

# **The New Mental Health Act**

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## **Transitional Training Guide**

### **Introductory Training for Mental Health Officers and Other Practitioners**

### **Social Circumstance Reports; Provisions for People with Mental Disorder within the Criminal Justice System; and Other Related Matters**

## **Reader 4**

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## **Reader 4**

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## FOREWORD

This is part of a package of training materials commissioned by the Scottish Executive. It was developed by Mike Maas-Lowit of Robert Gordon University who was assisted in this process by a multi-disciplinary Advisory Group drawn from services across Scotland and chaired by the Scottish Executive.

The training material is geared primarily to assisting Mental Health Officers gain knowledge of their new statutory roles and duties which have been expanded considerably in the Mental Health (Care and Treatment) (Scotland) Act 2003. The material, however, is organised in such a way as to be of value to others involved in implementing the new legislation. Ideally, wherever possible, training will be delivered on a joint basis.

By necessity the material had to be developed before the Code of Practice, Regulations and Forms had been finalised. References made are generally to draft versions of each (e.g. Volume 1 of the Draft Code of Practice published in March 2004 and Volumes 2 and 3 in June 2004). This material should not be taken as a definitive, legal interpretation of statute. Practitioners should refer to primary legislation and the associated Codes of Practice and seek their own legal advice when questions on implementation and/or interpretation arise.

All should feel free to reproduce any of the material included in the Mental Health (Care and Treatment) (Scotland) Act 2003 Transitional Training Guide series, although the name of the author and the publication from which it came should always be clearly stated. All the material can be downloaded from the Scottish Executive's mental health law website:  
[www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw)



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## 1. Introduction

**This section emphasises the requirement that all MHOs are conversant with both civil and criminal justice procedures. It also outlines the level of assumed knowledge underpinning the criminal justice materials and our approach to explaining these parts of the Act to you.**

Welcome to the final Reader in the series of transitional training materials. It deals with the writing of Social Circumstances Reports and provisions for people with mental disorder within the Criminal Justice System.

It is a requirement of the Directions from the Scottish Ministers that all MHOs who practice under the new Act have undertaken training to familiarise themselves with all relevant aspects of the legislation. These transitional materials are offered to you to enable you to meet that requirement. The chapters of the Act relating to criminal justice demand a greater MHO involvement in this area of work, much as the sections relating to CTOs do. Whatever arrangements have been made in the past by your employing authority to provide MHO cover to forensic psychiatry and the Criminal Courts, it cannot be assumed that these arrangements will be sufficient for the future. It must also be borne in mind that work with people whose needs are encompassed within the government's policy for mentally disordered offenders (Mel 5 1999), are in no way solely dealt with by specialised forensic mental health services, (where these exist.). Such people may be receiving services from general psychiatric services. Others may not be actively involved in criminal justice services but may (because of particular need and risk) be referred for care in conditions of special security, (e.g. referrals from local psychiatric hospitals still constitute the largest percentage of admissions to the State Hospital). Therefore, we cannot assume that certain MHOs will never be involved in what may appear to be a specialised area of work. For this reason we are asking all MHOs to study that section of this Reader and to undertake the final part of the 4<sup>th</sup> training session.

### 1.1 A brief word about the Codes of Practice

This material has been able to draw upon the Draft Codes of Practice for the 2003 Act which were out for consultation at the point when this material was completed. Please note that in the sections relating to SCRs, any reference to the Code of Practice is in relation to the Code for the 2003 Act. Reference to sections of the Draft Code of Practice relating to criminal justice is primarily about those sections of the legislation which amend the Criminal Procedure (Scotland) Act 1995. In such cases we are referring to Volume 3 of the Draft Code of Practice.

## 2. Provisions for people with mental disorder within the Criminal Justice System and other related matters

**This section introduces the major purposes of the 2003 Act in relation to the 1995 Act and sets the following discussion in the general context of criminal procedures for those MHOs who may be less familiar with the system.**

While a substantial part of the 2003 Act (82 pages) is given over to matters relating to criminal justice, not all of them have immediate relevance for MHOs. Medical colleagues still retain a lead role in presenting reports to the court, but the ethos behind such assessments and recommendations is now significantly changed, reflecting the expectation that multi-disciplinary joint work underpins such formulations, combined with the expectation and requirement to take into account the opinion of the designated MHO.

Therefore our discussion will focus on the MHO duties by:

- Placing the relevant sections in context by dealing briefly with those ‘pre-conviction sections’ relating to the detention of mentally disordered offenders where there is a statutory role for the MHO in preparing the SCR.
- Addressing in detail those sections relating to ‘post-sentencing orders’ in which the MHO has a larger prescribed role and by relating them to the sections on CTOs which they mirror in nearly all but the civil procedures of application.
- Directing you to the similarities between aspects of the MHO role in criminal procedures Compulsion Orders and other similar mental health disposals involving compulsion.
- Focusing on matters relevant to MHOs in relation to the other sections relating to criminal justice,
- Making only passing reference to those pre-existing aspects of other legislation that are little altered by the workings of the 2003 Act.

In relation to this last point, we will direct you to the relevant sections of the Draft Code of Practice. The Code gives a full account of such matters as, for example, the use of probation with a treatment requirement, as it occurs in the 1995 Act. In summary, the MHO role in criminal justice is largely new and expanded and is targeted on:

- The preparation of SCRs for orders made by the Court at any stage of criminal procedures;
- A substantial Mental Health Officer Report to the Court in consideration of Compulsion Orders; and
- A continuing role for the designated MHO, who has a duty to be consulted in the continuance, extension and variation of post-conviction orders.

As this may already sound jargon-laden to the generic MHO, part of our design is to render it comprehensible to those less familiar with the criminal justice system. However, in this part of the Reader we will assume a certain level of understanding. For example, we will assume that you know the difference between solemn and summary procedures. If you find that we have assumed a greater level of knowledge than you possess, we would direct you to the 1995 Code yet again, as it contains very good explanation of key terms.

It may be helpful to start by exploring how the Act works through the steps towards final disposal. While the Tribunal is the forum for determining applications under the civil procedures of the 2003 Act, the Courts (Sheriff Court and High Court) remain the locus for such matters in relation to criminal procedures. While there could and should never be any consideration of establishing guilt in relation to an offence under civil procedures, this is the first and proper preoccupation of criminal procedures, although the role of the MHO and the psychiatrists to solely advise on matters related to the mental health of the individual.

