end on a particular date. These are:

- when a patient is subject to an assessment order or treatment order under section 52D and 52M or an interim compulsion order under sections 53 or 57(2)(bb) of the Criminal Procedure (Scotland) Act 1995, once the case is finally disposed of by the Courts or proceedings dropped (unless a CORO is then made);
- when a determinate or extended sentence prisoner who is also subject to a transfer for treatment direction or hospital direction is released on licence at their earliest date of liberation (EDL) or is granted early release on the recommendation of the Parole Board for Scotland<sup>78</sup>;
- when an indeterminate sentence prisoner, who is subject to a transfer for treatment direction or hospital direction, is released on life licence<sup>79</sup>; or
- when a prisoner subject to a transfer for treatment direction or hospital direction is returned to prison to serve the remainder of their sentence.

### **Revocation of Compulsion Order**

12.3 In most cases, the CORO patient will have been under supervision in the community on conditional discharge for several years without incident before a decision about revocation of the compulsion order will be taken.

12.4 Where the Responsible Medical Officer (“RMO”) and Mental Health Officer (“MHO”) [supervisors] agree in consultation with the multidisciplinary team that neither social work nor psychiatric supervision is required, both should write to the PMO (FP) to recommend the revocation of the patient’s compulsion order. The MHO supervisor must provide a full comprehensive Community Care Assessment to support the viability, safety and effectiveness of the proposed end of special restrictions for a CORO patient. Evidence of a prolonged period of stability in the community which has been tested by a variety of normal pressures or experiences will be important. Supervisors should use their judgement and put forward a recommendation for an end to formal supervision whenever they consider it appropriate. Care should be taken, however, not to raise the patient’s expectations as ultimately a decision on whether to revoke the compulsion order rests with the Tribunal. The PMO (FP) will then assess the CORO patient. It may be appropriate to seek the advice of an independent psychiatrist. Following a recommendation the Scottish Ministers are required to make a reference to the Tribunal.

12.5 Where the Tribunal and the Tribunal agrees to the revocation of the compulsion order of a conditionally discharged CORO patient, a letter will be issued and copied to both

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<sup>78</sup> Cross reference to transferred prisoners

<sup>79</sup> Cross reference to transferred prisoners

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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.

12.6 A conditionally discharged CORO patient also has the right to make an application to the Tribunal seeking a variation in the conditions of their discharge or seeking revocation of the Compulsion Order.

12.7 The Tribunal are bound to revoke a compulsion order in certain circumstances, as laid down in section 193(3) and (4) of the 2003 Act. This is essentially once they are fully satisfied that the patient is no longer suffering from mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), or where, although the Tribunal is satisfied that the patient continues to have a mental disorder, they consider that he or she no longer presents (as a result of that mental disorder) a risk of serious harm to any other person, and that the compulsion order is no longer necessary. The exception is those restricted patients who are also life sentence prisoners.

**Reminder: if the Compulsion Order is revoked the Restriction Order also ceases to be in place<sup>80</sup>.**

12.8 It may be helpful for the RMO, after discussion with the MHO and Community Psychiatric Nurse ("CPN") supervisors to discuss a recommendation for revocation of a compulsion order in the first instance with the Scottish Government's Principal Medical Officer (Forensic Psychiatry) ("the PMO (FP)"). Prior to making a formal recommendation for revocation of the compulsion order the RMO must make a MAPPA referral. Consideration by the MAPPA Group will inform the Scottish Ministers' position in relation to risk. When a formal recommendation is submitted to the Scottish Ministers, the Scotland Government Health Directorate ("SGHD") will automatically refer the recommendation for consideration by the Tribunal.

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

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

12.10 Scottish Ministers shall make a reference to the Tribunal under the 2003 Act, following a recommendation from the RMO or the Mental Welfare Commission<sup>81</sup>. The Scottish Ministers shall make an application to the Tribunal following under their duty to keep the compulsion order and the restriction order under review<sup>82</sup>. Patients, or the patient's named person, may also make an application to the Tribunal for an order revoking the compulsion order and the restriction order<sup>83</sup>. It will be for the Tribunal to determine the sufficiency of evidence and to seek any additional information that they consider relevant to their deliberations.

12.11 Once a compulsion order is revoked, the Scottish Ministers no longer have a formal role to play in the patient's care. In most cases following revocation of compulsion order, the multidisciplinary care team, including the social worker, maintains informal contact.

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<sup>80</sup> See section 197 of the 2003 Act.

<sup>81</sup> Section 185 and 187 of the 2003 Act.

<sup>82</sup> Section 191 of the 2003 Act.

<sup>83</sup> Section 192(2) of the 2003 Act.

**Early Discharge Protocol for patients in secure hospital settings**

12.12 The Early Discharge Protocol complements the proper application of the established Care Programme Approach CPA, and applies to all patients who no longer, or may no longer meet the criteria for compulsory intervention under the 2003 Act or the Criminal Procedure (Scotland) Act 1995, as amended, but who have complex needs and continue to pose a significant risk to public safety. Whilst the [Protocol](#) refers to the State Hospital this should be read as referring as well to those exceptional cases where patients who meet the described criteria are being considered for discharge from local forensic services. An electronic version of the Protocol can be found on the NHS Scotland website<sup>84</sup>. [The Early Discharge Protocol may be used in conjunction with MAPPA where appropriate.](#)

**Revocation of the Restriction Order**

12.13 It should be noted in relation to a restriction order that the “risk of serious harm requiring detention in hospital” test is a quite separate test from the “necessity for a restriction order” test. A recommendation for revocation of a restriction order will only be appropriate where the RMO is satisfied that *both* tests are not met. In other words, even if the RMO considers that the restricted patient does not meet the test of “risk of serious harm requiring detention in hospital (whether or not for medical treatment)”, the RMO **must** separately go on to consider whether or not otherwise, or in any case, the restriction order “continues to be necessary”. In relation to that latter test of whether or not the restriction order “continues to be necessary”, Scottish Ministers’ view is that those applying the statutory test must have regard both to:

1. the original criteria which the court considered when imposing the restriction order, i.e. having regard to:
    - (i) the nature of the index offence,
    - (ii) the antecedents of the patient, and
    - (iii) the risk that the patient would commit further offences if at large;
  2. whether it is necessary for the protection of the public from serious harm for the patient to be subject to the restriction order;
- and
3. the nature and effect of the restriction order on the patient's present circumstances\*.

(\*With particular regard to the statutory overseeing role afforded to the Scottish Ministers under the 2003 Act; the decision making role of the Tribunal; the involvement of MAPPA in assessing risk; and the fact that without the restriction order, the compulsion order becomes time limited). See the [necessity for restriction order](#) test guidance attached to the RMO annual report template.

12.14 Revocation of the restriction order will leave the patient as a compulsion order patient, subject to Part 9 of the Act instead of Part 10, whose management is now solely at the discretion of the RMO, subject to the power of the Tribunal to order discharge. If the restriction order is revoked, this would take effect 21 days after receipt by the Scottish Ministers of the written judgement of the Tribunal

12.15 It may be helpful for the RMO, after discussion with the MHO and CPN supervisors to discuss a recommendation for revocation of the restriction order in the first instance with the PMO (FP). Prior to making a formal recommendation for revocation of the restriction order the RMO must make a MAPPA referral. Consideration by the MAPPA Group will

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<sup>84</sup> [www.show.scot.nhs.uk/sehd/publications/dischargeprotocol.pdf](http://www.show.scot.nhs.uk/sehd/publications/dischargeprotocol.pdf)

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

inform the Scottish Ministers' position in relation to risk. When a formal recommendation is submitted to the Scottish Ministers, the SGHD will automatically refer the recommendation for consideration by the Tribunal.

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

- why the restriction order is no longer considered necessary; and
- reports from the MHO supervisor providing a full comprehensive community care assessment to support the viability, safety and effectiveness of any proposed revocation of restriction order.

### **Reason for Lifting Restrictions**

12.17 It is worth remembering that the majority of patients who receive compulsion orders do not receive restrictions. The sentencing court can only subject the patient to the special restrictions set out in Part 10 of the 2003 Act if satisfied "that it is necessary for the protection of the public from serious harm so to do"<sup>85</sup>. In managing CORO patients you should ask yourself whether that requirement is still met. This test is not about whether detention in hospital is required (the "serious harm requiring detention in hospital, whether or not for medical treatment" test found in sections 183(6)(b)(i), 184(5)(b)(i) and 193(5)(b)(i)), but rather about whether or not the restriction order remains necessary (the second leg of the test for revocation, found in sections 183(6)(b)(ii), 184(5)(b)(ii) and 193(5)(b)(ii)). See [Compulsion and Restriction Order flowchart](#).

12.18 If you think that restrictions are no longer serving a useful purpose in protecting the public from a risk of serious harm, the next question is whether the patient still requires to be subject to a compulsion order or whether the compulsion order can be revoked (absolute discharge). Many restricted patients live safely after discharge, either because they no longer need treatment, or because they readily comply with it, without any compulsion, and as a result pose little risk.

12.19 If you are in any doubt about the impact on public safety, the recommendation should be that the restrictions should remain in place. If it is still necessary, but not under hospital conditions, then conditional discharge is not only appropriate but expressly designed to meet the need.

12.20 When it is not appropriate to recommend revocation of the compulsion order, it would normally be appropriate to lift the restriction order when:

- a patient continues to be detained in hospital with little prospect of conditional discharge due to the severity of their illness but has become frail, particularly due to age, and will never pose a threat of serious harm to others. [But look at offending behaviour as not all dangerous offences require strength (i.e. fire-raising or assault/attempted murder by poisoning)]; and
- the patient's management is almost entirely to protect his or her own health and safety needs rather than those of others.

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<sup>85</sup> Section 59 of the 1995 Act.

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
**13 TRANSFERRED PRISONERS**

13.1 Section 136 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the 2003 Act”) makes provision for persons serving a prison sentence to be transferred to hospital for treatment of mental disorder - a transfer for treatment direction (“TTD”).

13.2 Hospital directions, on the other hand, are a hybrid court order which combines a prison sentence with initial detention in hospital for treatment for mental disorder which may be followed by transfer to prison to complete the sentence.

**Overview of TTDs**

13.3 Where a person is subject to a transfer for treatment direction<sup>86</sup>, they will remain subject to the measures authorised by that direction for so long as the person would have been held in custody under their prison sentence had they not been transferred (unless they no longer require detention in hospital and so are returned to prison at an earlier stage). If a patient is to be detained in hospital beyond the expiry of their sentence, further steps should be taken, see paragraphs 7.17 to 7.19 below<sup>87</sup>.

13.4 A TTD patient subject to a transfer for treatment direction cannot be transferred from one hospital to another or be granted suspension of detention from hospital (“SUS”) without the consent of Scottish Ministers<sup>88</sup>. There is also no possibility of a TTD patient who is subject to such a direction being conditionally discharged from hospital under the 2003 Act. If it ceases to be appropriate for such a patient to be detained in hospital, the direction may be revoked by the Scottish Ministers, either upon reviewing the direction themselves or following a recommendation from the Responsible Medical Officer (“RMO”) in consultation with the designated Mental Health Officer (“MHO”)<sup>89</sup>. Where the direction is so revoked, the patient will be returned to prison by direction of the Scottish Ministers.

13.5 Where Ministers decide not to act on a recommendation from the RMO to revoke the transfer for treatment direction, they must refer the case for consideration by the Tribunal. Should the Tribunal conclude that the direction indeed be revoked in accordance with the relevant statutory tests, it will direct Ministers to revoke it and return the patient to prison<sup>90</sup>.

13.6 Return of a patient to prison is effected by warrant on the recommendation of the RMO and the Scottish Government’s Principal Medical Officer (Forensic Psychiatry) (“the PMO (FP)”), and following revocation of the TTD by Scottish Ministers. In no circumstances can the RMO return the person to prison without the Scottish Ministers’ instruction following on revocation of the TTD. If the RMO, after consultation with the patient’s designated MHO, concludes that it is no longer necessary or appropriate for the patient to remain in hospital, they should inform the PMO (FP) accordingly so that the appropriate steps may be taken.

**Alteration of sentence**

13.7 In the event of a patient 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 Scotland Government Health Directorate (“SGHD”) and Scottish Government Justice Directorate (“SGJD”) immediately as this may affect the transfer for treatment direction and the timing of a review of the case by the Parole Board.

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<sup>86</sup> Attached at Annex H (Page 109) is a Patient Guide to the current provisions covering transfer for treatment directions. A glossary of commonly used terms detailing sentencing options and what they mean can be found at Annex D.

<sup>87</sup> Steps set out in Chapter 1 of Part 7 of, and Schedule 3 to, the 2003 Act

<sup>88</sup> Sections 218(3)(b) and 224((3) of the 2003 Act.

<sup>89</sup> Sections 210 and 212 of the 2003 Act

<sup>90</sup> Similarly, where a patient who is a transferred prisoner successfully applies to the Tribunal for revocation of the direction, the Tribunal will direct Ministers to revoke the direction and return the patient to prison to complete the remaining part of their sentence.

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

13.8 If the RMO is aware that the person has been to court but not of the outcome, they must find out and inform the SGHD and SGJD (with a copy of the Court order or decision) and must keep in close contact with other interests within the hospital. The SGHD and SGJD do not receive notification direct from the courts.

### **Statutory provisions governing release for patients subject to TTDs**

13.9 A transfer for treatment direction ceases to have effect where the patient is released under Part 1 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 or otherwise (Section 217 of the 2003 Act refers). Therefore on admission to hospital of any transferred prisoner the RMO and the designated MHO should take careful note of when the prisoner is due to be released from their sentence because the direction will automatically cease to have effect on that date.

### **Transferred prisoners serving determinate or extended sentences**

13.10 A transfer for treatment direction given in respect of a determinate or extended sentence prisoner ceases to have effect on the date on which, but for the transfer to hospital, that person would have been released from prison<sup>91</sup>.

#### *Short-term prisoners*

13.11 A "short-term" prisoner, i.e. those sentenced to less than 4 years, or an extended sentence prisoner whose custodial term is less than 4 years, is automatically released as soon as he has served one half of the sentence. Short term prisoners convicted of sexual offences are released on licence where they are either subject to an extended sentence or (where they are not subject to such a sentence) have been sentenced to a term of imprisonment of 6 months or more and are subject to the notification requirements of Part 2 of the Sexual Offences Act 2003.

#### *Long-term prisoners*

13.12 A "long-term" prisoner, i.e. those sentenced to 4 years or more (excluding those sentenced to life imprisonment), or an extended sentence prisoner whose custodial term is 4 years or more, is eligible for parole (early release on licence) after serving one half of the custodial term (known as the "Parole Qualifying Date" or PQD). If the Parole Board for Scotland ("Parole Board") does not release the prisoner at this stage he must be released on licence after serving two thirds of the sentence (known as the "Earliest Date of Liberation" or EDL).

13.13 Long-term determinate and extended sentence prisoners qualify for consideration of early release on licence at the half-way point of sentence<sup>92</sup> (PQD) and if not released at that point they must be released at the two-thirds stage of the sentence (EDL). Where such a prisoner is transferred to hospital, a note should be taken by the RMO and the designated MHO of both of these dates. Scottish Ministers may release the individual on licence on any date between the PQD and EDL if this is recommended by the Parole Board.

13.14 Approximately 6 months prior to the prisoner's PQD, officials in the Criminal Justice and Parole Division (CJPD) 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 patient 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 patient's own views on the matter. He or she has the right to opt out of the review process (apart from when the Board is considering licence conditions).

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<sup>91</sup> Annex D provides explanations of the terms "determinate sentence" and "extended sentence".

<sup>92</sup> As mentioned in paragraph 13.12 above

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

13.15 In all of these cases, SGHD will take careful note of the date when the patient is either to be automatically released from his sentence or to have his suitability for early release on parole considered by the Board and will write to the RMO approximately 6 weeks prior to this date, highlighting the possibility of the patient's release and the need to consider re-detention under the 2003 Act.

13.16 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 his or her circumstances including a comprehensive report from the RMO on the patient's progress in the mental health system and reports from the designated MHO and a community based social worker. **RMOs and MHOs will wish to bear in mind that the Parole Board is concerned primarily with the question of the risk that the patient's early release would present to the public and they should make a specific comment about this in any report that they prepare for the Parole Board.**

13.17 Once all the reports have been received by the prison, the parole co-ordinator will assemble these into a dossier which will be submitted to SGJD. (It would be expected that the parole co-ordinator would receive all the reports from the hospital no later than 6 weeks from their being requested). SGJD will subsequently refer the case to the Parole Board to consider the patient'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 patient (and the RMO) who will be given the opportunity to submit written representations to the Board about his case and to be interviewed by a Parole Board member prior to the consideration of his case at a Parole Board casework meeting. This meeting is an administrative one to which the patient is not invited.

13.18 In other circumstances where the RMO is of the view that the patient meets or is likely to meet the criteria for discharge during the period between the PQD and the EDL, he or she may recommend through the PMO(FP) that release on licence direct from hospital should be considered. This will then be raised with SGJD to consider whether or not the individual's case should be referred to the Parole Board to consider his suitability for early release at that time.

### **Use of civil detention powers at end of prison sentence**

13.19 Where there are no plans to return a patient to prison or otherwise discharge from hospital before the date on which the transfer for treatment direction ceases to have effect<sup>93</sup>, the RMO, in consultation with the designated MHO, should consider whether it is necessary for the patient to continue to be detained in hospital under the 2003 Act when the direction ceases to have effect.

13.20 Where the patient meets the relevant criteria for making a Compulsory Treatment Order (CTO), an application should be made to the Mental Health Tribunal for the patient to be made subject to CTO which will have effect when the direction comes to an end. The Mental Health Tribunal may make a CTO in these circumstances within the 28 day period before the date on which the transfer for treatment direction ceases to have effect by virtue of section 217(2) of the 2003 Act. If these steps are not taken, 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.)

13.21 The Tribunal can grant an Interim Compulsory Treatment Order (ICTO) where an application for a CTO has been made. It lasts up to 28 days and can contain the same kind of conditions as a CTO. The Tribunal can make one or more ICTOs so long as this does not result in a continuous period of more than 56 days. It is revoked and so comes to an end with the making of a CTO (though it can be earlier revoked by the RMO or the Commission)

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<sup>93</sup> under section 217(2) of the 2003 Act

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

13.22 A Short Term Detention Certificate (STDC) allows the patient to be detained in hospital for up to 28 days to determine his/her medical needs and to be given medical treatment. It is a step towards detention, and an application would be made for a CTO thereafter. A STDC can only be granted by an approved medical practitioner; the consent of a MHO is mandatory, and allows right of appeal to the Tribunal to revoke the certificate. Where a CTO (or ICTO) is subsequently made, the STDC comes to an end.

13.23 A CTO is often the preferred option because it may be applied for in advance of the TTD coming to an end, and its effect is then suspended till the TTD is revoked and the CTO smoothly takes over such that there is no gap in detention<sup>94</sup>

13.24 The steps for the continued detention of the patient by way of a CTO are prescribed in Chapter 1 of Part 7 of the 2003 Act, as applied in a modified way by section 21 of, and Schedule 3 to, that Act. Given the timescale involved care should be taken in the timing of the application to the Tribunal. Best practice would suggest that at least 2 months before the direction is due to fall, the RMO, in consultation with the MHO and the other members of the multi-disciplinary team where relevant and appropriate, should review the case and make a decision as to whether an application for a CTO should be made to the Tribunal. Any such application requires to be accompanied by an MHO's report and proposed care plan and mental health reports by 2 medical practitioners, following examination of the patient. Best practice would suggest that where an application is necessary it should be made by the designated MHO.

13.25 The 6-month period during which the measures are authorised by the CTO does not begin until the day on which the direction ceases to have effect. In such cases, the patient has a right to apply to the Tribunal for an order revoking or varying the CTO but not until 3 months after the date on which the order was made.

### **Release on licence**

13.26 All determinate sentence prisoners sentenced to 4 years or more, those sentenced to 6 months or more for a sexual offence and all extended sentence prisoners, require to be released on licence. In cases where a transferred prisoner is in hospital prior to their release date, the licence authorising the release will be sent to the individual's RMO, with a copy to the designated MHO, with a request that the purpose and terms of the licence be explained to the patient. Ideally, both the RMO and the designated MHO should discuss the terms of the licence with the patient.

13.27 Information on parole eligibility or licence requirements of a transferred prisoner with a determinate or extended sentence can be obtained from Criminal Justice Parole Division, Scottish Government Criminal Justice Directorate, St Andrew's House, Regent Road, Edinburgh, EH1 3DG. (See [Annex E](#) for further contact details.)

### **Transferred prisoners serving indeterminate sentences**

13.28 Where a person has been sentenced to life imprisonment, detention for life or detention without limit of time, they will not have an "earliest date of liberation". Therefore, if they are transferred to hospital, the measures authorised by the transfer for treatment direction will apply indefinitely. If the person makes a full recovery from mental disorder, 2 options exist; either –

- a return to prison<sup>95</sup>; or
- release on life licence direct from hospital<sup>96</sup>.

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

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<sup>94</sup> section 21 and Schedule 3 of the 2003 Act

<sup>95</sup> by warrant under section 216(2) of the 2003 Act, following revocation of the transfer for treatment direction

<sup>96</sup> Such release would be under section 2(4) of the Prisoners and Criminal Proceedings (Scotland) Act 1993.)

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13.29 Under the relevant provisions of the Prisoners and Criminal Proceedings (Scotland) Act 1993<sup>97</sup>, a “punishment part” of the sentence is set by a judge in open court. This is the length of time that the judge considers a life sentence prisoner should serve in custody to satisfy the criminal justice requirements of retribution and deterrence. As soon as the punishment part has expired, the prisoner has the right in law to require Scottish Ministers to refer his case to the Parole Board for consideration of his suitability for release on life licence.