At the start, anyone within the criminal justice system must have been arrested and charged with an offence. Progress through the system thereafter may be divided into the following stages:

- **The Pre-conviction Stage**, in which the person accused of an offence, makes a plea of guilty or not guilty, assuming that they are fit to plead;
- **The Post-conviction, Pre-sentencing Stage**, in which, unless acquitted, reports may be requested to facilitate the Court's final decision in sentencing the person; and
- **The Sentencing Stage**, in which the Court determines what disposal ought to be given to the person having had regard for all the circumstances of the offence.

Under the 1995 Act, there are various pre-existing mental health options available to the Court (such as probation with a treatment requirement). These remain largely unaltered by the 2003 Act. Setting these aside, the various new orders that the 2003 Act inserts into the 1995 Act are all arranged in this sequence of the pre-conviction/ post-conviction/sentencing stages.

It is worth noting that Part 8 of the 2003 Act only amends the previous arrangement under the 1984 Act in relation to Part VI of the 1995 Act. The 1995 Act set out the range of disposals for Courts dealing with mentally disordered offenders while the 1984 Act dealt with the consequences of these disposals. For our purposes, the most important element of this was the relationship between Hospital Orders made under the 1995 Act and the link via section 60 of the 1984 Act to the framework of Section 18 detention.

While the 2003 Act repeals the 1984 Act in its entirety, it preserves the relationship between Criminal Procedures legislation, which contains the authority to make disposals, and Mental Health legislation, which deals with the way in which these matters are managed by mental health professionals and systems. Since the narrow, pre-existing disposals in the 1995 Act did not meet the requirements of the broad redesign of mental health law, Part 8 of the 2003 Act inserts new mental health disposals into the 1995 Act. Subsequently, parts 9 to 13 of the 2003 Act set

out the consequences of these changes in terms of reviews, extensions and variations of orders etc.

The insertion of new sections into the 1995 Act causes Part 8 of the 2003 Act to be ordered in a particular way. The sections seem to depart from their numerical sequence as they insert additional sections into the 1995 Act. The easiest way to track these changes is to note when the use of a capital letter denotes the insertion of a new section into an older piece of legislation. For example, you may recall that section 52 of the NHS and Community Care Act 1990 inserted 'section 12A' into section 12 of the Social Work (Scotland) Act 1968. In the same way, section 130 of the 2003 Act inserts sections 52A to Q into the 1995 Act following section 52. The simple message is, **look for the capital letter that denotes insertion into the 1995 Act**. This should alert you to the fact that the legislation relates to criminal procedures. If the capital letter is not there, the section being discussed relates to the civil procedure consequences of the 1995 Act upon the 2003 Act.

It should be noted that the principles set out in sections 1 to 3 of the 2003 Act still pertain to those sections which insert new legislation into the 1995 Act.

## 2.1 Aims of the new legislation

Volume 3 of the Draft Code of Practice suggests that, between the 2003 Act itself and the insertions it places in the 1995 Act, the intention is to:

- Create greater flexibility in the process of assessing and treating mentally disordered people before they face trial and before they are sentenced, in such a way as to parallel the civil proceedings for emergency and Short-term Detention;
- Introduce greater flexibility into the sentencing disposals available to the Court in line with the CTO potential for community-based compulsion as well as hospital detention; and
- Accommodate the changes imposed by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, whereby issues of public safety have to be taken into account in the assessment and disposal of those who have committed serious offences.

The policy intention was that those who are made the subject of powers of mental health compulsion or detention in criminal procedures should, as far as possible, be dealt with in a manner ( and in accordance with the same principles), as those who are being considered for or are subject to powers of compulsion or detention under civil procedures.

'Assessment' and 'Treatment Orders' (discussed below) may be used in either the pre-conviction or pre-sentencing stages of the process we delineated above.

## 2.2 An overview of pre-conviction provision

**This section introduces a more detailed discussion of the pre-conviction provisions of Assessment and Treatment Orders.**

For fuller discussion of the processes from arrest through charging with an offence, to the point of conviction, we would direct you to the relevant parts of the Draft Code of Practice. It gives a thorough outline of the circumstances in which a person may be detained under civil proceedings of Emergency Detention or Non-Emergency, Short-term Detention or application for CTO from the manifestations of mental disorder in the police cells or the at some point during the period before trial, where diversion or alternative action may be more appropriate than use of powers under criminal procedures. The Draft Code's discussion of these issues is rooted in practice around matters we have already covered in the second and third Readers. Therefore, we will restrict our brief outline to what is given in part 8 of the Act.

The period before conviction may be divided into the period before trial and the trial period up to the point of conviction (See Figure 1). The 'pre-trial period' begins when a person has been arrested and charged. In this period, during which the accused may be in custody or awaiting trial in the community, any one may alert the prosecutor to the potential presence of mental disorder and the prosecutor has authority to apply to the Court for an **Assessment Order** or a **Treatment Order**. Alternatively, where it appears to the Court that the accused has a mental disorder, the Court has authority to make such orders on its own initiative, subject to the availability of the appropriate medical recommendations.