### **Life Prisoner Tribunal**

13.30 The case is reviewed by the Parole Board sitting as a Life Prisoner Tribunal (LPT) held at the hospital. It consists of 3 members of the Parole Board. An official from CJPD attends the hearing to present the Scottish Ministers’ views on whether the patient continues to present an unacceptable risk and so should continue to be confined for the protection of the public. The Scottish Ministers’ views in this respect are set out in the dossier in a “Scottish Ministers’ Position Statement” and these are, in the main, based on the information contained within the reports received from the hospital although the patient’s previous offending history and any previous response in prison are also taken into consideration. The Position Statement requires to be approved by SGHD prior to it being submitted by CJPD for inclusion in the patient’s dossier. **If the RMO’s assessment of the patient’s risk and suitability for release subsequently alters significantly from the view previously stated in their report for the patient’s dossier, the RMO should inform SGHD and CJPD of this immediately.** The patient, his legal representative and the RMO are also invited to attend the hearing.

13.31 At the hearing the Scottish Ministers’ official will lead evidence from the RMO (usually in the form of questioning of the RMO) as to the patient’s progress in hospital, the level of risk that the RMO considers that the patient presents to the public at that time and the future management plan in place for him in terms of his care and treatment for mental disorder and rehabilitation. The Scottish Ministers’ official will discuss these issues with the RMO prior to the LPT taking place. **If there has been any key change in the RMO’s assessment of the patient’s risk and suitability for release since their discussion with an official, the RMO should inform the official of this as far in advance of the hearing as possible.** The patient is then given the opportunity to present his case to the LPT where he is representing himself or if not, through his legal representative. The LPT will ask questions of all parties during the hearing which it considers appropriate to the question of risk.

13.32 If the risk to the public is considered by the LPT to be acceptable, it will direct that the patient should be released on life licence. If that is the decision, it will direct the Scottish Ministers in writing to release him or her. The letter advising of the decision must be issued to the patient, (copied to the other parties at the LPT), by the Chairperson of the LPT no later than 14 days after the date of the hearing. The Scottish Ministers are statutorily obliged, on receipt of a direction, to release the patient as soon as practicable thereafter. The Parole Board will also decide on the conditions to be included in their life licence.

13.33 If the LPT considers that the level of risk is unacceptable, it will advise the patient in writing, (copied to the other parties at the LPT), no later than 14 days after the date of the hearing, explaining why it considers that they require to continue to be confined. The LPT may also make recommendations about the steps that could be taken to reduce the patient’s risk before the next hearing. It will fix the date for the next hearing no later than 2 years from the current disposal. (The right of a life prisoner to require the Scottish Ministers to refer his or her case to the Parole Board is not affected by transfer to hospital under the 2003 Act).

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<sup>97</sup> As amended by the Convention Rights (Compliance) (Scotland) Act 2001

**Release on life licence direct from the hospital**

13.34 A MAPPA [referral](#) should be made prior to a recommendation by the RMO for release on life licence.

13.35 Where a patient subject to life imprisonment, detention for life or detention without limit of time no longer meets the criteria for continued detention in hospital under a transfer for treatment direction they should be returned to prison to continue serving their sentence.

13.36 However, where the advice of the RMO is that the patient 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 patient to progress through a local hospital and be gradually re-introduced to the community and tested/prepared for release through a programme of increasing unescorted freedoms.

13.37 Where an RMO, after consultation with the designated MHO, intends to recommend that a transferred prisoner should be released in this way, this should be made clear to the PMO (FP) 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 SGHD 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 upon the transfer for treatment direction ceasing to have effect. The Scottish Government Health and Justice Directorates 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 Scottish Government, the RMO and the designated MHO.

13.38 Once the RMO considers that, in 6 to 12 months time, the patient will be well enough for release on life licence and will no longer present an unacceptable risk to the public, they should make their views known to the Scottish Ministers. Release on life licence may only take place once the patient 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 where it considers that the level of risk to the public is acceptable. 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, the Parole Board may take the view, from the wider perspective of the risk to public safety, that it is not appropriate to direct release on life licence. The RMO and the designated MHO should ensure that the patient's expectations about the timing of their discharge from hospital/release on life licence are not raised unrealistically.

**Transfer from hospital back to prison (revocation of the TTD)**

*Review of the TTD by the RMO*

13.39 A patient who is the subject of a [transfer for treatment direction](#) from prison to hospital may be considered for transfer back to prison once the RMO considers that the patient no longer needs to be detained in hospital for treatment. As noted in paragraph 13.3 above, this may arise as a result of the annual review of the transfer for treatment direction under section 206 or under the general "time to time" review requirement on the RMO under section 208. In that event the RMO submits a report to the Scottish Ministers which includes a recommendation that the transfer for treatment direction be revoked.

13.40 In such cases, the transfer for treatment direction is revoked. At the review, the RMO is required both to consider whether the conditions set out in section 206(4) and 207(3) of the 2003 Act continue to apply in respect of the patient, as well as whether or not

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either the serious harm requiring detention in hospital test is met or it is otherwise necessary for the patient to be subject to the direction.

13.41 In terms of the section 206(4) conditions that the RMO must consider in reviewing the direction, these are whether:

1. the patient has a mental disorder;
2. medical treatment which would be likely to –
  - prevent the mental disorder worsening; or
  - alleviate any of the symptoms or effects of the disorder, is available for the patient; and
3. if the patient were not provided with such medical treatment there would be a significant risk –
  - to the health, safety and welfare of the patient; or
  - to the safety of any other person.

13.42 The other consideration which the RMO must give, as above, is similar to that for the continuation of a restriction order for a CORO patient, namely whether: as a result of the TTD patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment (the "detention in hospital" test); OR, it is otherwise necessary for the patient to remain subject to the TTD. When considering "serious harm"<sup>98</sup>, it is relevant to consider the environment into which he will be transferred. Different considerations may apply depending on whether the patient is being released into the community or back to prison.

13.43 In considering whether revocation of a transfer for treatment direction is appropriate, the SGHD will need information about:

- the patient's progress and behaviour;
- why the patient is considered to no longer need treatment in hospital, and why the direction is thought to no longer be otherwise necessary; and
- what plans there are for the ongoing care of the patient's mental health while in prison, if appropriate.

13.44 The PMO (FP) will assess the patient and provide a view to the SGHD. The SGHD 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.

13.45 The information required by the SGHD 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
- details of Care Programme Approach arrangements made.

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

13.47 Where the Scottish Ministers decide not to revoke a transfer for treatment direction or on the recommendation of the RMO, they shall make a reference to the Tribunal in terms

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<sup>98</sup> Reference to the serious harm test

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of section 210(3) of the 2003 Act. The Tribunal will then, under section 215, either make no direction (thus maintaining the status quo), or it will direct the Scottish Ministers to revoke the TTD.

### *Review of the TTD by the Scottish Ministers and role of the Mental Welfare Commission*

13.48 The Scottish Ministers are also separately required to keep a transfer for treatment direction under review from time to time by virtue of the duties on them under section 212 of the 2003 Act, and to revoke the direction if appropriate.

13.49 The Scottish Ministers are then also required to refer the transfer for treatment direction to the Tribunal for consideration where either the Mental Welfare Commission has required them to do so, or for a two-year “catch up” consideration where there has been no reference to the Tribunal during that time. Again, the Tribunal has powers under section 215 either to make no order, or to direct the Scottish Ministers to revoke the TTD.

### *Notification of revocation of TTD and transfer back to prison*

13.50 The Mental Welfare Commission and the designated MHO will be notified by SGHD of the patient’s return to prison. Notification will be required to the MAPPAs coordinator to indicate the patients change in status. Most probably they will be leaving the MAPPAs system, or they may remain if they are also a registered sexual offender.

### **Hospital directions**

13.51 Hospital Directions<sup>99</sup> allow the courts to impose a sentence of imprisonment on someone who is in immediate need of treatment for mental disorder, and at the same time direct their admission to hospital for as long as they are in need of that treatment up to the release date in terms of their sentence. 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.

13.52 A patient subject to a hospital direction is subject to the same statutory procedures regarding review of the direction as a patient who is subject to a transfer for treatment direction, as described above in paragraphs 13.39 to 13.47. Where an RMO is considering the return to prison of a patient subject to a hospital direction he should, following consultation with the MHO, contact the PMO (FP) 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 PMO (FP). 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 above. For indeterminate sentenced prisoners on a Hospital Direction the steps outlined above should be followed.

13.53 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 above apply.

### **SUS for TTD and HD patients**

13.54 As discussed in Chapter 8, section 224 of the 2003 Act also enables suspension of detention from hospital “(SUS)” for patients who are on a hospital direction or a transfer for treatment direction. However, it would not normally be considered appropriate to consider SUS for prisoners who are not being rehabilitated through the mental health system other than for clinical or compassionate reasons. SUS for transferred prisoners follows the same principles as those for CORO patients. [Chapter 8](#) provides guidance on SUS and

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<sup>99</sup> Further guidance on hospital directions was issued by the then Scottish Government Health Directorate in NHS HDL (2005) 4.

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paragraph 8.35 covers SUS for life sentence prisoners being rehabilitated through the mental health system.

## 14 THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

14.1 The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") established a judicial body - the Mental Health Tribunal for Scotland ("the Tribunal"). The primary role of the Tribunal is to consider and determine applications, references and appeals in relation to compulsory detention and treatment of persons diagnosed as suffering from a mental disorder.

14.2 A tribunal comprises a panel of three members: a legal member (who acts as a convener) a medical member; and a general member. In most cases, the convener will be either the President of the Tribunal or a legal member. However, in the case of restricted patients and those patients subject to a hospital direction or a transfer for treatment direction, the convener must be the President or a sheriff; this is the case for all applications, references or appeals relating to such a patient other than proceedings relating solely to an application under section 255 or 256 of the 2003 Act (applications to Tribunal for order appointing a named person or declaring that a named person should not be the named person).

14.3 Tribunal hearings take place locally where possible, e.g. in the hospital where the patient is detained. To that end, NHS Boards and local authorities are required under the 2003 Act, in so far as it is reasonably practicable to do so, to provide appropriate accommodation where Tribunal hearings can be held. A purpose built hearing suite is also available at the Tribunal's headquarters in Hamilton.

### **Applications and References: overview**

14.4 A case relating to a CORO patient, and those patients subject to a hospital direction or a transfer for treatment direction, may be put forward for consideration by the Tribunal<sup>100</sup> by:

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

### **Application to the Tribunal by the patient or their named person – COROs and directions**

14.5 Under section 192 of the 2003 Act, a patient subject to a compulsion order and restriction order and their named person, may make an application to the Tribunal for an order under section 193 of the Act -

- conditionally discharging the patient;
- revoking the restriction order to which the patient is subject;
- revoking the restriction order and varying the compulsion order by modifying the measures specified in it; or
- revoking the compulsion order to which the patient is subject.

14.6 The CORO patient or their named person cannot make an application until at least 6 months after the compulsion order was made or within 3 months of a decision made by the Tribunal under section 193 of the 2003 Act. In addition the patient and the named person may make only one application in any subsequent 12-month period beginning with, or with an anniversary of, the expiry of the first 12-month period.

14.7 Under section 214 of the 2003 Act a TTD patient or HD patient and their named person may make an application to the Tribunal for the revocation of the direction to which the patient is subject. Where the patient is a HD patient an application cannot be made within 6 months of the direction being made. Where the patient is a TTD patient an application cannot be made within 6 months of the direction being made unless it is made

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<sup>100</sup> A list of approved forms can be found at [Annex J](#), and details of their use are contained in the following paragraphs.

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within 12 weeks of the direction being made. In the case of either type of direction, only one application can be made by each of the patient and named person in the 12-month period.

14.8 Where a restricted patient makes an application to the Tribunal under either section 192 or 214, the Scottish Ministers will receive notice of the application from the Tribunal and must respond to the Tribunal within 14 days indicating whether they wish to make representations (whether orally or in writing) or to lead or produce evidence. In effect this means that the Scottish Ministers will give notice of whether they intend to resist the application and, if so, the reasons for this or the position they intend to take in respect of the application. Prior to responding on behalf of the Scottish Ministers, SGHD officials will contact the Responsible Medical Officer (“RMO”) to discuss the appropriateness of any order sought by the patient in the application. A written report will also be required from the RMO and, in some cases, further reports may be sought from the social worker, psychologist or an independent clinician.

14.9 As the application will be determined by the Tribunal in accordance with its powers under section 193, it is crucial that the written report from the RMO addresses the sequential tests set out in that section, namely:

1. whether the patient has a mental disorder;
2. whether, as a result of the CORO patient’s mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment (the “risk of serious harm requiring detention in hospital” test);
3. whether medical treatment which would be likely to –
  - (i) prevent the mental disorder worsening; or
  - (ii) alleviate any of the symptoms or effects of the disorder,is available for the patient;

whether, if the patient were not provided with such medical treatment, there would be a significant risk –

- (i) to the health, safety and welfare of the patient; or
- (ii) to the safety of any other person;

4. whether it continues to be necessary for the CORO patient to be subject to the compulsion order (the “necessity for a compulsion order” test); and
5. whether it continues to be necessary for the CORO patient to be subject to the restriction order (even if not requiring detention in hospital) (the “necessity for a restriction order test”).(See [Chapter 7](#) for more details on the legal tests.)
6. whether it is necessary for the CORO patient to be detained in hospital (the detention in hospital test)

14.10 The RMO must consider whether each of the 6 criteria are met. It is important that reasons are given in the report for the conclusion reached in respect of each of the tests.

### **Review of CORO - application to the Tribunal by the Scottish Ministers**

14.11 The Scottish Ministers have a duty to keep a CORO patient’s compulsion order and restriction order under review<sup>101</sup>. This duty is separate from the duty to refer the CORO

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<sup>101</sup> Section 188 of the 2003 Act

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patient's case to the Tribunal where a recommendation has been received from an RMO<sup>102</sup> or notification has been received from the Mental Welfare Commission that it requires a reference to be made to the Tribunal<sup>103</sup>. Section 188 additionally requires the Scottish Ministers from time to time to consider the continued appropriateness of the compulsion order and restriction order<sup>104</sup>. Where they are not satisfied that the CORO patient continues to meet the relevant criteria they must make an application to the Tribunal for an order<sup>105</sup> -

- conditionally discharging the patient;
- revoking the restriction order to which the patient is subject;
- revoking the restriction order and varying the compulsion order by modifying the measures specified in it; or
- revoking the compulsion order to which the patient is subject.

The application to the Tribunal by the Scottish Ministers<sup>106</sup> is made using form [CORO2](#).

14.12 Where the Scottish Ministers are to make such an application to the Tribunal, they are required, as soon as practicable after the duty to make the application arises, to give notice of the making of the application to the following persons -

- the patient;
- the patient's named person;
- any guardian of the patient;
- any welfare attorney of the patient;
- the patient's RMO;
- the mental health officer; and
- the Mental Welfare Commission.

### **Review of hospital direction and transfer for treatment direction – no application to Tribunal**

14.13 Section 212 of the 2003 Act imposes on the Scottish Ministers a similar duty in respect of a patient's hospital direction or transfer for treatment direction, namely a duty to keep the relevant direction under review. Again, this duty<sup>107</sup> is separate from the duty to refer the HD or TTD patient's case to the Tribunal where a recommendation has been received from an RMO<sup>108</sup> or notification has been received from the Mental Welfare Commission that it requires a reference to be made to the Tribunal<sup>109</sup>.

14.14 Following such a review, however, the Scottish Ministers must themselves revoke the direction where they are not satisfied that the grounds for the direction continue to be met; unlike a CORO review, no application is made to the Tribunal for revocation. This requirement to revoke a hospital direction or transfer for treatment direction without further reference to the Tribunal sits alongside the requirement on the Scottish Ministers to revoke the direction<sup>110</sup> on receiving a relevant report from the patient's RMO.

### **Reference to the Tribunal by the Scottish Ministers – COROs and directions**

14.15 Scottish Ministers have a duty to make a reference to the Tribunal in respect of the compulsion order and restriction order or hospital direction or transfer for treatment direction to which a patient is subject, in the following circumstances -

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<sup>102</sup> section 185

<sup>103</sup> section 187

<sup>104</sup> the tests are as set out in [Chapter 4](#) paragraphs 4.10 to 4.14 refer

<sup>105</sup> under section 193

<sup>106</sup> section 191 of the 2003 Act

<sup>107</sup> under section 212

<sup>108</sup> section 210

<sup>109</sup> section 211

<sup>110</sup> under section 210(2)

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- on receipt of a recommendation from the RMO<sup>111</sup>;
- on receipt of notice from the Mental Welfare Commission<sup>112</sup>; or
- where no reference or application has been made to the Tribunal for two years i.e. two-year review provisions<sup>113</sup>

14.16 A reference to the Tribunal by the Scottish Ministers under sections 185(1) and 187(2) is made using form [CORO1](#)<sup>114</sup>; a reference to the Tribunal by Scottish Ministers under section 189(2) is made using form [CORO2](#)<sup>115</sup>; and a reference to the Tribunal by Scottish Ministers under sections 210(3), 211(2) or 213(2) is made using form [HD2](#)<sup>116</sup>.

14.17 When making a reference under these sections to the Tribunal, the Scottish Ministers must include: the name and address of the patient and the patient's named person; the recommendation submitted by the RMO, or the reason given by the Mental Welfare Commission or the Scottish Ministers for making the reference as the case may be. They must also give notice of the making of the reference.

### **Tribunal Hearings - procedure**

14.18 Hearings will take place on a date and at a venue set by the Tribunal. The Tribunal will notify all relevant parties of the arrangements and will issue a set of papers to the parties no less than 7 days prior to the hearing date. A "party" is defined in the Tribunal Rules as being—

- the person who initiated the proceedings before the Tribunal;
- the patient;
- the named person;
- any person whose decision (which includes any direction or order, determination or grant of a certificate) is the subject of the proceedings before the tribunal;
- any person added as a party under rule 48;
- in the case of proceedings under sections 264 to 267 of the 2003 Act, the relevant Health Board; and
- where the proceedings relate to a restricted patient, the Scottish Ministers.

14.19 The RMO and the Mental Health Officer ("MHO"), not being parties to the proceedings before the Tribunal, will not receive a full set of the papers for the hearing - consisting of the reports and other documents submitted by the applicant or authority making the reference, and those submitted by the respondent.

14.20 SGHD will provide the RMO and MHO with a copy of the Position Statement and the Inventory of Productions documenting the papers lodged – which in the main will have been submitted by the RMO. SGHD will copy to the RMO and MHO any independent reports submitted to the Tribunal by the Scottish Ministers (where instructed by Ministers) or received from the Tribunal by the Scottish Ministers (where instructed by the patient or named person).

14.21 Most restricted patients have legal representation at Tribunal hearings and members of the patient's clinical team are likely to be invited to give oral evidence. In most cases, Scottish Ministers are represented by officials from SGHD and also have legal representation from the Scottish Government Legal Directorate ("SGLD"). Scottish Ministers will provide written representations in uncontested cases with only the more complex or

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<sup>111</sup> sections 185(1) & 210(3) of the 2003 Act

<sup>112</sup> sections 187(2) & 211(2) of the 2003 Act

<sup>113</sup> sections 189(2) & 213(2) of the 2003 Act

<sup>114</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/coro1v6>

<sup>115</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/mha-Forms/CORO2>

<sup>116</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/mha-Forms/HD2>

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contested cases involving representation by SGHD officials or legal representation by a solicitor from the SGLD or by Counsel.

### **Appeals to the Tribunal by the patient or their named person**

14.22 The patient and their named person may appeal to the Tribunal:

- under section 201 of the 2003 Act<sup>117</sup>, against the Scottish Ministers' decision to vary the conditions imposed on a CORO patient's discharge within 28 days of receipt of the written notice from the Scottish Ministers;
- under section 204 of the 2003 Act<sup>118</sup>, against the Scottish Ministers' decision to recall a CORO patient from conditional discharge within 28 days of their return to hospital;
- under section 214 of the 2003 Act, for revocation of the transfer for treatment direction (patient seeking transfer to prison);
- under sections 219 & 220 of the 2003 Act, against the Scottish Ministers' decision to transfer a patient from one hospital to another (regardless of level of security);
- under regulation 13 of the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005), against the Scottish Ministers' decision to transfer a patient between jurisdictions i.e. a cross-border transfer.

### **Appeals to the Court of Session by various parties**

14.23 The patient, their named person, the Scottish Ministers and certain other people (depending on the decision appealed against), may appeal to the Court of Session against a decision taken by the Tribunal (section 322 of the 2003 Act).

### **Effect of certain applications, orders and appeals**

14.24 **An ongoing application to the Tribunal by a patient should not halt or delay the normal progress of their care and treatment.**

14.25 An ongoing application does not affect the Scottish Ministers' decision-making powers. The RMO should continue to report on progress and request permission for suspension of detention from hospital ("SUS"), 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 likelihood that an application for discharge will be successful, the RMO should inform the relevant local authority and other agencies to allow contingency planning to be put in place. It is important for this to be done at an early stage. The Early Discharge Protocol NHS HDL (2002) 85 is based on the principles of the Care Programme Approach and provides guidance in respect of a small number of patients who may no longer meet the grounds for detention under the mental health legislation but may continue to pose a significant risk.

14.26 **Where the Tribunal makes an order under section 193 revoking a compulsion order, revoking a restriction order, conditionally discharging a patient or varying a compulsion order the order does not have immediate effect.**

14.27 The order will not come into effect until the expiry of the appeal period (where no appeal has been made) or (where an appeal has been made) the end of the appeal process. Section 196 of the 2003 Act provides in that regard that the order will not have effect until one of the following events occur –

- the expiry of the period for appeal, provided no appeal has been lodged timeously within that period;

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<sup>117</sup> Section 200 of the 2003 Act gives Scottish Ministers the right to vary conditions set by the Tribunal when conditionally discharging a CORO patient under section 193(7) of the Act.

<sup>118</sup> Under section 202 of the 2003 Act, Scottish Ministers may recall a CORO patient from conditional discharge if they are satisfied it is necessary for the patient to be detained in hospital.

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- where an appeal has been lodged timeously under section 322 of the 2003 Act, where the Scottish Ministers have given notice that they do not intend to ask the Court of Session to make an order under section 323;
- where an appeal has been lodged timeously under section 322 of the 2003 Act, and the Court of Session refuses to make an order under section 323;
- where an appeal has been lodged timeously under section 322 of the 2003 Act, and any order made by the Court of Session under section 323 is recalled or expires.

14.28 Where the Scottish Ministers appeal to the Court of Session under section 322 of the 2003 Act against a decision made by the Tribunal, they can apply to the Court of Session for an order continuing the patient's detention and continuing the patient's compulsion order and restriction order, hospital direction or transfer for treatment direction. If an order is granted by the Court of Session under section 323 then it has the effect of continuing the patient's detention until the appeal is finally determined.

14.29 If an appeal is made to the Tribunal against a proposed cross-border transfer under the Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005, then the patient cannot be transferred pending determination of the appeal (regulation 11).

### **Preparation of reports and attendance at hearings**

14.30 SGLD will act on behalf of the Scottish Ministers in appeals and contested applications by restricted patients/named persons. Counsel will be instructed by SGLD for all Court of Session hearings and they may also be required for Tribunal appeals<sup>119</sup>.

14.31 On receipt of papers indicating an application or appeal to the Tribunal, the SGHD will write to the RMO and the MHO requesting a report containing their view of the patient's mental disorder, appropriate detention and any other aspect of their case, which is relevant to the appeal. SGHD will also request a report from the patient's MHO.

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

14.33 In cases where the Scottish Ministers intend defending an application, appeal or reference to the Tribunal, the SGHD may instruct a second medical report on the patient from a consultant psychiatrist with appropriate experience relating to the patient's mental disorder. It should also be noted that the PMO (FP) will examine, and thereafter give an opinion on the patient's case and that will be factored in to the Scottish Ministers' position in relation to the appeal.

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

14.35 **When giving oral evidence before a Tribunal it is important that the RMO and MHO should vouch their opinions with reference to the reports and assessments they have provided in advance of the hearing.** Although by no means exhaustive, below is a list of the documents which Tribunals appear to find most useful:

- annual reports;

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<sup>119</sup> Appeals by non-restricted patients are handled by Central Legal Office, the legal advisers to the NHS.

- risk assessments;
- risk management reports;
- community care assessments;
- treatment review reports; and
- CPA documentation.

**Applications against detention in conditions of excessive security (section 264)**

14.36 When the Mental Health (Care and Treatment) (Scotland) Bill was undergoing its passage through the Scottish Parliament, concerns were raised about “entrapped” patients in the State Hospital. As a result, patients detained in the State Hospital can make applications to the Tribunal for an order declaring that they are being detained in conditions of excessive security. Part 17, Chapter 3, of the 2003 Act refers. These provisions apply to any patient detained in the State Hospital not just restricted patients.

*State Hospital patients*

14.37 Restricted patients who are detained in the State Hospital may now therefore make an application to the Tribunal under section 264(2) of the 2003 Act seeking an order:

- (a) declaring that they are being detained in conditions of excessive security; and
- (b) specifying a period (not exceeding 3 months) within which the relevant Health Board must identify an alternative hospital, which the Scottish Ministers, Board and managers agree is appropriate, and in which accommodation is available.

14.38 The patient’s named person, any guardian or welfare attorney and the Mental Welfare Commission, may also make an application to the Tribunal for such an order in respect of the patient’s detention in the State Hospital. It should be noted, however, that an appeal may not take place within the first 6 months from the date of the compulsion order, HD or TTD being made or the first 6 months in the State Hospital and only one application may be made in any 12 month period.

14.39 Prior to determining any such application for an order that a restricted patient is being held in conditions of excessive security at the State Hospital, the Tribunal must allow various persons including Scottish Ministers the relevant Health Board, the patient’s RMO, the managers of the State Hospital, the MHO and the patient to make representations (orally or in writing) and to lead or produce evidence to the Tribunal.<sup>120</sup>

14.40 Thereafter, if satisfied that the patient does not require to be detained under conditions of special security which can only be provided in the State Hospital, the Tribunal *may* (ie it is not required to do so) make an order under section 264(2).

14.41 Following on from the making of the order if, within the specified period, the Tribunal does not receive notification from the Health Board that the patient has been transferred to an appropriate hospital, the Tribunal must hold a further hearing under section 265. At this hearing, the Tribunal may grant the Health Board a further period, again not exceeding 3 months, to identify a suitable hospital. It may also at this stage make a final 28 day order which would mean that the application would not automatically return to the Tribunal but would be directly enforceable by action in the Court of Session. If a further period, again not exceeding 3 months is granted and the patient is still not transferred within this period, the Tribunal will hold a final hearing under section 266 of the 2003 Act at which they may make a final order to the effect that the Health Board has 28 days to find a suitable place for the patient.

14.42 It should be noted that the “hospital” that the Health Board is required to identify will always be a Scottish hospital due to the terms of the 2003 Act. If it is ultimately intended

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<sup>120</sup> For the full list of persons see section 264(10) of the 2003 Act.

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therefore that a patient be transferred to a hospital outwith Scotland then they must either be transferred prior to an order under section 264 being made by the Tribunal (thereby avoiding an order requiring the Health Board to find alternative accommodation in Scotland). If an order is made and the patient is transferred outwith Scotland, then at the appropriate time an application should be made for recall of the order under the provisions of section 267, as on transfer of the patient to England the existing order would impose a statutory obligation on Health Boards that could no longer be complied with. The normal transfer provisions and procedures detailed in Chapter 8 are utilised.

14.43 When an order has been made by the Tribunal under section 264(2) or 265(2), either the Scottish Ministers or the relevant Health Board may make an application to the Tribunal for *recall* of the order. It should be noted that although the RMO has the right to apply to the Tribunal for recall of an excessive security order for non-restricted patients detained at the State Hospital, they do not have a similar right to apply for recall in respect of restricted patients and Scottish Ministers are instead given that role under the legislation. Again, other parties are given the right to make representations and to produce evidence for a recall hearing.

14.44 Otherwise, however, should the Health Board fail to comply with a final order of the Mental Health Tribunal, then the Board will be in breach of its statutory duty. The Mental Welfare Commission may, under section 45(b) of the Court of Session Act 1988, take the Health Board to court for failure to perform their statutory duty. This is without prejudice to any rights that the patient has to raise an action under section 45(b).

#### *Patients in other (non-State) hospitals*

14.45 Although the 2003 Act provides similar rights for patients in section 268 to 271 of the 2003 Act to make an application for an order from the Tribunal that they are being held in conditions of excessive security in the hospital in which they are detained, these provisions have not yet been commenced.

14.46 However, at present, what is required to bring into being the right of appeal for patients held in other hospitals, for example, at medium secure levels, is that regulations be made under section 268 of the 2003 Act to specify "qualifying patients" or "qualifying hospitals" to which the provisions in sections 268 to 270 would apply. In terms of when such regulations will be made, which would make sections 268 to 270 operative, and so bring in a similar right of appeal for patients in hospitals other than the State hospital, the Scottish Ministers are keeping this under review with a view to ensuring that patients are detained in the right conditions and care settings.

## CHAPTER 15: SUMMARY OF KEY POINTS

The key summary points contained in each chapter are noted below:

### **CHAPTER ONE: Introduction**

- this Scottish Government Memorandum of Procedure (MoP) for Restricted Patients replaces the last September 2005 Version of the MoP.
- the MoP is intended as a practical reference document for all those involved in the management and care of “restricted patients”, and does not have formal legal status.

### **Executive Summary**

- provides an overview of the Scottish Ministers’ statutory role in relation to restricted patients, in relation to supervision, transfers, SUS etc, and explains that the Ministers’ role is as an additional layer of scrutiny as regards the long term protection and security of the public from those patients who pose a risk of serious harm to the public.
- provides an overview of, and background to, the Scottish Ministers’ policy on the management of mentally disordered offenders, giving links to various extraneous documents and websites in that regard.
- provides a list of terminology used in the MoP.

### **CHAPTER TWO: Roles & Responsibilities**

- highlights that although Ministers have (as of the 2003 Act) remitted their previous powers to CD patients and to revoke restriction orders over to the MHTS, their ongoing statutory role in respect of restricted patients means that:
  - their consent is still required for any: transfers between hospitals; transfers between hospital and prison; cross border transfers; SUS; and, for CORO patients, any variation of conditions of discharge or recall from conditional discharge;
  - they may independently make certain references or applications to the MHTS in respect of a restricted patient
  - they will be a party to MHTS hearings involving restricted patients.
- provides an overview of the role and responsibilities of the other personnel involved in the care and management of restricted patients, namely:
  - SGHD staff;
  - the MHTS, as the judicial body;
  - the MWC, as the independent scrutiny and safeguarding body;
  - the RMO, as the medical practitioner who has primary responsibility for the patient’s care and treatment;
  - the MHO, as the qualified and experienced local authority social worker;
  - the ASW, who may provide support to the MHO
  - the CPN, who reports to the Ministers on the progress of CORO patients on CD; and
  - the police, in relation to sharing information with Health as the responsible authority for restricted patients under MAPPA, and helping to address any community safety issues for patients moving out of hospital to the community.

**CHAPTER THREE: Risk Assessment & Management**

- highlights that risk management and assessment is an overarching principle in the management of restricted patients, throughout the patient's journey, and that a multidisciplinary approach that engages the patient and has a focus on victim safety is an integral part of the risk management.
- highlights that good clinical care should therefore involve a multidisciplinary approach of structured risk assessment and management within the CPA.
- reminds that each of the decision points for multidisciplinary teams, Ministers and the MHTS must be supported by good quality risk assessments and risk management plans which are regularly updated within the CPA every 6 months and otherwise more regularly as circumstances change, thus requiring ongoing assessment and evaluation of the risk management strategies implemented and review of the patient's progress.
- highlights that the RMA Guidelines on risk management planning indicate that good quality risk management relies upon: collaborative working; risk assessment; mapping of multi-layered risk management strategies to each identified risk factor and to each active protective factor; and documenting preventive actions and contingency actions (traffic light section) in the CPA documentation.

**CHAPTER FOUR: Care Programme Approach (CPA)**

- provides a brief background to the CPA and notes that it has been adopted by the Scottish Government as the requisite mechanism for regular review for all patients subject to COROs, HDs, TTDs and ICOs with the purpose of maximising public safety and the reduction of risk of serious harm.
- CPA can be distinguished from MAPPAs as, despite having the same underlying principles of gathering information, CPA focuses on the care and treatment likely to minimise the risk posed, whilst MAPPAs focus on multi agency management of risk.
- highlights that for NHS Health Boards, adherence to the CPA will enable them to meet many of their statutory obligations under MAPPAs where they are the responsible authority, as the [CPA documentation](#) is used to record risk assessment and management plans as well as the ongoing care and treatment of the patient.
- provides a quick link to Scottish Government CEL 13 (2007) which contains guidance on the implementation of CPA
- provides link to Forensic Network updated guidance on CPA, the roles of individuals and templates for the documentation including a SUS plan which supports the CPA process.

**CHAPTER FIVE: Multi-Agency Public Protection Arrangements (MAPPAs)**

- explains that MAPPAs focus on multi agency management of risk, by providing systems and processes for relevant agencies to cooperate and share information about individuals who represent a risk to the community.
- explains that there are 3 levels of management in the MAPPAs model, with restricted patients normally falling within level 1 or 2:
  - Level 1 (ordinary risk management);
  - Level 2 (local inter-agency risk management); and
  - Level 3 (multi-agency public protection panel).
- highlights the circumstances in which:
  - a MAPPAs *notification* must take place, namely: admission of a restricted

- patient to hospital, and any transfer between hospitals or back to prison; and
- a MAPPA *referral* must take place, namely: unescorted ground parole or SUS; on identification of suitable accommodation in the community when planning CD; and when the RMO is considering recommending revocation of the CO or RO.

## **CHAPTER SIX: Patient Journey: Overview**

- provides an overview of the patient journey, starting from admission and ending with the end of special restrictions, in the form of a chart.

### **Patient Journey: Admission**

- summarises the different types of mental health court orders or directions which lead to admission to the mental health system from the criminal justice system.
- the pre-disposal orders are:
  - assessment orders (s52B-J), which authorise detention for up to 28 days for assessment of mental condition;
  - treatment orders (s52K-S), which authorise detention, enable compulsory treatment to be given, and can last until conviction or final disposal by the court; and
  - interim compulsion orders (s52), which authorise detention, enable compulsory treatment to be given, and can last for up to 12 weeks (and 12 months in total);
- the orders at disposal / sentencing:
  - compulsion orders (s57A) which can authorise detention, enable compulsory treatment to be given in hospital or in the community, and last for 6 months (thereafter extension by 6 months, following which 12 month renewals) or until revoked by the RMO;
  - compulsion orders (s57A) with restriction order (s59) (CORO), which authorise detention, enable compulsory treatment to be given, apply the restriction order without limit of time such that the compulsion order does not need to be reviewed, and can only be revoked by the MHTS (CORO may be direct or via s57(2)(a) & (b)); and
  - hospital directions (s59A) which are a hybrid order, authorising detention together with simultaneous imposition of prison sentence, enable compulsory treatment to be given, and can last until patient no longer requires treatment (transfers to prison) or until end of prison sentence;
- the post disposal / sentencing directions are:
  - transfer for treatment direction (s136 of 2003 Act), enables Scottish Ministers to transfer prisoner from prison to hospital for treatment of mental disorder, during which time patient is subject to restrictions, and lasts until end of prison sentence or TTD is revoked (sending patient back to prison); and
  - transfer from another jurisdiction, either via SSI 2005/467 for patients from other UK jurisdictions, or via the Repatriation of Prisoners Act 1984 for patients coming in from outwith the UK.

## **CHAPTER SEVEN: Patient Journey: Management in Hospital**

- highlights that Scottish Ministers require a report to be provided on admission of each restricted patient to hospital, together with a copy of the Part 9 Care Plan, and a

further report at the 3 month stage following admission.

- reminds that RMOs are thereafter required to prepare (having first consulted with the MHO) and submit to Scottish Ministers an annual report on each restricted patient, together with a copy of the most recent CPA documentation (for which a template is given) and either form CORO1 or HD1.
- provides guidance on the detail of the information to be included in the reports for CORO patients and HD/TTD patients, noting that this is circumscribed by the requirements of the 2003 Act, to include background information on the patient, the RMO's opinion of the patient's current mental state, and whether the patient is detainable under the 2003 Act at the time of making the report

#### **CHAPTER EIGHT: Patient Journey: Suspension of Detention (SUS)**

- Highlights that SUS means very simply that detention in hospital is suspended.
- SUS should be planned in the context of the [CPA](#) and SUS plan template given
- Section 224 of the 2003 Act sets out procedures for SUS and the consent of Scottish Ministers is required.
- The total sum of SUS granted over a year must not total more than 9 months.
- There is a requirement for the RMO to report back to Scottish Ministers no later than 3 months after the SUS
- SUS can be revoked at any point by the RMO or Scottish Ministers when satisfied that it is in the interests of the patient or for the protection of any other person.
- Prior to consideration of unescorted SUS for the first time either in the grounds of the hospital or in the community a MAPPA 2 referral must be made
- Where at all possible a programme of SUS over several weeks/months should be prepared using the template [SUS form](#).
- When there is a change in the RMO the new RMO must review the SUS and confirm they are content for the level of SUS to continue
- Four overnights is the maximum of overnights permitted in any one week other than in exceptional circumstances i.e. the Tribunal ordering conditional discharge
- SUS requests to cover emergencies such as urgent clinical appointments can be sought in advance
- SUS for restricted patients who are sex offenders must be notified to the police if they are to be released from detention for a period of 3 days or more
- Scottish Government must be informed immediately if restricted patient is involved in an incident while on SUS or absconds.

#### **CHAPTER NINE: Patient Journey: Transfers**

- Highlights that all transfers of restricted patients must have the Scottish Ministers' approval under S218(3) of the 2003 Act
- Patient and their named person must normally be given 7 days notice except in urgent cases when notification can occur afterwards.
- Pre-transfer CPA meetings should take place
- Risk assessment and management plans should be reviewed/updated
- The RMO must notify the local MAPPA Co-ordinator
- Ward to ward transfers are at the discretion of the RMO who should inform the SGHD and the MHO but in cases where this involves transfer from a locked ward to an unlocked ward the RMO should consult with SGHD and the PMO(FP) **prior to transfer**

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- A patient can appeal against transfer. If a patient appeals and the transfer has not yet taken place the patient cannot be transferred unless the Tribunal has made an order pending determination of the appeal.
- It is not possible to transfer between hospitals in Scotland patients on remand or detained on an Interim Compulsion Order. These cases must be remitted back to court to change the hospital named on the Order.
- It is not possible to transfer remand patients or those who have not yet received a final disposal between jurisdictions.

### **CHAPTER TEN: Patient Journey: Planning for CD**

- This chapter only applies to CORO patients as prisoners on transfer for treatment directions or Hospital Directions cannot be conditionally discharged.
- Only the Tribunal can grant conditional discharge and set such conditions as it sees fit.
- Conditions imposed normally relate to residence, supervision by RMO, MHO and CPN and any other additional conditions necessary for the protection of the public.
- Once on CD only Scottish Ministers can vary the conditions of discharge. The patient has a right of appeal to the Tribunal (S201 of the 2003 Act) against any change.
- Prior to accommodation being identified the police should be invited to a Pre-CPA meeting to share intelligence about the proposed accommodation
- Once accommodation has been identified and patient is progressing on overnight SUS a MAPPa referral should be made

### **CHAPTER ELEVEN: Patient Journey: Management whilst on CD**

- Highlights the requirement for the [RMO](#), [MHO](#) and [CPN](#) to provide monthly reports initially when patient first conditionally discharged
- Conditions of discharge must be stringently adhered to by the patient and any breach should trigger automatically whether formal recall or other supports are required
- A formal breach of conditional discharge is one where the SGHD have written directly to the patient copied to the managers of the Health Board, RMO, MHO and CPN.
- Provides guidance on role of RMO, MHO and CPN supervisors
- Scottish Ministers should be consulted when there is a change of address
- When RMO, MHO or CPN absent from their post responsibility for the case should be transferred to a colleague with any changes being notified to SGHD as soon as possible.
- CD does not preclude a CORO patient going on holiday.
- Under Section 202 of the 2003 Act Scottish Ministers have the power to recall a CORO patient from conditional discharge.
- There is a general duty to inform a patient within 72 hours of his recall to hospital, of the reasons for that recall
- The CORO patient has a right of appeal to the Tribunal within 28 days of formal recall

**CHAPTER TWELVE: Patient Journey: End of special restrictions**

- For CORO patients the Tribunal can order revocation of compulsion order, or revocation of restriction order
- Provides examples of certain patients detained under the mental health legislation whose status as a restricted patient automatically comes to an end on a particular date.
- If the Compulsion Order is revoked the Restriction Order automatically falls
- The Early Discharge Protocol which can be used in conjunction with MAPPA should be used for patients who no longer, or may no longer meet the criteria for compulsory intervention under the 2003 Act or the Criminal Procedure (Scotland) Act 1995.
- Prior to making a recommendation for revocation of the compulsion order and/or the restriction order a MAPPA referral must be made
- Provides link to the [necessity of the restriction order](#) guidance

**CHAPTER FIFTEEN: Patient Journey: Transferred Prisoners**

- Provides an overview of transfer for treatment directions and those subject to a Hospital Direction
- A “short term” prisoner is when the sentence is less than 4 years
- A “long term” prisoner is one who is sentenced to 4 years or more, excluding life sentence prisoners
- Civil detention powers may be used to compulsorily detain a prisoner at the end of the prison sentence if appropriate
- A MAPPA referral should be made prior to a recommendation by the RMO for release on life licence

**CHAPTER SIXTEEN: Patient Journey: MHTS**

- Provides background on the role of the Tribunal in considering and determining applications, references and appeals
- Applications to the Tribunal may be made by the patient or their named person
- Review of hospital direction and transfer for treatment direction
- The Scottish Ministers are required to make a reference on receipt of a recommendation from the RMO, on receipt of notice from the Mental Welfare Commission or where no reference or application has been made to the Tribunal for two years
- Appeals to the Tribunal by the patient or their named person
- The patient, their named person, the Scottish Ministers and certain other people may appeal to the Court of Session against a decision taken by the Tribunal.
- Where the Tribunal makes an order under section 193 revoking a compulsion order, revoking a restriction order, conditionally discharging a patient or varying a compulsion order this does not take effect until the expiry of the appeal period
- At the State Hospital, the patient, named person, any guardian or welfare attorney and the Mental Welfare Commission may make an application to the Tribunal declaring that the patient is being detained in conditions of excessive security.
- The RMO and MHO are responsible for providing background papers for the Tribunal and are expected to attend the hearing.