### **Purpose of Assessment Order:**

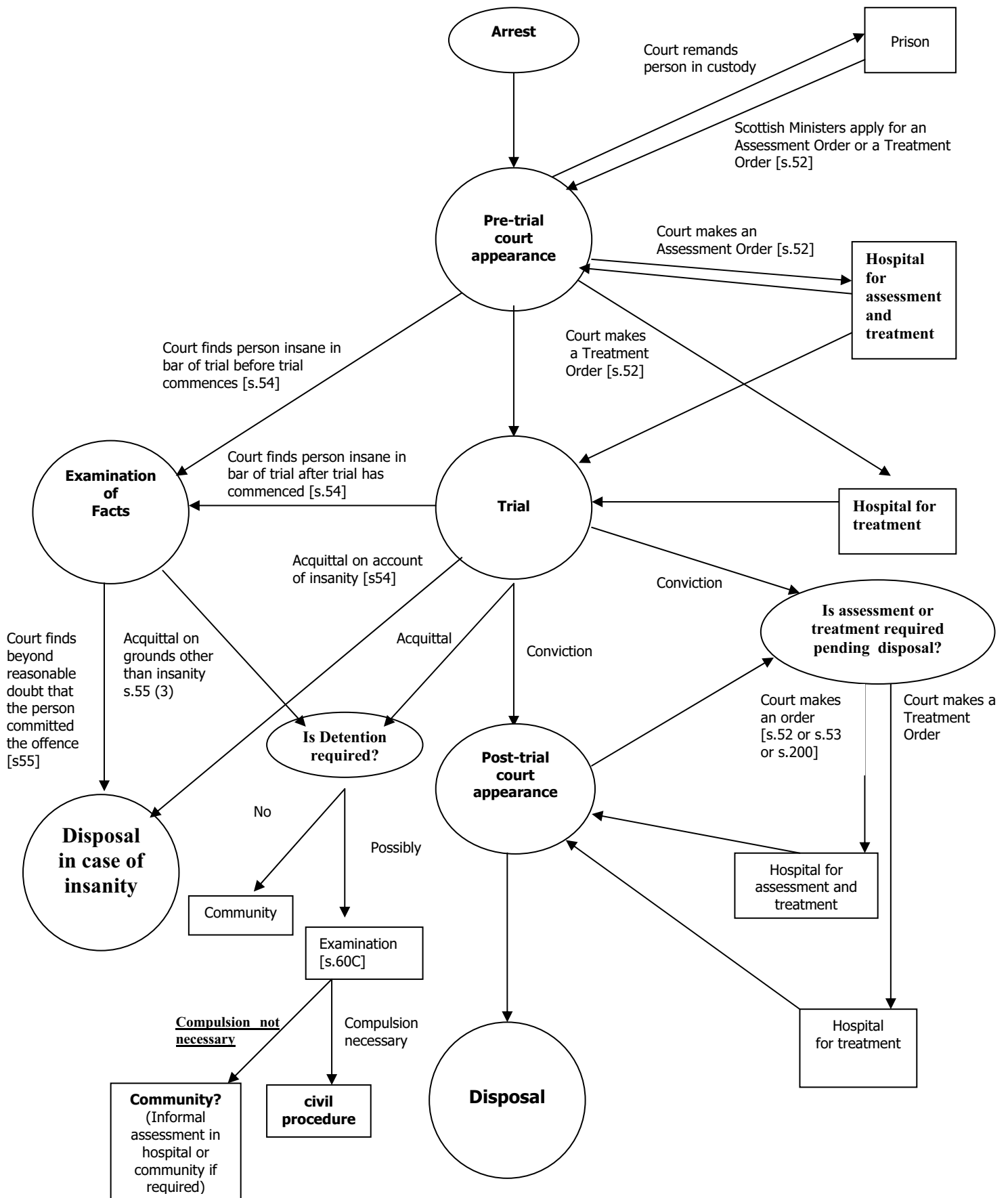
For our purposes we will resist getting drawn into the detail of Assessment Orders and loosely equate them with Short-term Detention. The order allows for examination of a person either awaiting trial or sentence by an approved medical practitioner. While the key focus is on assessment, it also authorises the giving of treatment in accordance with part 16 of the 2003 Act.

### **Similarities of Assessment Order and Short-term Detention:**

Some of the conditions for the order echo those of Short-term Detention:

- 'Reasonable grounds for believing' that the person has a mental disorder, necessity to detain the person for assessment and risk to health, safety, welfare or safety of any other person;
- Duration is for up to 28 days, non-renewable; and
- The treatment position of the order is comparable to that for Short-term Detention.

## OVERVIEW OF COURT PROCEDURES WHEN A PERSON WITH MENTAL DISORDER IS INVOLVED IN CRIMINAL PROCEEDINGS (Figure 1)



### **Differences between Assessment Order and Short-term Detention:**

The application is to the Court. It is not granted by the medical practitioner. Some significant differences from Short-term Detention in conditions needing to be satisfied include:

- There need only be 'reasonable grounds for believing' that the conditions are met;
- No test of the patient's ability to make decisions about treatment absence of a statement that available medical treatment would be likely to alleviate or prevent deterioration of the patient's condition;
- No role for MHO in making the application/ no consent required;
- Any medical practitioner (not just an AMP) may make recommendation;
- The order may be granted by Court upon application or the Court may make the order on its own initiative without any application, but with the required medical evidence;
- The order may make directions for the removal of the patient to the specified hospital;
- Upon application by the medical practitioner the order is extendable by 7 days only once, and subject to certain conditions (52G(4)); and
- No right of appeal.

Under section 52D(4)(b), the Court must have regard to 'any alternative means of dealing with the person', before it grants an Assessment Order. Therefore, although it is not a formal duty, the Draft Code of Practice encourages the RMO to consult an MHO, wherever possible, in advance of making such a recommendation, to assist in the consideration of any possible alternatives.

Section 52D(7) of the 1995 Act sets out what is to be assessed during the period of detention:

- The existence of a mental disorder;
- Available medical treatment would be likely to alleviate or prevent deterioration of the patient's condition; and
- Risk to health, safety etc if not provided with such treatment.

There is a duty on the RMO to provide a report to the Court before the expiry of the Assessment Order to address the question of whether a Treatment Order should be made. The Draft Code advises that the RMO should consult with the 'designated MHO'.

### **Treatment Orders:**

Where the focus of an Assessment Order is on allowing for assessment to be made, the Treatment Order can be made at any stage of the process prior to sentencing where the accused has an evident mental disorder that requires treatment.

As with an Assessment Order, it is either made by the prosecutor's application to Court or at the Court's own initiative. It requires evidence of two medical practitioners, one of whom must be an AMP. The evidence must persuade the

Court that the conditions for the order are met. The conditions are exactly the same as those matters set out in 53D(7), which an Assessment Order must assess:

- Existence of a mental disorder;
- Available medical treatment would be likely to alleviate or prevent deterioration of the patient's condition; and
- Risk to health, safety etc if not provided with such treatment.

Note that, unlike an Assessment Order, it does not state that there only need be 'reasonable grounds for believing' that the conditions are met. In their evidence to the Court, the two medical practitioners must be sure that the conditions are met. Duration of the order is for the period of remand or committal and the order is terminated when the Court has made its disposal.