## ANNEX A

### PATIENT CONFIDENTIALITY AND INFORMATION SHARING

Confidentiality of personal health information is the cornerstone of the patient/doctor relationship. Restricted patients are entitled to the same rights to confidentiality as any other patient. Nevertheless, sharing of information between agencies involved in the care and treatment of restricted patients is an essential part of risk management. When a patient is admitted into the mental health system, the RMO will receive details of their index offence and any previous medical or social circumstances reports. Additional intelligence on the patient's background, mental disorder and risk will begin shortly after admission and will continue to be gathered throughout their stay in hospital and will be used to inform the decision-making process at key stages in their rehabilitation, e.g. SUS, transfer and discharge. Where appropriate, consideration should be given to explaining to the patient what information is being shared, who with and why. The CPA form has been produced in order that only the relevant risk information is shared with the police and MAPPA ensuring the confidentiality of clinical information.

While all health professionals have a legal duty to provide confidential health care, the statutory provisions<sup>121</sup> which govern this allow the sharing of information in appropriate circumstances to protect the public or to prevent or detect crime – see the NHS Code of Practice on Protecting Patient Confidentiality<sup>122</sup>. The Codes of Conduct and associated guidance of health professional bodies similarly recognise the importance of promoting the public interest in the prevention and detection of crime through the appropriate sharing of information with the police and criminal justice system.

#### **Release of information to Third Parties**

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 a potential landlord.

Guidance on handling personal health information rests on the Code of Practice on Protecting Patient Confidentiality, issued to the NHS in Scotland, in 2003.<sup>2</sup> The Code sets out the main principles that 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.

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.

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

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<sup>121</sup> <http://www.opsi.gov.uk/ACTS/acts1998/80029--d.htm#29>

<sup>122</sup> <http://www.ehealth.scot.nhs.uk/wp-content/documents/nhs-code-of-practice-on-protecting-patient-confidentiality.pdf>

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instance, a police/hospital liaison officer, to ensure that its handling adheres to the requirements of the Data Protection Act 1998.

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

### **Management of Offenders etc (Scotland) Act 2005**

Full guidance on Multi Agency Public Protection Arrangements ("MAPPA") including guidance on the NHS Roles and responsibilities was issued in CEL (2007) 8 (Justice Directorate Circular 15/2006 – version 3 - as revised at September 2007)<sup>123</sup>.

As part of this duty, these agencies are required to:

- Establish joint arrangements for the assessment and management of the risk posed by restricted patients who are violent or sexual offenders
- Cooperate with each other and other "duty to cooperate" agencies.

In each local authority area, agencies must draw up a memorandum setting out the ways in which they will cooperate with each other.

MAPPA are all the processes that are in place to manage risk posed by offenders. MAPPA meetings are primarily to ensure that there is oversight of the management of the most concerning cases and that operationally risk is being assessed and managed appropriately.

Health Boards will be expected to have an appropriate Information Sharing Protocol (ISP) in place. Where health boards already have an ISP in place they will review to include an annex for MAPPA arrangements. The following basic principles should be used as a benchmark for management and treatment of restricted patients:

- All individuals should be treated with respect. Lack of respect and stigmatisation may increase the risk of an individual re-offending;
- Wherever possible, individuals should be asked for consent to share information about them. Wherever possible an individual's requests to keep particular information confidential should be respected provided it is not essential to assess risk;
- The level of risk in these individuals may change with circumstances. Staff should be vigilant for triggers such as alcohol, opportunity, etc;
- All individuals are likely to require information-sharing on a need-to-know basis, depending on the risk they present.
- Plans should include specific plans about information - sharing, who will be responsible and how this will be done;
- Each Health Board area should appoint MAPPA representatives (both managerial and clinical may be necessary) and should make local arrangements to ensure best practice.
- These persons should be available to give advice to other staff on risk, and coordinate all sources of information within Health; cover for this will be needed 24/7.

### **Concordat on sharing of information regarding sex offenders**

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<sup>123</sup> CEL (2007)8 Sections 10 and 11 of the Management of Offenders etc, (Scotland) Act 2005 :- Implementation of the Multi Agency Public Protection Arrangements (MAPPA) in Scotland  
<http://www.scotland.gov.uk/Publications/2007/10/03110820/0>

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The Concordat for sharing information on sex offenders stemmed from the work of the Expert Panel on Sex Offending. The Panel recognised that a large number of agencies including the police, prosecutors, courts, prison service, criminal justice social work, as well as housing, health and education authorities play a role in managing the risk posed by sex offenders. The Concordat provides a framework for information sharing and joint working and can be accessed via [Concordat on the Sharing of Information on Sex Offenders](#)

### **Information Sharing Between NHS Scotland and the Police**

The Scottish Government has provided guidance in [CEL 13 \(2008\)](#)<sup>124</sup> developed with the Association of Chief Police Officers Scotland. This guidance sets out how NHS Boards should work with the Police Forces in their area to develop procedures which will ensure that health professionals employed or contracted by them have the training and support necessary to balance their responsibilities for patient confidentiality with their wider public protection duties.

Other useful points of guidance on sharing of information may also be obtained from:

The National Concordat: Sharing Information On sex Offenders -

<http://www.scotland.gov.uk/Publications/2005/10/27174205/42063>

The Management of Offenders etc (Scotland) Act 2005 -

[http://www.opsi.gov.uk/legislation/scotland/acts2005/asp\\_20050014\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2005/asp_20050014_en_1)

Data Protection Act 1998 - [http://www.opsi.gov.uk/Acts/Acts1998/ukpga\\_19980029\\_en\\_1](http://www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1)

ICO Data Protection Guide: 2009

[http://www.ico.gov.uk/for\\_organisations/data\\_protection\\_guide.aspx](http://www.ico.gov.uk/for_organisations/data_protection_guide.aspx)ICO Framework Code of practice for Sharing Personal Information: 2007

[http://www.ico.gov.uk/upload/documents/library/data\\_protection/detailed\\_specialist\\_guides/pinfo-framework.pdf](http://www.ico.gov.uk/upload/documents/library/data_protection/detailed_specialist_guides/pinfo-framework.pdf)

Data Protection Act 1998 Legal Guidance - published by the Information Commissioner and available from the Commissioner's website [www.informationcommissioner.gov.uk](http://www.informationcommissioner.gov.uk)

Human Rights Act 1998 - [http://www.opsi.gov.uk/ACTS/acts1998/ukpga\\_19980042\\_en\\_1](http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1)

Guidance and Information Material on the Human Rights Act -

<http://www.scotland.gov.uk/Topics/Justice/Civil/17838/10722>

CEL(2007) 7 - Implementation of the Multi-Agency Public Protection Arrangements (MAPPA) in relation to Registered Sex Offenders required by Sections 10 And 11 of the Management of Offenders etc (Scotland) Act 2005

[http://www.sehd.scot.nhs.uk/mels/CEL2007\\_07.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2007_07.pdf)

NHS Code of Practice On Protecting Patient Confidentiality – <http://www.ehealth.scot.nhs.uk/wp-content/documents/nhs-code-of-practice-on-protecting-patient-confidentiality.pdf>

CEL 13(2008) Information Sharing Between NHS Scotland and the Police -

[http://www.sehd.scot.nhs.uk/mels/CEL2008\\_13.pdf](http://www.sehd.scot.nhs.uk/mels/CEL2008_13.pdf)

Data Sharing: Legal Guidance For the Public Sector -

<http://www.scotland.gov.uk/Publications/2004/10/20158/45768>

### **Information to Victims of Mentally Disordered Offenders (MDO)**

The current Victim Notification Scheme (VNS) does not apply to victims of MDOs but, where the court disposal is a Compulsion Order and Restriction Order (CORO) or Compulsion Order (without a Restriction Order), the Crown Office and Procurator Fiscal Service, Victim Information and Advice (VIA) Team provide victims with contact details if they require more information about these disposals.

Where the MDO is subject to a CORO, VIA advise the victim that they can contact the Scottish Government,  
Mental Health Division (MHD/SGHD),  
Room 2N.08,  
St. Andrew's House,

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<sup>124</sup> [http://www.show.scot.nhs.uk/sehd/mels/CEL2008\\_13.pdf](http://www.show.scot.nhs.uk/sehd/mels/CEL2008_13.pdf)

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Edinburgh, EH1 3DG  
or call 0131 244 2510.

The SGHD will provide them with information about what the CORO means; and also advise them of the Tribunal's decision making role and contact information for the Tribunal if they wish to receive more information about what the Tribunal Rules say about entering the proceedings of a case.

Where the MDO is subject to a Compulsion Order (without a Restriction Order) VIA advise the victim that they can contact:

The President's Office,  
The Mental Health Tribunal for Scotland,  
1st Floor,  
Bothwell House,  
Hamilton Business Park,  
Caird Park  
Hamilton  
ML3 0QA  
or call 0800 345 7060.

The Tribunal will provide them with information about what the Tribunal Rules say about entering the proceedings of a case where the Tribunal has a decision-making role.

### **Future Provision of Information to Victims of MDOs**

The SGHD is looking at extending the current VNS legislation to include provision of certain information to victims of MDOs. Any changes made to the current legislation would need to be approved by the Scottish Parliament. Please contact the SGHD on 0131 244 1822 or [mentalhealthlaw@scotland.gsi.gov.uk](mailto:mentalhealthlaw@scotland.gsi.gov.uk) if you require further information.

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**ANNEX B**  
**INCIDENT RECORDING AND NOTIFICATION**

**It is the RMO's responsibility to report all incidents to the Scottish Government and the Mental Welfare Commission, and best practice would indicate also informing the designated MHO. A checklist of information required when reporting an incident is given below<sup>125</sup>**

Hospital authorities must advise the police immediately of an escape, serious assault, abscond or other serious incident<sup>126</sup> involving a restricted patient. Immediately thereafter, the Responsible Medical Officer ("RMO") (or duty RMO) should make a telephone report to the Scotland Government Health Directorate ("SGHD").

**Out of hours' telephone and pager numbers for SGHD officials are given<sup>127</sup>. These should be used to contact officials between the hours of 5pm and 8.30am and on weekends and on public holidays<sup>128</sup>.**

Where, exceptionally, no contact can be made with an official, a message may be left with the Security Guards at the Scottish Government, Victoria Quay (by dialling the main Scottish Government 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.

**Definition of serious incident**

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

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

or involves:

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

A serious injury can be defined as any that 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;

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<sup>125</sup> cross reference

<sup>126</sup> this did state 'significant' although definitions given are for serious incidents

<sup>127</sup> Reference to list of contacts

<sup>128</sup> Notification of Incidents Circular issued by The Scottish Government Health Directorate

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- 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 harm to the patient or others. 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.

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. Further information is given in [Annex C](#).

### **Escape**

**The hospital authorities should notify police and the RMO (or duty RMO) should notify the SGHD immediately in all instances of escape.**

The definition of an escape is distinct from an abscond, in that the restricted patient has breached a physical barrier, (for example, breaking out of a locked ward).

If **either** of the following apply:

the most recent risk assessment indicates that the patient is “high risk”; or  
the patient’s recent conduct indicates that there may be some risk to the public,

SGHD officials will contact Communication Health to arrange the issue of a short statement to the media. Unless the restricted patient is considered as “high risk”, the statement will give the patient’s name and age, the hospital concerned and a brief physical description. Other information may be included as appropriate.

The media will not automatically be notified of the crime for which the restricted patient has been sentenced. Scottish Criminal Records Office is the holder of this information and it is a breach of the Data Protection Act to disclose this information. The Crown Office will be consulted on any occasion when a photograph is to be used.

In the case of an untried prisoner on transfer to hospital who escapes, no details will be volunteered and in response to enquiries care will be taken to ensure that no information that may be prejudicial to any future proceedings is revealed. For example, it is unlikely that the escapee would be described as ‘dangerous’. This would only be done on the basis of advice from the Crown Office.

### **Abscond**

An abscond is defined as an occasion when a restricted patient:  
is absent without authority

- from a ward;
- work placement; or
- open supervision (i.e. supervision which does not require the use of physical restraints nor continued oversight); or
- exceeds his or her authorised suspension of detention from hospital (“SUS”); or
- flees from an escort.

**The hospital authorities should notify police and the RMO (or duty RMO) should notify the SGHD immediately in all instances of abscond.**

If **neither** of the following apply:

- the most recent risk assessment indicates that the patient is “high risk”; or

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- the patient's recent conduct indicates that there may be some risk to the public;

then no immediate press statement is necessary.

Once 24 hours have elapsed and the patient has not returned, a short Press Release may be issued. Communication Health will be informed of the absconding to hold against any enquiries but will not volunteer information to the media in these cases.

Where the patient's recent conduct indicates that they may present some danger to the public, the procedure for an escape will be followed.

### **Drug and alcohol misuse while in hospital**

In the case of many restricted patients, their mental illness may be adversely affected by drug and alcohol misuse and in some cases may have led, albeit indirectly, to their admission to hospital. Misuse of alcohol and/or drugs either while in hospital or while on SUS 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 urgently to the Scottish Government's Principal Medical Officer (Forensic Psychiatry) along with details of the action taken, and copied to the designated Mental Health Officer ("MHO"). Circular [NHS HDL \(2002\) 41](#)<sup>129</sup> 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.

### **Patients on Conditional Discharge**

In setting conditions of discharge, there is an expectation that the patient will adhere to those conditions and that any breach of conditions will trigger consideration of recall, or other appropriate action by the multidisciplinary team.

When any breach takes place, it must be reported to the SGHD quickly, certainly within a few days of the breach in question. If the breach constitutes a serious incident, including testing positive for illicit substances, the reporting conditions for such incidents will apply.

A statement from the RMO should follow the initial report indicating what action has been taken and if recall is considered appropriate. In some cases, it will be appropriate for the RMO to convene a CPA meeting and in those cases; the RMO should provide an interim report to SGHD.

### **Transferred Prisoners**

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. Reliance Prisoner Custody Officers, as part of Reliance Custody Services, will normally provide such escort and they have responsibility for the prisoner while attending court. Good practice suggests that hospital staff should also 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. See [Annex C](#) for further guidance.

### **Reports to the Scottish Government Health Directorate**

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<sup>129</sup> [http://www.show.scot.nhs.uk/sehd/mels/HDL2002\\_41.pdf](http://www.show.scot.nhs.uk/sehd/mels/HDL2002_41.pdf)

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

### **Incident Review**

Following an incident involving a restricted patient, Scottish Ministers may seek an Incident Review (IR). In addition, the NHS Board, hospital managers or lead clinician involved in the case, may consider it appropriate to initiate an IR. In such circumstances, the RMO should advise SGHD officials of the likelihood of an IR when submitting their report on the incident

'Critical' incidents are defined in the Mental Health & Well Being Support Group – Risk Management Report<sup>130</sup> as follows:

- death of a resident, in-patient or outpatient which is sudden or unexpected or where suicide is the most likely cause;
- homicide allegedly committed by the in-patient or outpatient;
- "incidents" including those which might have resulted in suicide or homicide, episodes where there is evidence of serious intent of self-harm, violence to others or which led to injury or disability; and
- an event where an important policy, procedure, or practice was not followed by staff leading to a detriment or potential detriment of care – so called "near misses".

The Risk Management Report<sup>131</sup>, describes a method of 'critical' Incident Review which is intended to be seen as part of the NHS Board's wider risk management processes to link all levels of the organisation – ward, clinical managers and Board managers – into a system which takes the opportunity to learn from incidents and enact any changes in practice necessary to forestall a similar incident in future. It should not be seen as a disciplinary process<sup>132</sup>.

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<sup>130</sup> NHS HDL (2000) 16

<sup>131</sup> see Forensic network report on Incident review

<http://www.forensicnetwork.scot.nhs.uk/documents/reports/CIR%20Draft%20for%20consultation.pdf>

<sup>132</sup> procedures for CIRs can be found in Annex D of the Risk Management Report, circulated under cover of NHS HDL (2000)

**NOTIFICATION OF INCIDENTS - INFORMATION REQUIRED AND RECORDED**

Details of the notification:

- Date and time of call to SGHD:
- Name of caller and designation (i.e. Doctor, Nurse, etc):
- Name of Hospital, Telephone Number and Extension:

Details of the incident being reported, including:

- events leading up to it;
- what happened;
- when;
- where; and
- how.
- If an escape or abscond, what is known about money the patient has with them

Details of the patient involved:

- Name:
- Date of Birth:
- Home Address:
- Index Offence and Section:
- Restricted status (i.e. if Life Sentence Prisoner, transferred prisoner, on remand, originally held in State Hospital and, if so, date of transfer):

**RMO's view on perceived level of risk patient poses to himself and the public** (This is of great importance **particularly** if Index Offence involved culpable homicide, murder or rape, and patient has escaped or absconded). In cases where it is not possible to get the RMO's view out of hours SGHD staff will consult the most recent risk assessment and seek the view of staff on duty.

Summary of patient's presentation:

- Summary of patient's recent conduct i.e. any worrying incidents
- Mental state on day of incident
- Medication (i.e. when last received, when next due and whether recent compliance with medication has been good)

Who has been informed:

- Have the Police been informed? If so, when? Contact name and telephone number of police to be obtained:
- Is there a victim at risk? Has consideration been given to breaching medical confidentiality to inform victim of escape or abscond?
- In the case of abscond or escape, have relatives been informed?
- Has the Mental Welfare Commission been informed?
- Has the designated MHO been informed?

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
**ANNEX C**  
**RESTRICTED PATIENTS AND THE MEDIA**

**Incidents**

In the case of an incident involving a restricted patient, if the Hospital has a PR Company and/or Press Officer, names and telephone numbers must be provided to the Scotland Government Health Directorate ("SGHD"), who will then pass this information to the Communication Health Duty Officer

The SGHD official will contact the Scottish Government Communication Health during office hours, (Communication Health Duty Officer out of hours). In cases involving remand or where permission is required for the release of a photograph of the patient, SGHD officials will liaise with the Procurator Fiscal and/or the Crown Office.

While the Responsible Medical Officer has primary responsibility for the patient's care and treatment, the Scottish Ministers have specific responsibilities in relation to restricted patients and officials must, therefore, be advised of all serious incidents involving restricted patients. SGHD 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 the Scottish Ministers have a full and up to date record of each restricted patient

Communication Health of the Scottish Government will co-ordinate all media liaison about incidents involving restricted patients. However, arrangements can be made for a NHS Board's Public Relations staff to be authorised to carry out this function in liaison with the Scottish Government. In high profile cases, a press protocol will be drawn up with contact details for all the lead agencies including social work and the police.

**The Police Role**

Hospital authorities should note that, in addition to the statement put out by Communication Health, it is always open to the police to issue to the media any supplementary material that 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 SGHD of the information provided: they in turn will advise the Communication Health.

In cases where a press release has been issued by the police, it will be the responsibility of the police to inform the media in all instances where an escapee or absconder is recaptured. Communication Health will be responsible for issuing a short statement in those cases when a press release has been issued on behalf of the Scottish Ministers and the patient has been returned to hospital.

**The Communication Health Role**

The Communication Health will inform the SGHD, 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 Communication Health will refer all enquiries relating to the abscond or escape.

**The Role of Hospital Information Officers**

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

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
**ANNEX D**  
**MISCELLANEOUS ISSUES**

**Marriage**

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

While ultimately it is for the Registrar to satisfy himself on this point, there is an onus on the 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 the Scotland Government Health Directorate (“SGHD”) are informed of any impending marriage plans to allow the Scottish Government’s Principal Medical Officer (Forensic Psychiatry) and the Responsible Medical Officer (“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 Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act<sup>133</sup>) does not necessarily mean they are incapable of understanding the nature of marriage or of giving appropriate consent.

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, the Scottish Ministers’ consent will be required for suspension of detention from hospital (“SUS”) for inpatients.

**Withholding correspondence**

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

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

Any request for the purposes of paragraph (a) of this subsection requires to be made by a notice in writing to the managers of the hospital, the RMO or the Scottish Ministers. This provision applies to all patients detained in hospital. Sections 281 to 283 of the 2003 Act, along with the regulations made under those sections<sup>133</sup>, set out further information about when the power to withhold mail does not apply, when managers of the hospital may open and inspect any postal package, the functions of the managers of the hospital and the duty to notify the Mental Welfare Commission.

**Requests from the media to interview restricted patients**

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

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<sup>133</sup> The Mental Health (Specified Persons’ Correspondence) (Scotland) Regulations 2005 (SSI 2005/408) and the Mental Health (Definition of Specified Person: Correspondence) (Scotland) Regulations 2005 (SSI 2005/466).

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

should clearly record their reasons for their conclusions and a copy of this should be sent to the SGHD.

## ANNEX E CONTACT LISTS

### RESTRICTED PATIENT TEAM CONTACT LIST

Scottish Government Health Directorate  
Mental Health Division Branch 4  
Room 2N.08  
St Andrew's House,  
Regent Road  
EDINBURGH  
EH1 3DG

#### **In Office Hours**

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

These are also the numbers to be used for enquiries to the Restricted Patient Team

Dr M Morrison	0131 244 2809
Mrs R A Toal	0131 244 2510
Mr I Taylor	0131 244 2459 (Surnames A-G)
Mrs N Brown	0131 233 2546 (Surnames H-Ma including Mc & Macs)
Mrs J McNeill	0131 244 1818 (Surnames Me-Z)
Mr G Stirling	0131 244 2512 (Surnames A-G)
Mrs J Craigie	0131 244 2457 (Surnames H-Ma including Mc & Macs)
Mrs D Mitchell	0131 244 2171 (Surnames Me-Z)
Ms L Clark	0131 244 2171 (Surnames A-Z)
Mr G Huggins	0131 244 3749
Dr D Coia	0131 244 2805

Out of Hours contact sheet is available separately.

Where exceptionally no contact can be made with an official, a message may be left with the Security Guards at Victoria Quay by dialling the main Scottish Government 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.

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
VICTIMS, WITNESSES, PAROLE AND LIFE SENTENCE DIVISION CONTACT LIST**

<b>Name</b>	<b>Patient Surname</b>	<b>Telephone Number</b>
Miss Karen Nelson	Patient Surname – A to Ge	0131 244 8543
Mrs Lorraine McDonald	Patient Surname – Gf to Mc/Mac	0131 244 8529
[To be confirmed]	Patient Surname – M to Z	0131 244 8535

The address for written contact is:

Scottish Government Criminal Justice Directorate  
St Andrews House  
Regent Road  
EDINBURGH  
EH1 3DG

**ANNEX F****GLOSSARY OF COMMONLY USED TERMS**

<b>TERM</b>	<b>EXPLANATION</b>
<b>Determinate sentence</b>	When an individual is sentenced to a specific period of imprisonment.
<b>Earliest date of liberation (EDL)</b>	EDL is the date at which those sentenced to 4 years or more (see "long term offender" below) are entitled to be released on a non parole licence on reaching the two-thirds stage of their sentence where the Parole Board has not previously directed release on parole (see PQD below).
<b>Extended sentence</b>	<p>This sentence is imposed where the court wishes to impose an additional period of post release supervision. It comprises a custodial term and an extension period. All extended sentence offenders are released into the community on licence until the end of the extended sentence period. The expiry date of the licence is dependent upon the type of offender (i.e. sexual or violent), the length of the custodial part of the sentence and the date on which the offender is released.</p> <p>This type of sentence can only apply to:-</p> <ul style="list-style-type: none"> <li>• sexual offenders (where the accused would have received a determinate custodial sentence of any length) or</li> <li>• violent offenders (where the accused would have received a determinate custodial sentence of 4 years or more).</li> </ul> <p>An extended sentence prisoner who has been recalled to custody may only be re-released into the community on the direction of a tribunal.</p>
<b>Licence</b>	All offenders, apart from those sentenced to short term sentences of less than 4 years and who are not sexual offenders, are released subject to the terms of a release licence (and supervision in the community). The licence sets out the conditions of behaviour that they must keep. Should they breach the terms of that licence, they are liable to be recalled to custody and, if not re-released, may be required to serve the remainder of their sentence in custody.
<b>Life Prisoner Tribunal (LPT)</b>	Life Prisoner Tribunal is a tribunal comprising of 3 members of the Parole Board for Scotland convened to consider the prisoner's suitability for release on licence.
<b>Life sentence</b>	Mandatory in murder cases. For other offences which do

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

	<p>not carry a sentence prescribed by law, the High Court has discretion to impose a life sentence if it feels this is appropriate. This is a matter for the sentencing judge and it is within his or her discretion as to whether to impose such a sentence.</p> <p>Where a life sentence is imposed, the sentencing judge must specify the “punishment part” of the sentence and this period must be served by the offender before release can be considered. Once the punishment part has expired, the offender’s case is referred to the Parole Board sitting as a Tribunal, to consider their suitability for release on life licence. If it does not direct release, the Tribunal will fix a date to further review the case no more than 2 years later (subject to the imposition of any further sentence(s)). A life licence remains in place for life.</p>
<b>Long term offender</b>	Offender serving a sentence of imprisonment for a term of 4 years or more.
<b>Parole Qualifying Date (PQD)</b>	Prisoners sentenced to 4 years or more qualify for consideration of early release on parole at the halfway point of their sentence. This date is known as the Parole Qualifying Date or PQD.
<b>Punishment part</b>	The period fixed by the court in life sentence cases (at the time of sentencing) to reflect retribution and deterrence. The life sentence prisoner is required to spend this period in custody before his suitability for release on life licence can be considered by the Parole Board.
<b>Short term offender</b>	Offender serving a sentence of imprisonment for a term of less than 4 years.
<b>Victim Notification Scheme</b>	Under the provisions of the statutory scheme introduced on 1 November 2004, victims or their families have a right to receive information about the release of a prisoner. They also have a right to be told when a prisoner is being considered for release and to make written representations about his/her release to the Parole Board.

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
**ANNEX G**

**LIST OF OTHER RELEVANT LEGISLATION**

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

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

**Sexual Offences Act 2003**

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

The 2003 Act applies equally to:

- mentally disordered offenders who, on 1 September 1997, were detained in a hospital under Part VI of the Mental Health (Scotland) Act 1984XXXXX or Part VI of the 1995 Act; and
- offenders dealt with under these provisions following a conviction on or after 1 September 1997.

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.

Where it is not clear whether a patient is required to register under the 2003 Act, legal advice should be sought by the patient. The Responsible Medical Officer (“RMO”) should advise the patient about this.

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

## MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS

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

### **Sex Offender Order**

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

### **Schedule 1 Offenders and Sex Offenders**

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

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.

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.

For these offenders, and others who it is considered may present a risk to women or children, the SGHD 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 SGHD.

**Testing/DNA**

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

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
ANNEX H – Risk Management Traffic Lights for all levels of Security

**In Patient Undertaking Suspension of Detention**

<b>TRAFFIC LIGHT CONTINGENCY PLAN</b>		
<b>Issue</b>	<b>Early Warning Signs (Relapse Indicators)</b>	<b>Contingency Actions</b>
<b>Symptoms of Mental illness</b>  <i>(Note patient has been symptom free for 3 years)</i>	No symptoms of psychosis	Continue with current care plan.
	Some negative symptoms and an increased level of suspiciousness	Inform RMO on next working day; Potential need to review. Convene CPA. Need to monitor and increase supervision levels.
	<b>Clear evidence of psychotic relapse.</b>	<b>Immediately advise RMO or duty consultant if out of hours. Advise Scottish Gov. Health Division (SGHD). Urgent consideration for readmission.</b>
<b>Substance Misuse</b>	Shows no signs of using illicit drugs or alcohol.	Continue with current care plan.
	Showing an interest in Alcohol	Refer to CPA. Consider 1:1 Alcohol counselling, alongside AA group Increase frequency of alcohol tests.
	<b>Positive alcohol screen. Appears intoxicated</b>	<b>. Immediately advise RMO (or duty consultant if out of hours) and SGHD. Urgent consideration for readmission</b>
<b>Engagement with ongoing anger management and sexual violence risk reduction group work programme</b>	Consistent Involvement	Continue with current care plan.
	Erratic attendance, does not engage with programmes.	Need to review through CPA process. Consider 1:1 input.
	<b>Disengages</b>	<b>Immediately advise RMO (or duty consultant if out of hours). Advise SGHD. Urgent reassessment required.</b>
<b>Violence to staff or patients</b>  <i>(Note history of extreme aggression and violence)</i>	No evidence of threats or aggression	Continue with current care plan.
	Threatening (covertly) or aggressive behaviour	Immediately advise RMO or duty consultant if out of hours. Advise SGHD. Urgent CPA review. Consider readmission
	<b>Acts or threats of violence, carrying weapon,</b>	<b>Immediately advise Police, RMO (or duty consultant if out of hours). Advise SGHD. Readmission. Urgent CPA review.</b>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<b>Risk of absconscion)</b>	Compliant with treatment, returns on time from pass	Continue with current care plan.
	Pushing boundaries; suspicious phone calls and returning late from pass	Review level of observation and free time. Consider urine drug test
	<b>Absconding from pass</b>	<b>Immediately advise Police, RMO (or duty consultant if out of hours). Advise SGHD. Readmission. Suspend care plan. Review levels of observation and levels of security. Urgent CPA review.</b>

**Sorted by risk level (anonymised real examples)**

<b>CONTINGENCY PLANS - Transfer from high to medium security</b>		
<b>PRESENTATION</b>	<b>RISK GRADING</b>	<b>AGREED RESPONSE</b>
<ul style="list-style-type: none"> <li>• Cooperative and compliant.</li> <li>• Participating in all therapeutic and occupational activity</li> <li>• Listening to the advice of staff</li> <li>• Coping with support and supervision without complaint</li> <li>• No evasion of support and supervision</li> <li>• Addressing problems directly with appropriate person or seeking help to do so</li> </ul>	<b>GREEN</b>	<ul style="list-style-type: none"> <li>• Continue with current care plan and agreed levels of supervision</li> <li>• Continue to progress increasing levels of responsibility and community access while carefully considering risks and risk management strategies to ensure public safety</li> </ul>
<ul style="list-style-type: none"> <li>• Displaying an antiauthoritarian attitude periodically</li> <li>• Making unfounded accusations against nursing staff (e.g. bullying etc.)</li> <li>• Suspicion of trying to evade supervision</li> <li>• Arguing about level of support and supervision</li> <li>• Arguing about security procedures</li> <li>• Taking problems to another to solve rather than addressing directly or seeking help to do so.</li> </ul>	<b>AMBER</b>	<ul style="list-style-type: none"> <li>• Continue with current care plan but monitor carefully</li> <li>• Attempt to address any expressed or observed concerns through discussion</li> <li>• Do not resolve the issues for xxx but assist him to resolve the issues for himself</li> <li>• Only progress community access at a slow pace while continuing to address any risk through robust risk management strategies</li> </ul>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<ul style="list-style-type: none"><li>• Active evasion of supervision</li><li>• Rejection of advice from staff</li><li>• Threats to use his "ace card" or explicit threats towards staff</li><li>• Open aggression towards staff</li><li>• Total withdrawal of cooperation</li><li>• Actual physical assault</li></ul>	<p><b>RED</b></p>	<ul style="list-style-type: none"><li>• Abandon community access</li><li>• Review presentation and increase level of observation where necessary.</li><li>• Progression of Care plan suspended until sufficient level of cooperation and compliance is resumed</li><li>• Staff will actively pursue the origins of the deterioration of the therapeutic alliance with Damien</li></ul>
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**Transition to Lesser Security**

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<b>CONTINGENCY PLANS - Transfer from high to medium security</b>		
<b>Issue</b>	<b>Early Warning Signs (Relapse Indicators)</b>	<b>Contingency Actions</b>
<b>Symptoms of Mental illness</b>	<p><b>Green:</b> No Symptoms of mental illness, compliant with medications</p> <p><b>Amber:</b> Increase in suspiciousness/ persecutory ideation, heightened state of arousal, disengagement from services</p> <p><b>Red:</b> Persecutory delusions including those about the IRA, Auditory hallucinations, hostile – believing wife to be a double ( Capgras delusion)</p>	<p>Continue current care and treatment</p> <p>RMO and Clinical Team to review current treatment</p> <p>Urgent review of care and treatment</p>
<b>Substance Misuse</b>	<p><b>Green:</b> Abstinent from alcohol and substances, maintaining peer support via AA groups/ sponsor. Good insight evidenced into impact of substance use on offending behaviour/mental health.</p> <p><b>Amber:</b> Opportunities to use alcohol or substances, and suspicions that this may be the case. Perhaps seeking or acquiring alcohol/ substances in hospital setting. Associating with known users or negative influences from the past. Diminishing insight into impact of misuse.</p> <p><b>Red:</b> Clear evidence that alcohol/substances are being consumed/ acquired or supplied to. Noticeable impact on mental health, behaviours and attitudes. Potential for violence increased.</p>	<p>Continue current care and treatment</p> <p>Clinical team to monitor and review. Need for substance misuse input from services. RMO to be advised of current situation. Associations, grounds access and suspension of detention requests to be reviewed</p> <p>Urgent review of care and treatment</p>
<b>Engagement with treatment</b>	<p><b>Green:</b> Fully engaged and compliant with treatment and services. Values input and open in communications with staff.</p>	<p>Continue current care and treatment</p>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

	<p><b>Amber:</b> Evidence of some suspiciousness/persecutory beliefs or attitude to contact. Still engaging but concerns being noted by staff. Some evidence of selective disengagement from specific services.</p> <p><b>Red:</b> Disengagement from services and clear evidence of mental state deterioration. Open suspicions and reference to delusional material.</p>	<p>RMO and Clinical Team to review current treatment</p> <p>Engage in discussing the issues he may have with particular staff/services</p> <p>Urgent review of care and treatment</p>
<p><b>Violence to staff or patients</b></p>	<p><b>Green:</b> Mental State stable, no signs of disengagement and compliant with care and treatment. Verbal responses appropriate to given situation.</p> <p><b>Amber:</b> Evidence of minor verbal hostility not in keeping with situation, or appropriate to interactions from others. Suspiciousness and feelings of persecution.</p> <p>Becoming dissatisfied with his progress/ situation.</p> <p>Previous history of fractious and difficult presentation in prison.</p> <p><b>Red:</b> Actual violence, threatened violence or verbal hostility of a serious nature.</p> <p>Conversely, becoming more withdrawn, introspective and suspicious when interacting with others.</p>	<p>Continue current care and treatment</p> <p>Clinical Team to review situation</p> <p>Engage in work to address his attitude. Review mental state, compliance with medication</p> <p>Urgent review of care and treatment</p> <p>Consider risk to self (previous hanging attempt in prison environment – 1990) as well as high potential risk of violence to others</p>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<p><b>Other Relationship issues</b></p>	<p><b>Green:</b> are both engaged in care and treatment. Insight evidenced by both into difficulties which they may encounter. Both have clear strategies in place to seek support and guide their choices. Insight is good on potential for risk should mental health become unstable.</p> <p><b>Amber:</b> sense of disgruntlement evident from both. Insight impaired into need for care and treatment – pressurising from to progress care.</p> <p>Evidence that some pressure is being placed on by his wife i.e. stating that she will not visit after a certain date or anniversary. Reduction in her contact or visits.</p> <p>Unreasonable expectations from both.</p> <p>may show more evidence of suspicions with regard to actions i.e. questioning her whereabouts, seeking out telephone contact at different or unusual hours.</p> <p><b>Red:</b> Increase in all behaviours' in green and amber section to disproportionate levels.</p> <p>y has, when extremely unwell ( and prior to the second homicide), suffered from Capgras Delusions in relation to his wife – expression of this type of material should be seen as a significant violence risk factor to or others.</p>	<p>Continue current care and treatment</p> <p>Clinical team/ RMO to work with both to achieve resolution and achievable goals identified</p> <p>Situation to be monitored</p> <p>Urgent review of care and treatment</p>
<p><b>Sexual Relationship</b></p>	<p><b>Green:</b> are accepting of impact of prescribed medications on (impotency).</p> <p>Recognition exists that risk</p>	<p>Continue current care and treatment</p>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

	<p>of violence increases significantly when non-compliant with medication.</p> <p>Realistic choices are considered and treatment outcomes accepted.</p> <p><b>Amber:</b> Significant pressure exerted by both for medication change or decrease in order to alleviate symptoms of erectile dysfunction.</p> <p><b>Red:</b> Decrease in compliance with prescribed medications to achieve sexual relations.</p> <p>Full non-compliance with medications. No discussion with RMO or clinical team. Evidence of deteriorating mental state and function.</p> <p>Unrealistic expectations from both and disengagement from services in response to advice.</p>	<p>Clinical Team/RMO to discuss alternatives – risk discussed and balance sought from both</p> <p>Urgent review of care and treatment</p>
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**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

**Community**

<b>Contingency Plan</b>		
<b>Issue</b>	<b>Early Warning Signs (Relapse Indicators)</b>	<b>Contingency Actions</b>
Symptoms of Mental Illness	<p><b>Green:</b> Compliant with prescribed medication, fully engaged in care package and mood and mental state stable.</p> <p><b>Amber:</b> Reduction in engagement with support staff and other professionals, reduction in self care and home care; brittle on interaction and poor motivation to attend planned activities.</p> <p><b>Red:</b> Elation in mood and flight of speech and thought, florid psychotic symptoms and thought disorder. Non-compliant with prescribed medication and agreed support package</p>	<ul style="list-style-type: none"> <li>Weekly from FCPN, monthly out-patient contact with Dr Smith Fortnightly contact with social worker and daily support from Support provider.</li> <li>Increased frequency of FCPN contact, liaison with support staff. Urgent medical assessment of mood and mental state and testing procedures – alcohol breath testing and drug urine testing. CPA meeting to discuss intervention and package. Update Scottish Government.</li> <li>Immediate Medical review of mood and mental state; review of legal status, level of observation, level of security and level of risk. Referral to appropriate in-patient environment (Rowanbank Clinic unless otherwise agreed).</li> </ul>
Alcohol misuse	<p><b>Green:</b> Compliant with testing procedures – providing negative random breath tests. No issues with alcohol and stable mental state.</p> <p><b>Amber:</b> signs in presentation or environment, no firm evidence of alcohol misuse, but concern raised by staff.</p> <p><b>Red:</b> Evidence of alcohol use, unwilling to respond to advice and intervention. Non-engagement with support package.</p>	<ul style="list-style-type: none"> <li>Random breath testing, observation by all staff for evidence of substance misuse in home environment and presentation. 3 monthly liver function tests (LFTs) at GP surgery.</li> <li>Increase levels of support from FCPN and support staff, assessment of mood and mental state, CPA to discuss intervention and support. Consider increasing frequency of LFTs. Update Scottish Government.</li> <li>Immediate Medical assessment of mood and mental state and review of legal status. Consider re-call to hospital.</li> </ul>
Engagement with treatment	<p><b>Green :</b> Fully engaged with agreed care package, attending structured activities and professional appointments</p> <p><b>Amber:</b> occasionally misses planned appointments – but responds to intervention and advice. Increased complaining and attempts to negotiate interventions or plans.</p> <p><b>Red:</b> dis-engaged from agreed support package. Non – attendance at planned</p>	<ul style="list-style-type: none"> <li>Continue care package as planned and monthly contact with O.T staff</li> <li>Increased contact and support from support staff to attend appointments. Assess reason why appointments missed. Visit next day if misses appointment. Update Scottish Government</li> <li>Urgent CPA to discuss intervention and placement. Urgent Medical assessment of mood and mental state and review</li> </ul>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

	<p>appointments or activities. Avoiding professionals. Deterioration in mood and mental state.</p>	<p>of legal status, consider re-call to hospital.</p>
<p>Offending Behaviour</p>	<p><b>Green:</b> No concerns or issues. Compliant with prescribed medication and support package and stable in mood and mental state</p> <p><b>Amber :</b> Change in mood and mental state, alcohol use, decrease in Engagement with agreed package. Involvement in new relationship.</p> <p><b>Red:</b> Offending behaviour – index offence: 1999 – assault to severe injury and permanent disfigurement.</p>	<ul style="list-style-type: none"> <li>• Continue care package as planned.</li> <li>• Increased contact with FCPN and Support staff. CPA meeting to discuss package with multi-agency team and explore any stressors. Discuss how best to manage information-sharing with new partner</li> <li>• Medical assessment of mood and mental state and review of legal status. Re-call to hospital.</li> </ul>
<p>Non-Compliance with medication</p>	<p><b>Green:</b> No issues or concerns.</p> <p><b>Amber:</b> Ongoing complaints about medication or side effect profile and seeking to negotiate medication. Evidence of changes in clinical presentation</p> <p><b>Red:</b> Non-compliance with prescribed medication and not responding to advice or intervention. Deterioration in mood and mental state.</p>	<ul style="list-style-type: none"> <li>• Continue with agreed care package.</li> <li>• Increased contact with FCPN, liaison with support staff and CPA. Introduce supervised medication administration and blister packs to aid monitoring.</li> <li>• Immediate medical assessment of mood and mental state, review of placement and legal status and consider re-call to hospital.</li> </ul>

MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS  
ANNEX I – CPA Audit checklist

NHS Lanarkshire Mental Health Services <b>Lanarkshire Forensic Service</b> <b>Care Programme Approach Checklist Audit</b> <b>October 2009</b>	
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<b>CHI Number</b>		<b>Date of Audit</b>	(dd/mm/yyyy)
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<b>Date of Admission / Initial Contact</b>	(dd/mm/yyyy)	<b>Date Initial CPA meeting</b>	(dd/mm/yyyy)
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**Section 1 - Requirements under Care Programme Approach**

<b>1. Initial CPA meeting held within 6 weeks after admission?</b> <i>CEL 13 (2007)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>2. CPA review meeting held within last 6 months?</b> <i>CEL 13 (2007)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3. Evidence of Responsible Medical Officer with continued overall responsibility for care of the patient?</b> <i>CEL 13 (2007)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>4. Evidence of Care Programme Approach Care Co-ordinator managing case?</b> <i>CEL 13 (2007)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>5. Structured clinical risk assessment and management document completed? e.g. HCR 20, RSVP</b> <b>Risk indicators identified?</b> <i>CEL 13 (2007)</i>  <b>Has the assessment been updated in the past year?</b> <i>(Guidance from Risk Management Authority)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>6. Contingency plan (Traffic Light Approach) in place?</b> <i>CEL 13 (2007)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>7. Reporting system for breaching conditions completed?</b> <i>CEL 13 (2007)</i>  <b>Has the system for reporting breaches been followed?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<i>Memorandum of procedure for restricted patients</i>	
<b>8. Is there evidence of multi-disciplinary working within careplan? e.g. CPA Careplan</b> <i>CGRM Standards 2005 (NHS QIS) 2a4</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Section 2 - Requirements for Restricted Patients**

<b>1. Is there evidence of a Care Plan?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>2. If yes above, is the Care Plan dated?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3. Has the Care Plan been signed by a Clinician?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>4. Does the Care Plan have the review date recorded?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>5. Have all details within the Legal Status section been completed?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>6. Have problems / needs of the patient been identified?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>7. Is there evidence that the patient has had involvement?</b> <i>Memorandum of procedure for restricted patients</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Section 3 - Requirements under Multi Agency Public Protection Arrangements (MAPPA)**

<b>1. A MAPPA Notification/Referral completed?</b> <i>CEL 19 (2008)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
--	--