### **The MHO's role in the pre-conviction process:**

Having made the point that there is little formal role for an MHO in making an Assessment Order, the Draft Code of Practice does state that 'a recommendation for an Assessment Order or Treatment Order should only be made after the medical practitioner has discussed the case with a consultant from the unit where the person would be admitted and only after this consultant has agreed to admit the patient. The medical practitioner should also seek the opinion of an MHO in an advisory capacity to inform any knowledge of background and possible alternatives, and to assist in the assessment and decision making process.' The 1995 Code also recommends that an MHO's opinion has 'particular relevance in relation to the person's possible need for community care mental health services if there is a possibility of charges being dropped or if consideration is being given to civil procedures.'

Both assessment and Treatment Orders require the designated MHO to interview the patient and complete an SCR within 21 days of the order being made. This requirement strengthens the need for early consultation with the MHO when medical practitioners are considering the recommendations for either of these orders.

One purpose of the SCR is to inform the RMO of matters that need to be taken before the Court. For example, it may be that the SCR suggests that the RMO should consider recommending a mental health disposal to the Court. The scope of compulsion available is as wide as that for CTOs. Therefore, the MHO's early views on social circumstances in relation to potential services are essential here.

This is an interactive dynamic in the consultation process whereby the SCR might alert the RMO to consideration of such a disposal. Since the process of reports to the Court in pursuit of such an order is lengthy, more or less comparable to that for CTO, the RMO ought to be mindful of the need for early consultation with the designated MHO to make sure that they agree upon the recommendation. Early consultation is also important because the MHO has a duty to check that any community-based services that may be required in the order are actually available.

## Potential outcomes of the trial process:

There are three broad potential outcomes:

- Conviction of the offence;
- Acquittal of the offence; and
- Insanity in bar of trial.

We will discuss conviction and subsequent disposals, particularly **Compulsion Orders** later in this text. The Draft Code of Practice makes specific reference to acquittal as an outcome, to acknowledge that a mentally disordered person acquitted of any offence may still require treatment if necessary by compulsion of any of the civil routes – ‘Emergency, or Short-term Detention’ or by application for a ‘CTO’. However, upon acquittal there is one emergency measure that the Court may impose under **Section 60C**.

Upon evidence from two medical practitioners, the Court may authorise the removal of the acquitted person to a place of safety and detention there for up to six hours, for the purpose of securing a medical examination. The order ceases before expiry of this six-hour period, if the patient is subsequently detained under either emergency or Short-term Detention. Section 60C clearly exists to meet the contingency of an acutely mentally disordered person being acquitted from Court and being free to leave while manifesting potential need for treatment and risk to self or others.

‘Insanity in bar of trial’ implies that the accused has a mental disorder that renders him or her unfit to plead, unable to instruct a legal defence and unable to participate in the trial process. The disposals available in this case are out-with the scope of our material, being pre-existing elements of the 1995 Act. Although insanity in bar of trial accounts for a very small portion of mentally disordered people dealt with by the criminal justice system, the MHO carries particular duties in respect of Supervision and Treatment Orders. If you need to find out more about it, we refer you to Volume 3 of the Draft Code of Practice.

### 2.3 Post-Conviction Assessment and Treatment

**This section expands upon the use of Assessment and Treatment Orders after a person has been convicted of an offence. It also introduces the ‘Interim Compulsion Order’ as a post conviction disposal.**

After a person who may have had no previous symptoms has been convicted of an offence, she/he may appear to be mentally disordered and to require assessment and/or treatment *before* sentencing can take place, to take best account of the overall circumstances. In such cases the Court may consider either making an Assessment Order (if the need is for assessment of the matters from section 52D(7), listed above) or a Treatment Order (if the need is to secure a period of treatment before sentencing, as per section 53D(7)). In either case the RMO must make a report for the Court and should make recommendations especially if any mental health disposal is being considered. At every point in this process the Draft

Code of Practice emphasises the need for the RMO to consult with the designated MHO.

**Note:** In the case of either an Assessment or a Treatment Order an SCR is required of the designated MHO as they are 'relevant events' as defined in Section 232.

### **Interim Compulsion Order (Section 53 A to D):**

This option allows for a prolonged period of in-patient assessment before the final disposal is made. This is distinguishable from an Assessment Order because the Interim Compulsion Order is renewable, thereby allowing for the lengthy assessment that may be required of people who have committed serious offences and/or appear to pose considerable risk. It would therefore be considered where more serious disposals of greater restriction were being considered. The Draft Code of Practice emphasises the special need for close consultation of the RMO with the MHO in such a case.

### **Details of the Interim Compulsion Order (ICO):**

- Lasts for a period of 12 weeks; and
- Renewable for consecutive periods of 12 weeks adding up to one year in total.
- The order gives authority to:
  - Detain the patient in a place of safety;
  - Convey him or her to a specified hospital within 7 days of the order being made;
  - Detain him or her in that hospital; and
  - Give medical treatment in accordance with Part 16 of the 2003 Act.

For the Court to consider an order of this length, the offender must have been convicted of a serious offence punishable by imprisonment, other than murder. The court must be satisfied that there are reasonable grounds for believing that the offender's mental disorder is such that it would be appropriate to make a disposal of a Compulsion Order with Restriction or a Hospital Direction. The Court must also be satisfied that it is appropriate to make an ICO, having regard to all the circumstances, including the nature of the offence and having regard to any alternative disposal available.

For this latter consideration again a key role of the MHO comes to the fore. For the Court to be aware of any potential alternatives, some of which may involve community-based compulsion, the RMO must obtain an MHO's view of suitability and availability of such services. Only having discounted these options may the RMO advise the Court of the appropriateness of the ICO. It is possible that an SCR has been prepared by this point, from a preceding assessment or Treatment Order. This would be of assistance to the RMO.

The McLean Report (in respect of serious violent and sexual offenders) recommended the use of Interim Compulsion Orders (extended assessment), before a Court reaches a final decision about a mental health disposal in the case of serious violent offenders, the intention being to ensure that a serious offender is

not inappropriately made the subject of a mental health disposal. The 'Millan Report' supported this recommendation.