Please ensure that this form is fully completed and returned to:  
**Iain MacKenzie, Team Leader,  
 Lanarkshire Forensic Service,  
 Bute Building, Hartwoodhill Hospital, Shotts, ML7 4LA**

**Outcomes Based Variance Analysis Tool**

**Section 1 - Requirements under Care Programme Approach (CPA)**

<p><b>1. Initial CPA meeting held within 6 weeks after admission?</b> <i>CEL 13 (2007)</i></p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> Not Relevant  <input type="checkbox"/> RMO unavailable  <input type="checkbox"/> Partners availability  <input type="checkbox"/> Complex Ward Diary  <input type="checkbox"/> Other (please specify)</p>
<p><b>2. CPA review meeting held within last 6 months?</b> <i>CEL 13 (2007)</i></p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> Not Relevant  <input type="checkbox"/> RMO unavailable  <input type="checkbox"/> Partners availability  <input type="checkbox"/> Complex Ward Diary  <input type="checkbox"/> Other (please specify)</p>
<p><b>3. Evidence of Responsible Medical Officer with continued overall responsibility for care of the patient?</b> <i>CEL 13 (2007)</i></p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> CPA documents not available  <input type="checkbox"/> CPA documents not clear  <input type="checkbox"/> Other (please specify)</p>
<p><b>4. Evidence of Care Programme Approach Care Co-ordinator managing case?</b> <i>CEL 13 (2007)</i></p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> CPA documents not available  <input type="checkbox"/> CPA documents not clear  <input type="checkbox"/> Other (please specify)</p>
<p><b>5. Structured clinical risk assessment and management document completed? e.g. HCR 20, RSVP</b> <b>Risk indicators identified?</b></p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> Assessment not complete  <input type="checkbox"/> Not Required</p>

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

<p>CEL 13 (2007)  <b>Has the assessment been updated in the past year?</b>  <i>(Guidance from Risk Management Authority)</i></p>	<p><input type="checkbox"/> Assessment paperwork not available  <input type="checkbox"/> Other (please specify)</p>
<p><b>6. Contingency plan (Traffic Light Approach) in place?</b>          CEL 13 (2007)</p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> Assessment not complete  <input type="checkbox"/> Not Required  <input type="checkbox"/> Assessment paperwork not available  <input type="checkbox"/> Other: (please specify)</p>
<p><b>7. Reporting system for breaching conditions completed?</b>          CEL 13 (2007)</p> <p><b>Has the system for reporting breaches been followed?</b>  <i>Memorandum of procedure for restricted patients</i></p>	<p><b>If no, reason:</b></p>
<p><b>8. Is there evidence of multi-disciplinary working within careplan? e.g. CPA Careplan</b>          CGRM Standards 2005 (NHS QIS) 2a4</p>	<p><b>If no, reason:</b></p> <p><input type="checkbox"/> In process of being developed  <input type="checkbox"/> Paperwork not available  <input type="checkbox"/> Other (please specify)</p>

**Section 2 – Requirements for Restricted Patients**

<p><b>1. Is there evidence of a Care Plan?</b>  <i>Memorandum of procedure for restricted patients</i></p>	<p><b>If no, reason:</b></p>
<p><b>2. If yes above, is the Care Plan dated?</b>  <i>Memorandum of procedure for restricted patients</i></p>	<p><b>If no, reason:</b></p>
<p><b>3. Has the Care Plan been signed by a Clinician?</b>  <i>Memorandum of procedure for restricted patients</i></p>	<p><b>If no, reason:</b></p>
<p><b>4. Does the Care Plan have the review date recorded?</b>  <i>Memorandum of procedure for restricted patients</i></p>	<p><b>If no, reason:</b></p>
<p><b>5. Have all details within the Legal Status section been completed?</b>  <i>Memorandum of procedure for restricted patients</i></p>	<p><b>If no, reason:</b></p>



**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**  
Pre – CPA Minute and Other Third Party Information

Name	
Date of Birth	
CHI Number	
Ward	
Date of Pre-CPA	

1. List of those in attendance

2. Apologies

3. Discussion

4. Other third party issues

5. Action points

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**  
**CPA Standard Documentation**

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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Patient Details			
Name			
Date of Birth			
Permanent Address			
Telephone Number			
CHI Number			
Sex			
Occupation			
Marital Status			
Religion			
Ethnic Origin (Standard Codes)			
First Language			
Communication Assistance Required (Yes/No)			
Service Details			
Hospital			
Date of Admission			
Ward			
Phone Number			
Responsible Local Authority			
Responsible Health Board			
Relationship Details			
Named Person :			
Relationship to Patient			
Address			
Phone Number			
Next of Kin:			
Relationship to Patient			
Address			
Phone Number			
Useful Contacts			
Designation:	Name:	Office Hours Contact Number	Out of Hours Contact Number
Key Worker/ Care Coordinator			
RMO			
MHO			
General Practitioner			
CPA Coordinator			
Scottish Government			

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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<b>Legal Details</b>	
Legal Status & Section	
Date of Conviction/Insanity Acquittal (if appropriate)*	
Date order began *	
Date of most recent statutory review*	
Next 2 month statutory review period *	<b>From:</b> <b>To:</b>
<b>RMO</b> details	
<b>MHO</b> details	
<b>For Determinate Sentences</b> Liberation date/ Parole Qualifying date	
<b>For Life Sentences</b> Punishment part	
<b>Index Offence</b>	
Details of Index Offence	
Brief Statement	
<b>Subject to Requirements of other Legislation</b>	
Notifiable under part 2, Sexual Offences Act 2003 (2) Yes / No *	
If yes to above – Detail offence(s) and period of order *	
Schedule 1 Notification Yes/ No *	
<b>MAPPA Status</b>	
Is patient subject to MAPPA ? (Yes/ No)	
Local Office	
MAPPA Coordinator Name	
Contact Number	
Level	
<b>Driving Licence</b>	
Does patient hold a current driving licence	
If yes, have DVLA been informed of current status	
Specify any restrictions in place	

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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Compulsory Treatment Details				
Compulsory Measures authorised under Mental Health (Care and Treatment) (Scotland) Act 2003				
Date of T2 / T3 Certificate				
Description of Treatments authorised by T2 or T3 certificates				
Conditions Set for Conditional Discharge				
Safeguarding Children				
Is the patient likely to have contact with own or other children ?				
Child Protection Liaison Officer	Name		Contact No	
Outcome of Child Protection Case Review				
Safeguarding Adults at Risk				
Is the patient likely to have contact with an adult at risk of harm?				
Adult Protection Coordinator	Name		Contact No	
Outcome of Adult Protection Case Conference				
Advance Statement				
Does the patient have an advance statement?				
Consent to CPA				
Has the Care Programme Approach been explained to the patient?				
Has the patient signed a CPA Consent Form?				

**MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS**

**Care Plan Dated: 00/00/00**

**Patient Name:**

**Date of Birth: 00/00/00**

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<b>Details of those involved in CPA</b>		
<b>Name</b>	<b>Contact Address</b>	<b>Telephone</b>
	<b>Forensic Consultant Psychiatrist</b>	
	<b>Keyworker (Nursing)</b>	
	<b>Social Work (MHO)</b>	
	<b>Ward Manager</b>	
	<b>Psychology</b>	
	<b>Advocacy</b>	
	<b>Occupational Therapy</b>	
	<b>The Scottish Government (Senior Casework Manager)</b>	
	<b>Social Work (Other)</b>	

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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*This section sets out the identified needs in relation to Medical Treatment for mental disorder, other forms of treatment, needs in respect of current planned community care, risk management issues and should document any unmet needs. The table is populated with an example. This is not an exhaustive list and additional/alternative headings may be included, for example, media or victim issues*

Record of identified needs and plan to meet these				
Need	Objective	Action Plan	By Whom	N/D/ C/O
Address mental health issues				
Address physical health issues				
Address offence related therapeutic issues				
Address relationship issues				
Address occupational and recreational issues				
Address self care issues				
Assess self control and acceptance of personal responsibility				
Address other risk management issues				
Develop future plans				
<b>Column 5 : N – New, D- Discontinued, C – Continued (With change), O – Ongoing (No changes)</b>				

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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Risk Management/Contingency Plan			
Category	Relapse Indicators/Early Warning Signs		Contingency Actions
Symptoms of mental illness	Green		
	Amber		
	Red		
Substance misuse	Green		
	Amber		
	Red		
Engagement with treatment	Green		
	Amber		
	Red		

<b>RISK SUMMARY</b>		
<b>Offending History</b>		
<b>Index Offence</b>		
<b>Other Offences</b>		
<b>Strengths and protective factors</b>		
1.		
2.		
3.		
4.		
<b>History of .....</b>		
	<b>Yes/No</b>	<b>If yes - Brief Details</b>
Violence		
Sexual Aggression		
Fire Raising		
Hostage Taking		
Use of Weapons		
Alcohol or Substance misuse		
Absconding/Escape		
Self Harm		
Harm to Children		
Harm to Vulnerable Adults		
Other factors of relevance		
<b>Current Risk Status</b>		
<b>Setting</b>	<b>Likelihood, imminence, frequency &amp; severity of harmful behaviour towards whom &amp; under what circumstances</b>	
In Hospital		
Escorted in Community		
Unescorted in Community		
Other		

<b>RISK SUMMARY (continued)</b>		
<b>Victim Considerations</b>		
	<b>Yes/No</b>	<b>Details</b>
Is/are there specific person(s) whom the patient poses a risk to?		
Does the patient pose a potential risk to certain types of people? (e.g. children, women, vulnerable adults)		
<b>Monitoring &amp; Supervision Requirements</b>		
<b>In Hospital</b>	Nursing observation level	
	Restrictions regarding contact with staff	
	Restrictions regarding access to indoor areas	
	Restrictions regarding access to outdoor areas	
	Restrictions on telephone use and letters	
	Room searches	
	Personal searches	
	Alcohol/drug testing	
	Access to sharps & other utensils	
	Visitors	
Other hospital requirements		
<b>In the Community</b>	Escort requirements	
	Special considerations for staff visiting patient	
	Special consideration for out-patient appointments	
	Alcohol/drug testing	
	Other community requirements	

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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**Minutes of CPA meeting**

**Present:**

**Apologies:**

**Summary of discussion (Date)**

Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

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<b>Patient Views</b> (To be completed by keyworker on receipt of minutes and kept in notes)	
<b>Patient Comments on Care Plan</b> (If no comment made – please state)	
<b>Staff signature:</b>	
<b>Patients signature:</b>	
<b>Date of discussion:</b>	
<b>The Care Programme has been verbally agreed by those concerned</b>	
<b>Patient</b>	
<b>RMO</b>	
<b>MHO</b>	
<b>Care Coordinator</b> (on behalf of all consulted)	
<b>Arrangements for next CPA</b>	
<b>Date</b>	
<b>Time</b>	
<b>Venue</b>	

<b>Copy of details from ADVANCE STATEMENT made under the Mental Health (Care &amp; Treatment) (Scotland) Act 2003</b>	
Name of person making this statement:	
<b>1. I would like to receive the following treatments:</b>	
<b>2. I would not like to receive the following treatments:</b>	
<b>3. Details of witness:</b>	
Full name of witness:	
Address of witness:	
Designation of witness:	
The following is a list of the names of everyone who has a copy of this statement:	

## Suspension of Detention Plan

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Ward \_\_\_\_\_ Status \_\_\_\_\_  
 RMO \_\_\_\_\_ Date \_\_\_\_\_ of \_\_\_\_\_  
 Submission \_\_\_\_\_

**The goal of this Suspension of Detention programme is to allow you to practice having time out of the ward with staff. It is about showing that you can cope with one stage before moving to the next.**

### Definitions

**Suspension of detention (SUS);** time outwith the unit within the boundaries of the hospital grounds, time outwith the hospital grounds, area identified within the pass plan

**Identified areas;** agreed by patient and the Clinical Team as locations useful to ongoing rehabilitation.

**Escorted;** accompanied by a member of Orchard Clinic staff, or student where approved by the clinical team. Escort will be carried out following the relevant policy and any instructions specified in the pass plan, utilising two way radio or mobile telephone. Patients may progress to family escort - this will be specified in the programme.

**Duration / Frequency;** Individual must return to the ward for at least 30mins between separate SUS. The agreed time may be divided into shorter durations of SUS, but total must not exceed the agreed limit.

**The pass plan will be reviewed every fortnight within the clinical team meeting and progression agreed as appropriate.**

### Current Suspension of Detention Program

Existing Approved Pass and Leave of Absence

Type of Escort	Location
<b>Unescorted</b>	<b>None</b>
<b>Escorted (with a member of staff)</b>	<b>None</b>

### Suspension of Detention Program

Stage	Additions/changes to previous stage pass/leave of absence (to be reviewed every fortnight within the clinical team meeting with progression agreed as appropriate) <b>**It is expected that you will use your suspension of detention out with group/individual session times**</b>	Clinical Team Signature	Date agreed
1	<b>1 x 15min escorted pass daily</b> in hospital grounds <b>excluding</b>		
2	<b>1 x 30min escorted pass daily</b> in hospital grounds, <b>excluding</b>		
3	<b>1 x 60min escorted pass daily</b> in hospital grounds, <b>excluding</b> . Can be taken as two 30mins.		

## Suspension of Detention Plan

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Ward \_\_\_\_\_ Status \_\_\_\_\_  
 RMO \_\_\_\_\_ Date \_\_\_\_\_ of \_\_\_\_\_  
 Submission \_\_\_\_\_

**The goal of this Suspension of Detention programme is to allow you to practice having time out of the ward with staff. It is about showing that you can cope with one stage before moving to the next.**

### Definitions

**Suspension of detention (SUS);** time outwith the unit within the boundaries of the hospital grounds, time outwith the hospital grounds, area identified within the pass plan  
**Identified areas;** agreed by patient and the Clinical Team as locations useful to ongoing rehabilitation.

**Escorted;** accompanied by a member of Orchard Clinic staff, or student where approved by the clinical team. Escort will be carried out following the relevant policy and any instructions specified in the pass plan, utilising two way radio or mobile telephone. Patients may progress to family escort - this will be specified in the programme.

**Duration / Frequency;** Individual must return to the ward for at least 30mins between separate SUS. The agreed time may be divided into shorter durations of SUS, but total must not exceed the agreed limit.

**The pass plan will be reviewed every fortnight within the clinical team meeting and progression agreed as appropriate.**

### Current Suspension of Detention Program

Existing Approved Pass and Leave of Absence

**Escorted**            **1 x 90min escorted pass daily** (in hospital grounds, **excluding** )-  
 Accessing Hive, hospital shop, walk in grounds, veranda club etc  
 This may also be taken as 1 x 1hr and 1 x 30 mins or 3 x 30 mins.  
 Male or female escort

**Unescorted**        **None**

### Suspension of Detention Program

Stage	Additions/changes to previous stage pass/leave of absence (to be reviewed every fortnight within the clinical team meeting with progression agreed as appropriate) <b>**It is expected that you will use your suspension of detention out with group/individual session times**</b>	Clinical Team Signature	Date agreed
1	<b>With male or female escort</b> <ul style="list-style-type: none"> <li>• <b>Add 1 x 1 hour escorted pass to _____once weekly</b> (shops, library, coffee etc)</li> <li>• <b>Increase escorted leave within hospital grounds (excluding) to 2 x 1 hour escorted pass in hospital grounds daily.</b> Can be taken as 2hours, 2 x 60min or in 30min periods as required. (Suggestions for pass; consider groups at the Hive, walk, shop, pool, referral to physiotherapy gym)</li> </ul>		
2	<ul style="list-style-type: none"> <li>• <b>Add in 1 x 1 hour escorted pass to____ twice weekly</b> (shops, library, coffee)</li> <li>• <b>As appropriate on a weekly basis add in 3 hours escorted pass specifically for the purpose of attending hospital based</b></li> </ul>		

	<p><b>groups/projects</b> i.e. woodwork, physiotherapy gym groups</p> <p><b>Continue</b></p> <ul style="list-style-type: none"> <li>• <b>Continue escorted leave within hospital grounds (excluding) of 2 x 1 hour escorted pass in hospital grounds daily</b></li> </ul>		
3	<ul style="list-style-type: none"> <li>• <b>Add in 1 x 1 hour escorted pass to _____daily</b> (shops, library, coffee)</li> </ul> <p><b>Continue</b></p> <ul style="list-style-type: none"> <li>• <b>As appropriate on a weekly basis add in 3 hours escorted pass specifically for the purpose of attending hospital based groups/projects</b> i.e. woodwork, physiotherapy gym groups</li> <li>• <b>Continue escorted leave within hospital grounds (excluding) of 2 x 1 hour escorted pass in hospital grounds daily</b></li> </ul>		
4	<p><b>Add in</b></p> <ul style="list-style-type: none"> <li>• <b>3 hours weekly escorted pass with Out and About group</b> (Occupational Therapy facilitated group within _____ area - accessing community resources i.e. art galleries, city parks etc)</li> </ul> <p><b>Continue</b></p> <ul style="list-style-type: none"> <li>• <b>1 x 1 hour escorted pass to _____ daily</b> (shops, library, coffee)</li> <li>• <b>As appropriate on a weekly basis add in 3 hours escorted pass specifically for the purpose of attending hospital based groups/projects</b> i.e. woodwork, physiotherapy gym groups</li> <li>• <b>Continue escorted leave within hospital grounds (excluding ) of 2 x 1 hour escorted pass in hospital grounds daily</b></li> </ul>		

## Suspension of Detention Plan

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Ward \_\_\_\_\_ Status \_\_\_\_\_  
 RMO \_\_\_\_\_ Date \_\_\_\_\_ of \_\_\_\_\_  
 Submission \_\_\_\_\_

**The goal of this Suspension of Detention programme is to allow you to practice having time out of the ward with staff. It is about showing that you can cope with one stage before moving to the next.**

### Definitions

**Suspension of detention (SUS);** time outwith the unit within the boundaries of the hospital grounds, time outwith the hospital grounds, area identified within the pass plan  
**Identified areas;** agreed by patient and the Clinical Team as locations useful to ongoing rehabilitation.

**Escorted;** accompanied by a member of Orchard Clinic staff, or student where approved by the clinical team. Escort will be carried out following the relevant policy and any instructions specified in the pass plan, utilising two way radio or mobile telephone. Patients may progress to family escort - this will be specified in the programme.

**Duration / Frequency;** Individual must return to the ward for at least 30mins between separate SUS. The agreed time may be divided into shorter durations of SUS, but total must not exceed the agreed limit.

**The pass plan will be reviewed every fortnight within the clinical team meeting and progression agreed as appropriate.**

### Current Suspension of Detention Program

Existing Approved Pass and Leave of Absence

Escorted	<ul style="list-style-type: none"> <li>• 1 x 1 hour five times a week to physiotherapy gym</li> <li>• 1 x 1 hour daily to church centre, hospital shop or walk around grounds</li> <li>• 2hour 2 x week on hospital grounds for specified activities (eg. pool competition)</li> <li>• Ward Groups – facilitated fortnightly- Walking Group (3 hours weekly) and Fishing Group (6 hours monthly) escorted within Lothian</li> <li>• 4 hours once a fortnight to visit local cinema escorted</li> <li>• Escorted attendance at sports centres in Scotland to play hospital 5 a side football. (Max 8 hours twice per month)</li> <li>• Escorted outing to visit ___ in ___ 1 x month for 4 hours</li> </ul>
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Unescorted	<ul style="list-style-type: none"> <li>• 1 hour unescorted to ____ 2 x week</li> <li>• Weekly attendance at hospital 5-side football at _____, _____ (Friday 11.30-3.00). Ward staff to take to drop of at _____, _____ and collect from there. Unescorted whilst at group.</li> <li>• Unescorted to _____ 1 hour daily</li> <li>• _____ gym unescorted 3 x 2 hours weekly</li> <li>• Attendance at swimming pool unescorted- 3 hours weekly (will cycle or bus there)</li> <li>• Unescorted on hospital grounds to 2 x 1 hour daily ( 1 hour in am , 1 hour in pm)</li> <li>• Unescorted to _____ town centre for 3 hours 1 x week (café, music shops, internet)</li> <li>• Weekly attendance at college 8-6pm for course</li> </ul>
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**Suspension of Detention Program**

Stage	Additions/changes to previous stage pass/leave of absence (to be reviewed every fortnight within the clinical team meeting with progression agreed as appropriate) <b>**It is expected that you will use your suspension of detention out with group/individual session times**</b>	Clinical Team	Date agreed
<b>1</b>	<b>Change current unescorted on hospital grounds to unlimited with a purpose</b> (e.g walking, pool, computing) <b>Change attendance at 5-side- football to unescorted</b>		
<b>2</b>	Add any specific arranged study groups at college up to <b>2 x 4 hours a week unescorted</b>		
<b>3</b>	<b>Increase unescorted</b> attendance at Commonwealth pool to <b>2 x 3 hours week</b>		
<b>4</b>	<b>Change 4 hours escorted fortnightly to cinema to 4 hours weekly unescorted</b>		
<b>5</b>	<b>Increase unescorted attendance at _____ gym to 3 hours 3 x week</b>		
<b>6</b>	<b>Change unescorted weekly to town to 3 hours daily with a purpose</b> (e.g. shops, gardens, bowling)		
<b>7</b>	<b>Increase escorted leave to up to 8 hours daily within Scotland</b> for specific rehabilitation purposes (e.g. unit groups, outings such as football, appointments)		

## MAPPA NOTIFICATION FORM

Details from restricted patient Care Plan Dated: 00/00/00

Patient Name: \_\_\_\_\_ Date of Birth: 00/00/00

Restricted patient notification to MAPPA			
CJA area			
MAPPA Coordinator	Name		
	Address		
<input type="checkbox"/>	<b>Notification Only</b>		
<input type="checkbox"/>	<b>Notification accompanied by referral to level 2 (attach the referral form)</b>		
<input type="checkbox"/>	<b>Notification accompanied by referral to level 3 (attach the referral form)</b>		
<input type="checkbox"/>	<b>Referral to follow</b>		
Patient Details			
Name			
Date of Birth			
Permanent Address			
Previous significant address			
Sex		Ethnic Origin (Standard Codes)	
CHI number		Unit number	
Prison number (if known)		SCRO number(if known)	
PNC number (if known)		ViSOR number(if known)	
Notifying Service Details			
RMO details (name address telephone no.)			
MHO details (name address telephone no.)			
Police contact details	(if not known, request for police contact to be identified)		
Responsible Local Authority			
Responsible Health Board			
Legal Details			
Legal Status & Section			
Sentencing court			
Date of Conviction/Insanity Acquittal *			
Date order began *			
Date of previous annual review*			
Date of next annual review *			
<b>MANAGEMENT STAGE</b>	<input type="checkbox"/> Interim Compulsion Order <input type="checkbox"/> Escorted SUS <input type="checkbox"/> Unescorted SUS <input type="checkbox"/> Conditional Discharge		
<b>For Determinate Sentences</b> Earliest Liberation date/ Parole Qualifying date			
<b>For Life Sentences</b> Punishment part			
Notifiable under part 2, Sexual Offences Act 2003 (2) Yes / No			
If yes to above – Detail offence(s) and period of order			
Schedule 1 Notification Yes/ No			

Signature \_\_\_\_\_

Date of completion \_\_\_\_\_

Date of notification \_\_\_\_\_

## MAPPA REFERRAL FORM

Details from restricted patient Care Plan Dated: 00/00/00

Patient Name: \_\_\_\_\_ Date of Birth: 00/00/00

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Restricted patient referral to MAPPA			
MAPPA Local Office			
MAPPA Coordinator	Name		
	Contact Number		
Suggested Level			
<b>MANAGEMENT STAGE</b>			
Notifiable under part 2, Sexual Offences Act 2003 (2) Yes / No *			
If yes to above – Detail offence(s) and period of order *			
Schedule 1 Notification Yes/ No *			
Patient Details			
Name			
Date of Birth			
Permanent Address			
Previous significant address			
CHI number			
Unit number			
Prison number			
PNC number			
SCRO number			
ViSOR number			
Sex			
Ethnic Origin (Standard Codes)			
Referring Service Details			
Hospital			
Ward			
Phone No			
Responsible Local Authority			
Responsible Health Board			
Clinical Team			
Useful Contacts			
Designation:	Name:	Office Hours Contact Number	Out of Hours Contact Number
Key Worker/ Care Coordinator			
RMO			
MHO			
General Practitioner			
CPA Coordinator			
Scottish Government			

**MAPPA REFERRAL FORM**

**Details from restricted patient Care Plan Dated: 00/00/00**

**Patient Name:**

**Date of Birth: 00/00/00**

**Page \_ of 6**

<b>Legal Details</b>	
Legal Status & Section	
Sentencing court	
Date of Conviction/Insanity Acquittal *	
Date order began *	
Date of previous annual review*	
Date of next annual review *	
RMO details *	
MHO details *	
<b>For Determinate Sentences</b> Earliest Liberation date/ Parole Qualifying date	
<b>For Life Sentences</b> Punishment part	

## MAPPA REFERRAL FORM

Details from restricted patient Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

Page \_ of 6

### Risk Summary

Offending History		
<b>Index Offence</b>		
<b>Other Offences</b>	<i>Highlight all violent/sexual offences Highlight all offences or concerns relating to children young persons. Detail any children within or outside the family who may be at risk with names and dates of birth</i>	
History of ...		
	Yes/No	Brief Details
Violence		<i>Include a list of all known incidents of violence to staff of any agency</i>
Sexual Aggression		
Fire Raising		
Hostage Taking		
Use of Weapons		
Alcohol or Substance misuse		
Absconding/Escape		
Self Harm		
Other factors of relevance		<i>(e.g. past child protection referral or vulnerable adult referral)</i>

Current Risk Status	
Setting	Likelihood, imminence, frequency & severity of harmful behaviour towards whom & under what circumstances
In Hospital <i>List all known concerning incidents whilst in an institution (e.g. prison or hospital)</i>	
Escorted in Community	
Unescorted in Community	
Other	
Conditional Discharge Conditions	

## MAPPA REFERRAL FORM

Details from restricted patient Care Plan Dated: 00/00/00

Patient Name:

Date of Birth: 00/00/00

Page \_ of 6

Medication		
	Yes/No/not applicable	Comment
Is the patient prescribed medication with out which his/her risk may be increased?		
Is the patient compliant with this medication?		

Victim Considerations		
	Yes/No	Details
Is/are there specific person(s) whom the patient poses a risk to?		
Does the patient pose a potential risk to certain types of people? (e.g. children, women, vulnerable adults)		

Monitoring & Supervision Requirements		
<b>In Hospital</b>	Nursing observation level	
	Restrictions regarding contact with staff	
	Restrictions regarding access to indoor areas	
	Restrictions regarding access to outdoor areas	
	Restrictions on telephone use and letters	
	Room searches	
	Personal searches	
	Alcohol/drug testing	
	Access to sharps & other utensils	
	Visitors	
Other hospital requirements		
<b>In the Community</b>	Escort requirements	
	Special considerations for staff visiting patient	
	Special consideration for out-patient appointments	
	Alcohol/drug testing	
	Other community requirements	

**MAPPA REFERRAL FORM**

**Details from restricted patient Care Plan Dated: 00/00/00**

**Patient Name:**

**Date of Birth: 00/00/00**

**Page \_ of 6**

**Additional Comments**

*Please give details of any other information held which may assist with public protection ( e.g. details of any known violent/sexual behaviour, previous allegations, domestic abuse incidents)*

**MAPPA REFERRAL FORM**

Details from restricted patient Care Plan Dated: 00/00/00

Patient Name: Date of Birth: 00/00/00

Page \_ of 6

Risk Management /Contingency Plan		
Issue	Early Warning Signs (Relapse Indicators)	Contingency Actions
examples	<p><b>Green :</b></p> <p><b>Amber:</b></p> <p><b>Red:</b></p>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
examples	<p><b>Green:</b></p> <p><b>Amber :</b></p> <p><b>Red:</b></p>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>
examples	<p><b>Green :</b></p> <p><b>Amber :</b></p> <p><b>Red :</b></p>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>

**RESTRICTED MEDICAL  
RMO SUPERVISOR'S REPORT**

**Patient Name:**

**Date of Birth: 00/00/00**

Page \_ of 2

**REPORT TO THE SCOTTISH MINISTERS FROM THE RMO SUPERVISOR OF A  
CONDITIONALLY DISCHARGED RESTRICTED PATIENT**

In completing this report, please refer to the Memorandum of Procedure. In particular, please note the requirement for immediate reporting of adverse incidents and the procedure to be followed should recall be considered.

Patient Details	
Name	
Address	
Conditional Discharge Details	
Date of Conditional Discharge	
Reporting interval	monthly
Recent Changes or proposed changes to Conditions of discharge	
Any other changes in circumstances	
Meetings since last report	
Dates of interviews since last report :	
Dates of CPA meetings since last report Relationship to Patient	

Diagnosis and treatment	
Current diagnosis and treatment :	
Mental state and any changes since last report	

**RESTRICTED MEDICAL  
RMO SUPERVISOR'S REPORT**

**Patient Name:**

**Date of Birth: 00/00/00**

**Page \_ of 2**

<b>Risk Management</b>	
Date of most recent update of the risk management plan	
Any adverse incidents since last report :	
Any change to level of risk to patient or others and action taken	
Any media/victim issues since last report	
Any issues regarding drugs/alcohol since last report	
Dates and results of drug/alcohol testing ( if relevant)	

<b>Other relevant issues or additional details</b>

Name and address of Supervisor

Signed: ..... Date .....

To be returned on the last day of      to:

Scottish Government Health Directorate,  
Mental Health Division,  
Room 2N.08,  
St Andrew's House,  
Edinburgh,  
EH1 3DG.

**NB Copies should be sent to the supervising MHO and supervising CPN.**

**RESTRICTED MEDICAL  
CPN SUPERVISOR'S REPORT**

**Patient Name:**

**Date of Birth: 00/00/00**

Page \_ of 2

**REPORT TO THE SCOTTISH MINISTERS FROM THE COMMUNITY PSYCHIATRIC NURSE SUPERVISOR OF A CONDITIONALLY DISCHARGED RESTRICTED PATIENT**

In completing this report, please refer to the Memorandum of Procedure. In particular, please note the requirement for immediate reporting of adverse incidents and the procedure to be followed should recall be considered.

Patient Details	
Name	
Address	
Conditional Discharge Details	
Date of Conditional Discharge	
Reporting interval	monthly
Is the patient compliant with the treatment plan and the conditions of discharge? (provide details of any noncompliance)	
Meetings since last report	
Dates of CPA meetings since last report	

Contact with Patient	
Dates of contact since last report (provide a summary of contact history)	
Does the patient show signs of deteriorating mental health?	
If there are signs of deterioration, what level of alert has this triggered and what actions have you discussed/ agreed with the multidisciplinary team?	

**RESTRICTED MEDICAL  
CPN SUPERVISOR'S REPORT**

**Patient Name:**

**Date of Birth: 00/00/00**

**Page \_ of 2**

Risk Management	
Date of most recent update of the risk management plan	
Any issues regarding drugs/alcohol since last report	
Dates and results of drug/alcohol testing ( if relevant)	

Other relevant issues or additional details

Name and address of Supervisor

Signed: ..... Date .....

To be returned on the last day of      to:

**Scottish Government Health Directorate,  
Mental Health Division,  
Room 2N.08,  
St Andrew's House,  
Edinburgh,  
EH1 3DG.**

**NB Copies should be sent to the supervising MHO and supervising RMO.**

**RESTRICTED MEDICAL  
MHO SUPERVISOR'S REPORT**

**Patient Name:**

**Date of Birth: 00/00/00**

**Page \_ of 2**

**REPORT TO THE SCOTTISH MINISTERS FROM THE MHO SUPERVISOR OF A  
CONDITIONALLY DISCHARGED RESTRICTED PATIENT**

**In completing this report, please refer to the Memorandum of Procedure. In particular, please note the requirement for immediate reporting of adverse incidents and the procedure to be followed should recall be considered.**

<b>Patient Details</b>	
Name	
Address	
<b>Conditional Discharge Details and changes since last report</b>	
Date of Conditional Discharge	
Reporting interval	monthly
Any change to the agreed care plan over the reporting period	
Any relevant change to the patient's social circumstances since last report	
Any change, where relevant, to family/carer circumstances	
<b>Meetings since last report</b>	
Date(s) and location of Social Work contact since last report:	
Dates of CPA meetings since last report	
<b>Supervision</b>	
Any change in the Social Work supervisory role since last report:	
Any issues arising in relation to compliance with Social Work supervision over the reporting period	

**RESTRICTED MEDICAL  
MHO SUPERVISOR'S REPORT**

**Patient Name:**

**Date of Birth: 00/00/00**

Page \_ of 2

Risk Management	
Date of most recent update of the risk management plan	
Any issues arising in relation to the risk management plan and risk to patient or others	

Other relevant issues or additional details

Name and address of Supervisor:

Signed: ..... Date .....

To be returned on the last day of            to:

**Scottish Government Health Directorate  
Mental Health Division Branch 4  
Room 2N.08  
St Andrew's House  
Regent Road  
EDINBURGH EH1 3DG**

**NB Copies should be sent to the supervising RMO and supervising CPN.**

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

From 13 August 2007 the forms recommended for use under the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) changed. Some forms were deleted, others were amalgamated and there are some new forms.

A good practice guide for using the forms required by the Mental Health Tribunal and the Mental Welfare Commission is provided on the Scottish Government website<sup>134</sup>.

<a href="#"><u>ADM1</u></a>	Notification by hospital managers of the admission of a patient following criminal justice proceedings.
<a href="#"><u>AO or TO</u></a>	Medical report in respect of person (not in custody) awaiting trial or sentence: Assessment Order or Treatment Order
<a href="#"><u>AO Review</u></a>	Responsible Medical Officer's review report in respect of person subject to an Assessment Order
<a href="#"><u>CORO1</u></a>	Responsible Medical Officer's (RMO) review of a compulsion order and restriction order.
<a href="#"><u>CORO2</u></a>	Application by Scottish Ministers to the Mental Health Tribunal. Reference by Scottish Ministers to the Mental Health Tribunal. Record of application made by the patient to the Mental Health Tribunal. Record of Mental Health Tribunal determination.
<a href="#"><u>HD1</u></a>	RMO's review of a hospital direction or transfer for treatment direction.
<a href="#"><u>HD2</u></a> direction RMO.	Record of the Scottish Ministers' decision whether or not to revoke the to which the patient is subject, following receipt of report from RMO.  Reference made by the Scottish Ministers to the Mental Health Tribunal. Record of application by the patient to the Mental Health Tribunal. Record of direction made by the Mental Health Tribunal. Record of revocation of direction by the Scottish Ministers.
<a href="#"><u>MHT</u></a> <a href="#"><u>Annex A</u></a>	Medical Report: Application for an Assessment Order in respect of person in custody awaiting trial or sentence
<a href="#"><u>MHT</u></a> <a href="#"><u>Annex B</u></a>	Medical Report: Application for a Treatment Order in respect of person in custody awaiting trial or sentence
<a href="#"><u>MHT</u></a> <a href="#"><u>Annex C</u></a>	Medical Report: Transfer for Treatment Direction in respect of person serving a sentence of imprisonment
<a href="#"><u>SUS3a</u></a>	SUS certificate granted by RMO Revocation of SUS certificate by RMO or the Scottish Ministers and record of notifications.
<a href="#"><u>TX1a</u></a>	Notification by hospital managers of patient transfer outwith Scotland.

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<sup>134</sup> <http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/mha-Forms/goodpracticeguidance>

[TX2](#) Notification by hospital managers of patient transfer within Scotland.

[TX3](#) Appeal by patient against transfer within Scotland.

[TX4](#) Appeal by patient against transfer outwith Scotland.

All of the forms listed above are available on the Scottish Government website at:  
<http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/mha-Forms>

## MENTAL HEALTH OFFICER MOCK REPORT

<b>Name</b>	
<b>Date of Birth</b>	
<b>Address (current)</b>	
<b>Address (home)</b>	

### **Basis of Report**

This report is based on numerous contacts with Mr XX since the writer became involved with his care in September 2004. These contacts have been in the ward and most recently in his flat when Mr XX has been out on suspension of detention.

I have also interviewed Mr XX sister in one occasion (11/3/05), when I was carrying out a Community Care Assessment of Mr XX needs. I have had regular contact with ward staff in the XX ward and have spoken to his Responsible Medical Officer. Dr X, on several occasions. I have attended multi-disciplinary Care Programme Approach meetings (4/10/04; 10/1/05; 21/3/05; 25/7/05; 29/8/05; 14/11/05; 16/1/06; 13/3/06; 16/6/06; 3/8/06; 14/9/06; 12/10/06; 30/11/06; 22/2/07; 25/4/07; 29/6/07; 10/8/07; 27/9/07; 5/11/07; 17/12/07).

For the purpose of this report I have had sight of medical notes and a Psychological Risk Assessment report prepared/updated on Mr XX by Clinical Psychologist Ms X on 2/5/06. I have also spoken to nursing staff on various occasions when visiting Mr XX in the ward.

I have attended Social Work Planning meetings with the purpose of discussing Mr XX social care needs and the provision of services required for his rehabilitation in the community.

I have further maintained contact first of all with our XX housing officer in relation to finding Mr XX appropriate accommodation in XX through the homeless team. I have also made contact with different housing associations also in XX as Mr XX wishes were to live in the XX area. I have contacted and maintained this contact with XX care provider regarding

support services for Mr XX also with Occupational Therapist, in order to assess the current level of functioning and support, Mr XX needs with personal, domestic and community living skills.

### **Purpose of the Report**

Mr XX is a Restricted Patient on a Compulsion Order Section 58/59 of the Criminal Procedure (Scotland) Act (“the 1995 Act”) who is working towards a conditional discharge to the community through the use of the Care Programme Approach. Mr XX is in the ‘severely at risk’ category. A multi-disciplinary risk assessment and multi-disciplinary care plan is incorporated with this report which focuses on the management of Mr XX care in the community in the event the Tribunal orders his conditional discharge.

I was verbally advised by Dr X, Mr XX’s Responsible Medical Officer (RMO) on the 22/10/07, that Mr XX continues to meet the criteria of having a mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003 “the 2003 Act”, this being a mental illness and his diagnosis being schizo-affective disorder. The current medical treatment is alleviating the symptoms he first presented and this medical treatment will continue being available to him as well as monitoring by medical and nursing community staff in the community.

This report is prepared under Section 191(b) of the Act in relation to Mr XX’s preparation towards a conditional discharge into the community.

### **Summary of Personal History/circumstances leading to his admission into hospital**

#### **a. Childhood and family siblings**

Mr XX was born in the XX area of Xx. He moved with his parents to XX when he was aged 7. His mother died in 1986 of a brain tumour. Mr XX, following his mother’s death, began drinking alcohol excessively and had an admission into hospital for 6 months following an overdose of Paracetamol tablets. His diagnosis was then endogenous depression. Notes indicate that Mr XX was close to his mother. Mr XX father died in 1990 (Index Offence).

When the family moved to XX, Mr XX being 6 at the time attended XX Primary and XX Schools respectively. Mr XX left school at the age of 16 with 3 standard grades. On leaving school he had various jobs as well as periods of unemployment. He worked as a store man in an Industrial Estate and worked in the Council in Xx. Mr XX was on sick leave from his job at the time of the index offence.

Mr XX sister XX informed the writer that they both related quite well with each other when they were younger but they were not particularly close. They had their own friends and socially they led their own lives.

Medical notes indicate that Mr XX sister used to visit him in hospital many years ago and had been observed their relationship to be a superficial one. These visits had stopped and Mr XX tends to write to his sister at the end of each CPA Meetings. Mr XX does not get a reply. However, his sister sends him greeting cards and gifts for birthdays and Christmas.

#### **b. Schools/Adulthood prior to index offence**

As said earlier in this report, Mr XX attended the local schools in XX Primary and XX High). Reports suggested that he was an average pupil and played truancy. He left at 16 with 3 standard grades in English, Geography and Arithmetic. Mr XX had various employments. Reports suggest that Mr XX knew a lot of people and socialised more visiting local pubs. The writer is not aware of Mr XX having had a formal, serious relationship with any female.

There have not been any concerns of Mr XX had experimented with illicit drugs, apart from him admitting trying cannabis in 1992 (Psychological Risk Report 2/5/06). In the days prior to the Index Offence, (1 April 1991), Mr XX abused alcohol to excess around 1985 to 1992. Notes indicate that he began binge drinking after the death of his mother. He had been feeling depressed and had been to see his GP with his complaint. He had an admission to XX Hospital in 1986 and was treated for psychotic depression. Medical notes also indicate that after the death of his mother, his father became depressed, withdrawn and unwell. Mr XX and his father seemed to have argued a lot. Mr XX began to experience the beliefs that his father was Hitler and became afraid of him. He developed persecutory delusions that seem to have led to him stabbing his father with a knife. He then contacted the police and told them what he had done. Mr XX seems to have drunk to reduce his symptoms. He developed depressive symptoms around 2/3 months prior to the time of the offence developing a number of delusional beliefs which involved the belief that his father had killed his mother and intended to kill him. Mr XX lived with his father at the time of the Index Offence which took place on the XX, XX was charged with murder of his father, (patricide) then 75 years old. At first Mr XX went to XX Prison while the trial was progressing. He was then admitted into the State Hospital under a Hospital Order, Restriction Order Section 58/59 of the 1995 Act.

### **While in hospital**

Mr XX was transferred from the State Hospital to XX on the 26/2/2001. The staff's impression at the time was that Mr XX mental state and his general behaviour appeared settled and initially staff did not think that Mr XX would need to be in the Forensic Ward for any extended length of time. At the time he was treated with Clozapine, the writer understands that he stated he was unhappy with the side effects of this particular medication ie flu symptoms, weight gain. It appears that Mr XX spoke to nursing staff who recommended he had been very well on the medication and the side effects were minimal. After discussion he had agreed to remain on this medication. However, he wrote to his Solicitor and the Mental Welfare Commission, who in turn asked for the RMO to review his medication resulting in it being changed. This incident appears to have occurred in September 2001 and according to notes Mr XX within a matter of days became seriously unwell. His mind was racing, there was an increase of paranoia, he was not sleeping and sweating profusely. He had a serious fixation about staff being spies. Notes indicate that after 3~4 weeks he was put back on the same medication and dosage. It was observed that his positive symptoms declined very quickly, he was more settled, showed some insight into his diagnosis and the need for treatment.

The writer understands from medical and nursing staff that Mr XX does not present any of the above issues at present. He appears to have some understanding of his need for taking his medication, he has been self medicated for about three years and has informed me him taking his medication is well established in his routine and he faithfully takes it. However, the writer foresees this as an issue which should be closely monitored by the clinical staff,

because this presents as a risk factor. The clinical team is fully aware of close monitoring is required when in the community.

While in the ward Mr XX was found to have a good residual pool of skills and had been able to go out escorted by nursing staff to XX and go around shops. However, he had also been observed he can be unmotivated in getting involved in activities available to him needing encouragement to make use of his free time. At present he attends XX 3 times a week. This is his only structured activity. He participates in recreational activities in with his Support Worker. It would appear Mr XX will benefit in obtaining gradually other purposeful and structured activities.