Bearing in mind the important role MHOs play in risk assessment and management considerations, MHOs may be able to contribute significantly to the consideration of when an ICO may be appropriate, and also what form of final disposal in respect of care, treatment and supervision may be suitable at the end of this more thorough and protracted period of assessment and possibly treatment.

An ICO requires two medical recommendations, one by an approved medical practitioner. The conditions that must frame the evidence of the medical practitioners are as follows:

- The offender has a mental disorder;
- There are reasonable grounds for considering that available medical treatment would alleviate or prevent deterioration of the condition;
- There are reasonable grounds for considering that the offender would be at risk to his/her health, safety or welfare or that any other person's safety would be at risk if such treatment were not provided; and
- An ICO is necessary.

There are reasonable grounds for considering that one of the following final disposals would be appropriate:

- Compulsion Order with Restriction;
- Hospital Direction. (For discussion of these, see below); and
- A suitable hospital placement which is available.

The assessment process should be multidisciplinary and a designated MHO must be allocated for this purpose, if one is not already involved. The MHO must prepare an SCR (see paragraph above re MHO contribution to risk assessment/management considerations, and ICOs).

On completion of the assessment process, whether or not it involves renewals of the ICO, the RMO must provide the Court with a written report. As with those following assessment and Treatment Orders, the purpose of the report is to assist the Court in making the appropriate disposal. At this stage the Court should request a MHO Report that will address the extensive issues described in the Draft Code of Practice, and referred to below.

## 2.4 Post-Conviction Disposals

**This section introduces ‘Compulsion Orders’, ‘Restriction Orders’ and other post-conviction disposals. It also briefly discusses the interface of the 2000 Act and the 1995 Act in relation to Guardianship.**

Following conviction of an offence and any proper assessment for mental disorder, the Court must determine what to do with the offender. In this respect there is a wide range of disposals available under the 1995 Act:

- Imposition of any sentence, custodial or community based;
- Interim Compulsion Order (as discussed above);
- Compulsion Order (inserted into the 1995 Act by the 2003 Act and consequently discussed in detail below);
- Compulsion Order with a Restriction Order (inserted into the 1995 Act by the 2003 Act and consequently discussed in detail below);
- Hospital Direction (inserted into the 1995 Act by the Crime and Punishment (Scotland) Act 1998 and briefly discussed below);
- Welfare Guardianship or Intervention Orders (1995 Act in relation to the 2000 Act, predating the 2003 Act and therefore not discussed in any detail below); and
- Probation Order with a requirement for treatment (Section 230 of the 1995 Act, predating the 2003 Act).

Since our remit here is only to deal with those disposals in relation to the 2003 Act, we refer you to the Draft Code of Practice if you wish to find out more about the other options listed above. In this matter, the only one of those options that the Code does not discuss in any detail is the ‘imposition of any sentence’. This is because it is not a disposal that is given specifically as a result of a mental disorder.

Interim Compulsion Order is listed as a disposal available at the sentencing stage as well as at the pre-sentencing stage, because it is an interim disposal; an option available to the Court to enable it to make the most appropriate final disposal. Therefore, it spans the pre- and post-sentencing stages, much as assessment and Treatment Orders span pre- and post-conviction periods.

You may have noted from the above discussion that it is a means of making prolonged and in-depth assessment of cases where serious offences have been committed or where the mental disorder poses considerable risk. Therefore, the Interim Compulsion Order may be seen as an assessment bridge to orders of greater restriction, the Compulsion Order with a Restriction Order and the Hospital Direction.

**Hospital Direction** was introduced into section 59A of the 1995 Act by the Crime and Punishment (Scotland) Act 1998 in order to allow a convicted offender to be given a hospital disposal alongside a custodial sentence. It is discussed in some detail in the Draft Code of Practice. The references made to it in relation to our purposes in the 2003 Act are as follows:

- The Court should request a Mental Health Officer Report, prior to making such a disposal. ( Draft Code of Practice);
- To require the MHO to take all reasonable steps to identify the named person as soon as is practicable after the order is made;
- To require an SCR of the designated MHO where a Hospital Order is made; and
- To require the RMO to consult with the MHO on review of the order.

Welfare Guardianship and Intervention Orders from section 84 of the 2000 Act facilitate the appointment of a guardian and/or intervenor under section 57(2)(c) or 58(1) of the 1995 Act. In this matter the principles of the 2000 Act would apply to the administration of the order within the framework of parts 5, 6 and 7 of that Act. You are referred to the Draft Code of Practice (Volume 3) and the Code of Practice for the 2000 Act for details.

**Compulsion Orders** replace Hospital Orders. Just as the Hospital Order mirrored Section 18 of the 1984 Act, the Compulsion Order mirrors the civil provision of CTO. We may therefore avoid much repetition by comparing and contrasting Compulsion Orders and Compulsory Treatment Orders.

Similarities of the orders:

- Recommendations are required by two medical practitioners (one approved), verifying the conditions for the orders;
- There must be evidence of mental disorder;
- There must be availability of medical treatment likely to alleviate or prevent the disorder from worsening;
- There must be presence of risk factors (health, safety, welfare or risk to the safety of any other person);
- There must be a demonstrable necessity for making the order;
- Both orders endure for up to six months renewable for six months in the first instance and thereafter annually;
- Both may enforce Detention in hospital or compulsion in the community. The measures set out in section 66 (1) of the 2003 Act and discussed in the Reader 3, apply to both orders;
- Both may require a report to be written by the MHO. There are some differences in these reports as discussed below; and
- Both require an SCR to be written within 21 days of the order being made. (See the section on SCRs below).

**Differences between Compulsion Orders and CTOs:**

- The CTO is made by application to the Tribunal, through civil procedures, while the CO is made by the Court through the 1995 Act;
- The recommendations by the medical practitioners for CTO are framed within civil law while the recommendations for CO are framed as evidence within criminal procedures;
- The CTO requires a test of significantly impaired judgement re the provision of medical treatment;

- With the CO, the offender must have been convicted of an imprisonable offence other than murder;
- Where detention in a state hospital is required by CO, the Court must be satisfied that the offender requires to be detained in conditions of special security such as can only be provided in a state hospital;
- In making a CO, the Court must have taken into account all circumstances of the case, including the nature of the offence. There could be no such a requirement upon the Tribunal in making a CTO;
- There is no requirement for an MHO's Proposed Care Plan in relation to a CO, although the Draft Code of Practice advises that one should be included in the MHO Report. A CTO requires a Proposed Care Plan as part of the application;
- There is no duty upon the MHO to inform the offender of the availability of advocacy in relation to the process of making a CO. Indeed, advocacy being a form of civil representation to enable the patient to make their views heard, it has no forum in criminal procedures. (There may be an argument that they can assist the service user in meetings with their legal representative and in generally negotiating this process). However, as we will see below, this and other rights-related duties fall into place as the order comes into the orbit of civil procedures once a psychiatric disposal has been made, for instance, in respect of reviews, renewals, etc; and
- In the process of a CO, the MHO has no expressed duty to advise the offender of his or her rights, while such a duty exists in relation to a CTO. The MHO, however, would do so in reference to their own professional Code of Practice.

### **Provision of Medical Treatment:**

The 2003 Act includes separate reference to personality disorder as one of the three categories of mental disorder (along with mental illness and learning disability) (section 328). While not wishing to stereotype personality disorder in proximity to Criminal Procedures, we do have to acknowledge the heavy representation of people within this category in the Criminal Justice system. Therefore, this section of the materials seems the best place to locate a discussion of issues of treatability in relation to the personality disorder and other difficult to treat disorders in Act. Furthermore, the case study for session 4 concerns personality disorder.

Psychiatry appears divided about the nature of personality disorder - illness, psychological dysfunction, learned behaviour or learning disability. It also remains divided about the general efficacy of medical treatment of the disorder, with a substantial prevailing view that many people who have personality disorder remain unresponsive to treatment.

Before examining how this issue relates to Assessment, Treatment and Compulsion Orders let us be reminded of how the Act interprets 'treatment'. Section 329 gives the meaning of treatment to include:

- Nursing;
- Care;
- Psychological intervention;
- Habilitation; or
- Rehabilitation.

Therefore, where 'medical treatment' is discussed in relation to these orders, it may be taken to have a wider meaning than the treatments we discussed in Reader 3 (ECT, artificial nutrition, medication to reduce sex drive, other psychiatric medication and psychosurgery).

Assessment and Treatment Orders (Sections 52D and 52M) both contain a condition that available medical treatment would be likely to alleviate or prevent deterioration of the patient's condition (Section 52D(7)).

The implication is that the purpose of the order is to assess whether these available treatments are appropriate for the person, in the circumstances of the case. Therefore, if the result of the enforced period of assessment is that there is no available medical treatment which would be likely to alleviate or prevent deterioration of the patient's condition, the outcome must be that the person cannot be made subject to a Compulsion Order or any other authority which might impose treatment.

This is underpinned by the conditions for making a Compulsion Order that medical treatment which would be likely to alleviate or prevent deterioration of the offender's condition is available.

The core purpose of mental health legislation is to secure the individual's right to treatment while unwell, even in circumstances where that person may, because of their mental disorder, have lost sight of the need for the treatment themselves. It therefore follows that, no matter how strongly the other conditions are met (existence of mental disorder, risk factors etc), no measure of compulsion may be enforced if the condition is considered untreatable or if the treatment for it is unavailable.

### **The MHO Report for a Compulsion Order:**

Where a Compulsion Order is being considered by the Court, it may instruct the MHO to prepare a report. Unlike the timeframe of 14 days from the completion of the last medical examination in relation to the submission of a CTO application, the timeframe for the submission of the report for a CO is at the Court's discretion. The purpose of this report is to assist the Court in determining the suitability of a CO, and consideration of any alternative mental health disposals that may be appropriate and available.

Many aspects of this report are the same as those for a CTO. The report must include:

- Details of the offender, including name and address;
- Name and address of primary carer and named person (if they are known);
- Details of personal circumstances; and
- Any other relevant information.

The report should discuss:

- The personal circumstances of the offender, as far as they are relevant; views of relevant others (named person, carer and others);

- The MHO's views of the suitability of the measures being sought by the medical reports, a proposed care plan;
- Confirmation on behalf of the local authority of availability of community services that are to be delivered by compulsion; and
- A description of any alternative mental health disposals that the Court may wish to consider.

All of this implies close and timely interdisciplinary working between RMO and MHO.

### **Restriction Orders:**

A Restriction Order allows additional scrutiny of a mentally disordered offender who may pose a serious risk to others. The emphasis is therefore on protection of the public as the offender progresses through rehabilitation. It is granted without time limit and, while it is always made in conjunction with a Compulsion Order, it cannot be made in respect of compulsory measures in the community. In short, a Restriction Order made with a Compulsion Order has the effect of indefinite Detention. There are safeguards, however, in that Scottish Ministers are under a duty to keep such an order under review the order has to be reviewed by the Tribunal every two years, the Mental Welfare Commission can require Scottish Ministers to make a reference to the Tribunal, and, if the RMO after reviewing an order submits a report to Ministers recommending conditional discharge, Ministers must make a reference to the Tribunal. The patient and their named person also has the right to apply to the Tribunal for Conditional Discharge, revocation of the Restriction Order, revocation of the Restriction Order and variation of the Compulsion Order by modifying the measures specified in it, or revocation of the Compulsion Order.

Being so restrictive of the subject's liberty, a Restriction Order must satisfy fairly rigorous conditions. It is ordinarily made following an extensive period of assessment under an Interim Compulsion Order. In the exceptional minority of cases where this has not happened, there must be reason for not having made such an Interim Order and such an initial assessment.

The Restriction Order is made with oral evidence given to the Court by one of the medical practitioners (must be an AMP) recommending the Compulsion Order. The conditions that must be satisfied place emphasis on the level of risk posed, with particular emphasis on the protection of the public from serious harm and the strength of relationship between that risk and the specified mental disorder.

Where a Restriction Order is recommended by the AMP, the MHO's report for the Compulsion Order should consider the merits (or demerits) of such an order. This report should consider:

- The need for compliance with any lesser restrictive options available;
- Risk management requirements; and
- The context for any future rehabilitation.

This should be discussed in the context of the Principle of ‘the least restriction in relation to the freedom of the offender’. However, this principle must be balanced against the core of the Restriction Order:

- The protection of the public;
- The conditions of serious risk to the public; and
- The relationship between that risk and the mental disorder.