### **Preparation and Response to Rehabilitation into the Community**

Mr XX have been an in-patient in the XX Ward, rehab ward since Feb 2001. Mr XX has been subject to Care Programme Approach meetings. Planning towards conditional discharge commenced on 4 October 2004 to prepare Mr XX for the stage of him spending overnight passes at his new home. The writer understands while Mr XX being in hospital his medication had been reviewed regularly and monitored with the purpose of improving his mental state. Prior to accommodation being identified the police were involved and confirmed from a risk perspective that the accommodation was appropriate situated.

The writer also understands that Mr XX mental state has been stable for the past three years. A nursing summary dated 19/12/05 indicates that Mr XX since his initial transfer to the XX Ward (July 2004), Mr XX's mental state appeared stable and there had been no overt signs or symptoms or psychosis and his mood and manner were settled and appropriate. He is regularly tested for drugs and alcohol use and results had been negative.

With regard to his medication this nursing summary indicates that Mr XX self medicates and he appears to be coping well. He regularly has blood samples taken to test his Clozapine levels and they have always been within an acceptable range and caused no concern, at present Dr X is negotiating for blood tests to be done in his local health centre where his flat is situated.

While in hospital Mr XX had at first been introduced to the day services at XX Clinic with the aim for him joining in activities. He was initially escorted and this progressed to the stage where he was travelling unescorted. He had also attended XX one day per week. He was also being escorted at first and progressed to the unescorted stage. He commenced attending XX House 2001 in where he engaged in computing course. He also engaged well in other social activities like going to the cinema, library, shopping etc. I understand that permission from the Scottish Government was sought to allow Mr XX to attend to all these recreational, social and educational programmes which have assisted him in the rehabilitative process.

Mr XX was subsequently referred to Social Work with the purpose of carrying a community care assessment of his needs and finding suitable accommodation (to be risk assessed by the police) and support resources to meet his needs. The writer while being in the process of completing his Community Care Assessment met with Mr XX sister (11/2/05) at the social work office in the XX Resource Centre. I understand his RMO, had tried to make contact with Mr XX sister but had been unsuccessful.

When the writer saw Mr XX's sister she said there is no contact between them and she was then clearly anxious about Mr XX possible discharge into the community. She was extremely anxious with the prospect and possibility of Mr XX presenting himself to her house. His nephews do not know of Mr XX existence. His sister was clear in expressing that she and her family would not be able to support him although at the same time not wishing for Mr XX to stop his rehabilitation into the community. The Psychological Risk Assessment Report (2/5/06) indicates that Mr XX had a belief that his sister may socialise with him following discharge and did not recognise that communication between them was and is "one sided", ie Mr XX writes to her after each CPA meeting and does not obtain a reply. This report also comments that in 2004 Mr XX seemed to have spoken on the phone to his brother in law, this initiated by him. His sister had not returned the phone call as requested and Mr XX was observed to have been upset.

The writer's observations in this issue are that Mr XX internally wishes for some family contact however, he appears to respect his sister's wishes and claims not to have the intention in contacting her in any other form apart from writing letters. My other observation is that Mr XX on 20 August 2007, learnt from a family member of his father's side (cousin), that 'his sister has separated from her husband'. Mr XX although was observed to have coped well with this unconfirmed news he was somehow concerned for his sister's well being and required support and reassurance in this matter. The writer feels Mr XX requires support and reassurance with respect of family issues/rejection and this will need close monitoring in the community for Mr XX benefit considering the family concerns.

Mr XX nominated named person is, by default, his sister. However, Mr XX has decided to complete a declaration (27/6/06) that his sister should not be his named person under section 253 of the 2003 Act. He has not nominated anyone else and he feels there is no-one he could nominate.

A Community Care Assessment on Mr XX was completed in April 2005 indicating that Mr X required to reside in Supported Accommodation outside XX as his sister resides in this Local Authority area. Mr XX primarily wished to reside in the XX part of XX. He had no access to supported accommodation in XX. He completed several applications for Housing for different Housing Associations in XX where he had a preference to live. Mr XX eventually obtained a 2 bedroom flat from the XXs Housing Association. He signed the tenancy agreement on 4/12/06. Support from XX care provider commenced around the same time. He started to spend time with them in preparation to have his flat decorated and furnished for commencing his first overnight pass at his flat, (9/3/07). At the time of writing this report he has a 24 hour care package provided by XX. It is envisaged that soon after Mr XX is conditionally discharged this care package will be according to his needs and progress be reviewed and subsequently reduced where necessary.

Mr XX has been well supported and work has been done to his own pace, introducing him to his new environment. He commenced his 1st overnight pass on the 01/04/07 and he is now on 4 overnight passes to his flat. Requests to permit these passes have been made by his RMO, Dr X and authorised by Scottish Government.

### **Risk Assessment and Care Plan**

This has been discussed at multi disciplinary care programme approach meetings. Psychologist Ms X in the Psychological Risk Assessment dated 02/05/06 offers the opinion

that Mr XX presents "with a low moderate risk of future violent offending in the community". I enclose page 10 of Ms X report with key conclusions and recommendations for risk management.

The writer has further discussed with the RMO on the 17/12/07 a risk management plan for Mr XX and this is also attached to this report. The writer further understands the following risks are well covered in the risk management plan and staff as well as Mr XX co-operate with the plan. Mr XX is supported in the following areas:

#### Maintenance of mental health in the community

This is to be monitored by RMO who sees Mr XX monthly and (F) the Community Psychiatric Nurse (CPN) weekly.

- Maintenance of compliance with prescribed medication

This is to be monitored by (F)CPN, RMO and local health centre for blood tests.

- Continue monitoring abstinence from alcohol and support his abstinence

This is to be monitored by RMO, FCPN, observations from all team and communicate to RMO.

- Physical health

Mr XX general health to be monitored by health staff

- Relationship with his sister/cousin

This to be observed by all the team especially XX workers who will see Mr XX on a daily basis. Observations to be communicated to the whole team. Mr XX may find it upsetting not to have family contact.

- Structured activities

Mr XX to continue structured activities in the community. Support and motivate him to engage in activities he enjoys.

- Housing/advice of financial matters/benefits

Mr XX has functioned well with assistance in this area. However he has been in hospital for many years and will continue to need support from XX to alleviate issues and assist to increase independency.

#### **Present Circumstances**

Mr XX is currently spending 4 overnights at his flat situated in the Xx. This consists of him spending overnights at his flat on Monday to Thursday. He is supported by XX workers who stay in through the nights with him. Mr XX has familiarised himself with the local area finding out where amenities are. He is close to the shops and he had participated in a cycling

club in the area. Mr XX with the assistance of the Occupational Therapist has prepared in relation to domestic, practical matters, building up self confidence and independency for living in the community. Mr XX is much more confident and attends to house chores independently.

Mr XX from the professional point of views continues seeing his CPN Mr X, once a week, normally on a Friday. He also sees her RMO Dr X also every week and attends all CPA meetings. Mr XX is visited by the writer (MHO) every 4 weeks at his flat.

### **Views of Current Support Providers**

Mr XX is supported by XX. They have commented that the patient engages well with the workers and other clients. He is co-operative and motivated. His flat is kept reasonably tidy.

### **Engagement with Addiction Services**

Mr XX will meet with the Addiction Services initially following conditional discharge to carry out some booster work in addressing alcohol abuse.

### **Views Nominated Named Person/Advance Statement**

The writer has assisted in explaining and providing information about named persons and advance statements to Mr XX. As stated above Mr XX completed a declaration (27/6/06) that his sister XX should not be his named person, Mental Health (Care and Treatment) (Scotland) Act 2003. Mr XX has preferred for the writer not to contact his sister to discuss this and his possible forthcoming conditional discharge to the community. The writer therefore cannot offer any views of a named person. Mr XX has not nominated anyone else.

Mr XX has made use of Advocacy services. Ms XX is his advocacy worker and can be contacted at XX. She attends all CPA meetings with Mr XX

Mr XX has not completed an advance statement.

### **Views of Mental Health Officer**

Mr XX is currently detained under section 58 and 59 1995 Act. I am informed by Mr XX Medical Responsible Officer, Dr X, that Mr XX suffers from a mental disorder as defined in the Mental Health Care and Treatment Scotland Act 2003, this being a mental illness and his diagnosis being schizo-affective disorder, that he has been in the XX, following the Index Offence. Mr XX medication had been reviewed regularly and he has been mentally stable for a long period of time, his present medication is as follows:

Lithium 600mg (once per day),  
Simvastatin 40mg (once per day),  
Clozapine 475mg (once per day),  
Lansoprazole 30mg (once per day),  
Tetracycline 500mg (twice per day)

Mr XX self medicates and the writer understands that he has no problems in complying with taking his medication. He sees this being part of his routine in the morning and night times.

He seems to appreciate the importance of him needing medication. The writer is only aware of an incident when he wanted a change of medication this issue is explicit in another part of this report.

Mr XX was transferred to the XX and Rehabilitation ward in July 2004 he has participated in all based activities and others like attending XX in preparation towards his conditional discharge. Mr XX's history indicates that he has presented a risk to others (index offence), he had been charged with the murder of his father and being in hospital on a compulsion order and restriction order (CORO) he has undergone intensive and extensive psychiatric treatment over the years.

A psychiatric Risk Assessment completed by Psychologist Ms X dated 2/5/06 indicates that Mr X presents with a low moderate risk of future violent offending in the community. Dr X also indicates in her last care and treatment plan (7/6/07) that he requires close monitoring of his mental state by all professionals involved and maintain this with a rehabilitative programme as motivation seems to be one of his negative symptoms. It has also being indicated that Mr XX offence was linked to psychosis and alcohol consumption appeared to have increased at index offence and this requires to be closely monitored regularly and at random.

A Community Care Assessment of Mr XX needs was completed identifying he required supported accommodation in the XX area. He did not wish to return to XX as Mr XX is well known in the XX area. Mr XX sister also resides in XX and as explained earlier in this report Mr XX sister had concern of him approaching her and her family who do not know of his existence.

It is the writer's impression that Mr XX appears to seek involvement with his sister although he rationalises and accepts that he respects his sister's decision.

Mr XX had no access to supported accommodation in XX. He obtained a 2 bedroom flat in the XX and 24 hour support care package has been contracted from XX provider. This care package will be regularly reviewed and reduced as Mr XX increases his confidence, involvement with structured activities and settling in the community once he is conditionally discharged.

### **Opinions and Recommendations**

***Mr XX has a mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003, this being a mental illness and his diagnosis being schizo-affective disorder.***

***As a result of Mr XX mental disorder, it not necessary, in order to protect any other person from serious harm for the patient to be detained in hospital, whether or not for medical treatment.***

Mr XX's history indicates that he has presented a serious risk to others (index offence) and the risk of serious harm is still present should he stop taking his medication and relapse. Mr XX displayed lack of insight into the need to take his medication in September 2001 when he wrote to his solicitor and Mental Welfare Commission suffering a serious relapse within a matter of days displaying an increase in paranoia. He has undergone intensive and extensive

psychiatric treatment over the years. However, the writer's opinion is that it is *not necessary* for Mr XX to be detained in hospital.

***Medical treatment is available for Mr XX which would be likely to:***

- (i) prevent the mental disorder worsening; or***
- (ii) alleviate any of the symptoms, or effects, of the disorder.***

The current medical treatment is alleviating the symptoms and this medical treatment will continue to be available to him as well as continued monitoring by medical and nursing staff in the community

***If Mr XX was not provided with such medical treatment there would be a significant risk –***

- (i) to the health, safety or welfare of the patient; or***
- (ii) to the safety of any other person.***

Mr XX index offence was an act of violence committed in the context of deteriorating mental illness. Without medical treatment there would be a significant risk of violence recurring.

***It does continue to be necessary for X to be subject to the compulsion order.***

***It does continue to be necessary for the patient to be subject to a restriction order.***

Mr XX history indicates that he has presented a serious risk to others (index offence) and the risk of serious harm is still present should he stop taking his medication and relapse.. Mr XX displayed lack of insight into the need to take his medication in September 2001 when he wrote to his solicitor and Mental Welfare Commission suffering a serious relapse within a matter of days displaying an increase of paranoia. He has undergone intensive and extensive psychiatric treatment over the years. The nature and effect of a restriction order is to give a supervising and monitoring role to the RMO and to the Scottish Ministers in the public interest because of the circumstances in which the original order was made. Mr XX requires the restriction order to remain with the resultant safeguards this provides. However, conditional discharge allows supervision, assessment and monitoring which is in the public interest at a time when Mr XX will be coming into increasing contact with the wider community.

***It is not necessary for Mr XX to be detained in hospital.*** Mr XX is stable on medication, he is self medication and has good insight into the need to take medication. He has successfully completed a period of extensive testing out building up to 4 overnights a week without incident.

**Mental Health Officer**

Date

## **RMO ANNUAL REPORT PRO FORMA**

### **Patient Details**

Name

Date of birth

Hospital number

Legal status

Index Offence details

Date of original section

Date of renewal

Date of MHTS hearing

MAPPA level

### **Diagnosis and Treatment**

Current diagnosis/es including any axis 2 diagnosis ie personality disorder

Current mental state and any changes since last report

Current activities

Progress since last report

Details of treatment including psychological interventions and response to treatment

Compliance

Changes in circumstances

Response to suspension of detention or conditions of discharge  
(if appropriate)

### **Risk Management**

Date of most recent update of the Risk Management Plan

Details of any amber or red incidents/contingency plans since last report

Any other adverse incidents since last report

Any change to level of risk to patient or others and action taken

Any media/victim issues since last report

Any issues regarding drugs/alcohol since last report

Dates and results of alcohol/drug testing (if relevant)

CPA documentation including care plan

### **Opinions and Recommendations**

4. [Patient's name] does/does not have mental disorder.

[If yes specify the nature of mental disorder(s)]

5. As a result of [patient's name] mental disorder, it is/is not necessary, in order to protect any other person from serious harm for

- the patient to be detained in hospital for medical treatment or
- the patient to be detained in hospital whether or not for medical treatment.

[Please specify nature of serious harm, who the potential victim may be and how detention in hospital reduces or minimises the risk of serious harm. Refer to HCR-20/CPA documentation if relevant.]

6. Medical treatment is/is not available for [patient's name] which would be likely to:

- (i) prevent the mental disorder worsening; or
- (ii) alleviate any of the symptoms, or effects, of the disorder.

[Please specify the nature and the effect of the treatment provided.]

7. If [patient's name] was not provided with such medical treatment there would/would not be a significant risk –

- (i) to the health, safety or welfare of the patient; or
- (ii) to the safety of any other person.

[Specify the nature of any significant risk to the health, safety or welfare of the patient and specify the nature of any significant risk to the safety of any other person. Refer to HCR-20/CPA documents.]

8. It does/does not continue to be necessary for [patient's name] to be subject to the compulsion order.

[Specify the reasons why.]

9. It does/does not continue to be necessary for the patient to be subject to a restriction order.

[Comment on the relevance of the index offence, patient's antecedents, the risk of serious harm to the public if [patient's name] is at large and on the features of the restriction order which are relevant to [patient's name].\*

10. It is/is not necessary for [patient's name] to be detained in hospital.

[Specify why you believe that to be the case. Refer to risk factors, treatment, testing out and any other relevant considerations. Comment on whether you support or do not support a Conditional Discharge]

### **Level of Security**

11. [Patient's name] does/does not require to be detained under conditions of special security that can only be provided in the State Hospital.

[Specify why with reference to risk posed by [patient's name] and the environmental, procedural and relation features of security which are relevant to the detention of [patient's name].]

12. [Patient's name] requires [medium/low] level of security.

[Specify the reasons for that opinion and the features of that security which are necessary in order to manage the patient and the risk.]

Responsible Medical Officer

\* See attached note on purpose and effect of restriction order

## **Continuing Necessity of Restriction Order**

1. In considering the continuing necessity of the restriction order (in terms of s193(5)(b)(ii)) the Tribunal must consider the extent to which the original criteria for imposition remain relevant, as well as the nature and effect of the restriction order on the patient's current (and future) circumstances.

### **Criteria for imposition**

2. In respect of Compulsion Order and Restriction Order patients, Section 59 of the 1995 Act allows a restriction order to be imposed where, (a) having regard to the nature of the offence with which he is charged; (b) the antecedents of the person; (c) **the risk that as a result of his mental disorder he would commit offences if set at large; it is necessary for the protection of the public from serious harm to do so.**

### **Nature and Effect**

3. The nature and effect of a restriction order is to give a supervising and monitoring role to the Scottish Ministers in the public interest, because of the circumstances in which the order is made. The patient is subject to this public interest supervision and monitoring, in addition to supervision by the RMO. The nature and effects of a restriction order are as follows:

(a) Where a patient is subject only to a compulsion order, that order lasts only 6 months, unless renewed by the RMO. It can therefore be revoked by the RMO acting (or failing to act) alone. A restriction order continues the compulsion order without limit of time, and means that it can only be revoked by the Mental Health Tribunal. Removing the restriction order at this stage does not allow future RMOs the choice of maintaining the patient on a restriction order with the resultant safeguards this provides. It also shifts the onus and responsibility of renewing the patient's compulsion order, which is likely to be required indefinitely, onto the RMO (present and future) alone.

(b) A restriction order also prevents the patient being released from compulsion (either within a hospital or community setting) without a decision of the Mental Health Tribunal after a hearing at which the Scottish Ministers have the right to make representations (Section 193(8) and (9) of the 2003 Act); for example it prevents the RMO and/or Mental Welfare Commission being able to terminate the compulsion order (and accordingly detention) unilaterally either deliberately (Sections 141 and 143) or by omitting to refer the case to the Tribunal for an extension to the compulsion order under Section 167.

(c) Decisions about transfer of the patient (for example to lower security hospitals) and suspension of detention (for example for testing out in the community) are subject to scrutiny and approval of the Scottish Ministers (see Sections 218 and 224 of the 2003 Act). The Scottish Ministers may revoke the suspension of detention. The restriction order will not prevent the patient from progressing to conditions of lower security or on to the community, but it will mean that Scottish Ministers will be involved in that decision making process.

(d) A restriction order also involves the Scottish Ministers in monitoring the patient on a continuing basis (reports from RMOs and MHOs) and referring the case to the Tribunal at appropriate intervals (see Part 10 and especially Section 188 of the 2003 Act).

(e) Restricted patients are subject to 'MAPPAs', multi agency public protection

arrangements. Under Sections 10 and 11 of the Management of Offenders etc (Scotland) Act 2005 (A13), a statutory function is placed on police, local authorities, health services, and Scottish Ministers to establish joint arrangements for assessing the risk from mentally disordered offenders. As a result it is mandatory for all restricted patients to be subject to the Care Programme Approach to managing risk, which means that there is multidisciplinary input to care programmes.

(f) Patients subject to a restriction order must be conditionally discharged when it is no longer necessary to detain them in hospital. Conditional discharge allows supervision, assessment and monitoring in the public interest at a time when patients are coming into increasing contact with the community. Scottish Ministers would be consulted on the conditions of discharge suggested by the multi disciplinary care team and may vary conditions of discharge as appropriate either strengthening the conditions or reducing the conditions.. Reporting on restricted patients conditionally discharges is initially on a monthly basis by the RMO, MHO and FCPN.

4. The Scottish Ministers expect a period of testing out prior to conditional discharge. This would generally involve a period of unescorted suspension of detention before moving on to overnight testing building up from one night to four overnights over a 4 month period.

5. The majority of patients who receive compulsion orders do not receive restrictions. The sentencing court can only subject the patient to the special restrictions set out in Part 10 of the 2003 Act if satisfied **“that it is necessary for the protection of the public from serious harm so to do. This test is not about whether detention in hospital is required** (the “serious harm requiring detention in hospital, whether or not for medical treatment” test found in sections 183(6)(b)(i), 184(5)(b)(i) and 193(5)(b)(i)), but rather about whether or not the restriction order remains necessary (the second leg of the test for revocation, found in sections 183(6)(b)(ii), 184(5)(b)(ii) and 193(5)(b)(ii)).

6. Under the 1983 Act there was no right of appeal to the Sheriff to revoke the restriction order and only the Scottish Ministers had this power. The 2003 Act reversed this position. (It remains the position in England and Wales where there is no appeal right to the Mental Health Tribunal to revoke the restriction order, the power rests with the Secretary of State). The focus for the Tribunal, as it was for Ministers under the 1983 Act, in consideration of revoking the restriction order is entirely on risk.

6. Where the patient continues to meet the requirement that he/she requires medication without which he/she would pose a significant risk to the public, the patient would remain subject to the compulsion order. Our policy position remains that generally when a compulsion order remains necessary because of risk to others we would oppose the lifting of the restriction order for the reasons set out above.

7. The Scottish Ministers would not generally oppose the revocation of the restriction order in cases where there is a recommendation to revoke the compulsion order and the patient has demonstrated an extended period of compliance, insight into the illness and offending behaviour, consideration of the severity of the index offence, no incidents over a prolonged period, an ability to abstain from drugs/alcohol and engagement with the clinical team.

8. The Scottish Ministers have agreed to revocation of the restriction order exceptionally in respect of patients detained in hospital where the patient suffers from a severe and enduring mental illness which makes it probable he will remain in hospital for the remainder of his/her life. In these cases there is no prospect of rehabilitation to the community in the foreseeable future for these patients. However, the expectation is that the patient will have been free of acts of violence for several years. The Scottish Ministers have also not opposed the revocation of the restriction order where the risk has been to the patient and not to the public.