This balance must be reflected in the MHO’s report.

## **2.5 Duties following making of orders**

Much as with CTOs, the lead role of management and review of orders is given to the RMO. However, there is a clear continuing role for the designated MHO who must take reasonable steps to identify the named person, as soon as practicable. Part 9 of the 2003 Act sets out the framework of review, extension and variation of Compulsion Orders, where the MHO who has a duty to be consulted upon review of the order and before variation or extension of the order.

Once made, Compulsion Orders closely mirror CTOs, just as ‘Hospital Orders’ under the 1995 Act mirrored section 18 of the 1984 Act via section 60, once the offender had been received into hospital detention. While Compulsion Orders are made by the Court, they may be varied or extended by the RMO’s application to the Tribunal. Consequently, the same processes as we discussed in Reader 3 pertain here. The MHO has a duty to inform the patient of his or her rights in general and, in particular to make the patient aware of the availability of advocacy services, etc.

While there is no appeal against the order as made by the Court, following any extension or variation of the order by the Tribunal, the patient has the same rights as any patient who is subject to a CTO under civil procedures. It may be helpful to think of the order made by the Court as being within the orbit of the criminal justice system in relation to the 1995 Act. Once the order has been varied or extended by the Tribunal, it comes into the orbit of civil procedures in relation to the 2003 Act, and therefore, all the rights accorded under the 2003 Act begin to apply. The patient or the nearest relative may then apply to the Tribunal to have the order revoked or varied. Similarly, in part 10 of the 2003 Act, a patient subject to a Compulsion Order with a restriction order may not apply to the Tribunal to revoke the orders within the first six months, but may do so there after.

Unlike a CTO, the First Review of a Compulsion Order (after the first 6 months) requires referral to the Tribunal by the RMO, even if the RMO is not recommending any changes.

After the first 6 months of the Restriction Order, when it falls into the orbit of civil procedures, the designated MHO’s role becomes comparable to that of the MHO in relation to a renewed Compulsion Order or a CTO.

### **Transfer from prison to hospital:**

A prisoner serving a custodial sentence may be transferred to hospital for treatment under a Transfer for Treatment Direction under section 136 of the 2003

Act. This direction is made by the Scottish Ministers upon application by 2 medical practitioners, one of whom must be an AMP. Once treatment is no longer required, the direction may be terminated and prisoner returns to serve the remainder of the sentence in custody. Where a transfer for treatment direction is made, an MHO must be designated and an SCR must be completed in 21 days.

### **3. Provision of Social Circumstance Reports**

**In this section we will look at the legal requirements for an SCR. We will also look into the nature and purpose of the SCR in addressing the question - what added benefit can an SCR offer on top of the weight of reports written in pursuit of an application?**

#### **3.1 When is an SCR required?**

Section 231 (1) requires the designated MHO to submit an SCR whenever 'a relevant event occurs', within 21 days of the event occurring. The meaning of 'relevant event' is given under section 232:

- a) The granting of a short-term certificate;

The making of:

- b) An interim CTO;
- c) A CTO under civil procedures of the 2003 Act;

Or, any of the following under criminal procedures of the 1995 Act:

- d) An Assessment Order;
- e) A Treatment Order;
- f) An Interim Compulsion Order;
- g) A Compulsion Order;
- h) A hospital direction; and
- i) A transfer for treatment direction.

Unless Section 231(2) (discussed below) is invoked, the designated MHO has a duty to provide an SCR within 21 days of any of the above being made.

#### **3.2 When would the preparation of an SCR 'serve little or no practical purpose'?**

Section 231(2) states that, provided the MHO records a statement to that effect and notifies the RMO and the Commission of such, she/he need not prepare an SCR if it is his/her judgement that it would serve little or no purpose.

Clearly this helps MHOs to avoid going through the time-consuming process of writing a report where there is nothing new to say about its subject. This Section 231(2) allows the MHO to use judgement on when a report is required, targeting SCRs on situations where they serve a useful purpose.

The production of an SCR is a duty under the Act and is therefore an action referred to in the principles refer as 'discharge of any function'. Therefore, the production of an SCR is an action in which the MHO is bound by the principles and it would not be acceptable to use Section 231(2) as an excuse for not producing a report because the MHO is too busy, or because it is inconvenient. Similarly, the local authority has a responsibility under Section 32(1) to appoint a sufficient number of MHOs to discharge the statutory duties which fall to the service.

The most obvious situation where invoking Section 231(2) would be justified is where a recent SCR has been written and circumstances have not changed. To illustrate this point, consider that a report has been produced for a Short-term Detention, stating the intention to apply for a CTO requiring continuance of detention. If the CTO has then been granted without problems and there has been no subsequent change in the patient's circumstances, a further SCR may serve little or no practical purpose. In this case, the only new information, that the CTO had been granted, would be contained in the statement required by Section 231(2) (b)(ii), informing the RMO and the Commission of why the report would serve no useful purpose.

Other situations in which it might be felt that providing an SCR would serve little, or no, practical purpose is where a patient is discharged from hospital and the order has been revoked relatively shortly after the order had taken effect. At present a sizeable percentage of Emergency Detentions do not proceed to Short-term Detentions. If we assume that as the primary entry point for patients subject to compulsion will be Short-term Detention, it may well be that a significant percentage of these detentions are discharged and the patient out of hospital prior to the local authority being notified. In such cases it would still be expected that the MHO discuss the potential value of such a report with the RMO.

In considering whether a report would serve no useful purpose, the MHO must be mindful of the dual audience of the RMO and the Commission. A report may seem to serve no practical purpose to the RMO, who is as familiar with the facts of the case as is the MHO. However, the Commission may still benefit from being informed of circumstances.

### **3.3 What is the general purpose of an SCR?**

An SCR has various purposes depending on the situation in which it is required. For some measures of compulsion such as Short-term Detention, focused on assessment of the patient's need for longer and more involved measures of compulsion such as a CTO, an SCR might have the purpose of informing the RMO of social circumstances in order to facilitate the decision whether or not to make a recommendation for the order. In other situations, such as the SCR required of a CTO, the purpose may be far broader than the narrow confines of regard for the need for compulsion. In respect of the SCRs required of orders under criminal procedures, it may be seen as a tool to enable the RMO to make appropriate recommendations to the Court but also to ensure that health and social care services are alerted to and pay proper regard to the assessed needs of the patient, irrespective of the outcome of the criminal proceedings.

It must also be borne in mind that the RMO and Commission may have very different needs of the same SCR. For the RMO it may facilitate better

understanding of the patient's background and circumstances, whether to make further decisions about compulsory measures or to facilitate the better provision of treatment.

For the Commission it provides a broad view of any circumstances that enable it to carry out its remit. The general remit of the Commission under **Section 5** of the 2003 Act is to monitor the operation of the Act and to promote best practice in relation to the Act. In this regard the monitoring brief is partly fulfilled by reading SCRs. The promotion of best practice may arise out of any issues that the Commission picks up from SCRs in relation to practice it wishes to highlight as good or practice it wishes to pick up or investigate as poor. Several of the Commission's Deficiency in Care and Treatment Enquiries originated with information provided in SCRs. The MHO may knowingly draw to the Commission's notice issues s/he is uncertain about or issues of genuine concern. It should be stated, however, that such concerns should never remain buried in a report but should be brought to the attention of the Commission, and/or an RMO in a covering letter.

### **3.4 What is the purpose of an SCR prepared after Short-term Detention or pre-sentencing orders of the 1995 Act?**

The main purpose of Short-term Detention and Assessment Orders is the assessment of the patient. Power to require treatment by compulsion is arguably secondary to this assessment process. In both cases, decisions about further measures of compulsion may be required, arising out of the period of assessment. With Assessment Orders these decisions are couched in recommendations to the Court in respect of the need for a Treatment Order or for one of various disposals at the point of sentencing. While Treatment Orders are focused on securing a longer period of treatment before conviction or sentencing, there is an element of assessment in these orders too, since the Court will expect a recommendation from the RMO at the end of the order or any subsequent renewal. In Short-term Detention these decisions are framed around whether or not to make an application for CTO.

In this frame of assessment the RMO needs to gather as broad a picture of the patient's social circumstances as possible. While the 2003 Act balances care and treatment in support of mental disorder, it must also balance the medical and social circumstances out of which mental disorder arises. If the RMO has expertise in medical aspects, the MHO has expertise in the provision of social care and in the social dimensions of mental disorder. It is clear that both medical and social factors are of equal importance and, to make the best possible assessment in this statutory frame, the RMO will need the MHO's views, contained in the SCR.

### **3.5 Some words about SCRs required by virtue of criminal procedures**

We do not wish to replicate the Draft Code's detailed outline of matters that ought to be addressed in respect of the various orders that require an SCR. However, it fits our more general brief for this Reader to touch on the matter of SCRs in relation to 'SERs', discussed in the Draft Code. The SER is a direct means of communicating information to the Court and is a tool specifically used by the Court to facilitate the sentencing process. The SCR in criminal procedures might achieve similar ends via the mediation of the RMO. The Court would not ordinarily read an

SCR, as they are not prepared for their purposes. However, the RMO ought to take account of its contents in fulfilling his/her duty of making recommendations to the Court. In certain circumstances, however, the Court might request a report from an MHO.

### **3.6 What differentiates the SCR from the Proposed Care Plan and other reports in the CTO application?**

At the core of the matter, the MHO Report to accompany the CTO application should focus on the assessed needs and why the criteria for compulsion are felt to be met, whereas a Proposed Care Plan, while commenting on assessed needs, primarily focuses on future care plans. And, while an SCR should comment to the extent possible on areas of assessed need that should be addressed in future care plans, the emphasis is more on the gathering and analysing of relevant information relating to the interplay between the patient's mental disorder and their social circumstances. Valuable information may be gathered during the process of compiling an SCR which may assist both in the assessment and diagnosis as well as future care and treatment plans. The RMO might not, in the general course of their work, be able to devote the same amount of time to focused discussions with key people such as named persons, carers and advocates as the MHO. The MHO in the SCR will be putting the person's mental disorder and its current manifestation in a broader social and personal context. How has the individual managed their illness, what has triggered acute episodes in the past, what has worked, what has not, what has changed to upset the equilibrium, what support is there, what has been lacking, what is the patient's attitude towards their illness and its management, and, what is the patient's view of detention are all questions which could be addressed in the SCR. The SCR, in general, should provide key information, reflect the analysis and multidisciplinary discussion which focuses on the information uncovered in the process of compiling the SCR and make recommendations about what needs to be addressed in future care plans. As such it informs the MHO Report and Proposed Care Plan submitted with the CTO application. It should be the case that the writing of the MHO Report and the Proposed Care Plan should be greatly facilitated by the creation of an SCR. Ideally, while the SCR will cover a range of issues and information not appropriate for the consideration by the Tribunal, much of the information which is required in the MHO Report and the Proposed Care Plan could be lifted from the SCR.

It may be difficult to disentangle these issues. Indeed, while one should anticipate an interactive dynamic between the broader social circumstances and those factors which cause a person to require measures of compulsion, in the main the Tribunal will primarily, but not exclusively, be interested in the latter issues. Therefore, the reports for an application should focus on these matters, though not to the exclusion of other needs and required services which could be provided without compulsion but would be necessary to support the viability of the overall care plan. As far as the RMO is concerned, valuable MHO views on broader issues may be lost were s/he not to be prepare an SCR.

As regards the Commission, information contained in an SCR written within 21 days of a CTO having been made might impact in two important ways. It may help to inform the Commission in relation to its power under section 81, to revoke an order where it is satisfied that not all of the conditions for the order continue to be met. The SCR may also provide information aiding the Commission in its power to

make a referral to the Tribunal in relation to any aspect of a CTO (section 98). The Commission would do this where it wished a review of any aspect of the order short of the order being revoked.

In writing an SCR, the MHO should be mindful of the possibility that, once lodged with the Commission, the report may inform matters at some future development in the implementation of the order.

### **3.7 A Template for SCRs**

Draft Regulations for civil procedures of the 2003 Act set out a template for SCRs. This contains three sections:

**Section 1** contains standard details about the patient- name, address etc.

**Section 2** asks the MHO to identify the appropriate 'relevant event' (Short-term Detention, CTO, CO, etc) that has triggered the duty to provide an SCR and requires the MHO to give any reasons why an SCR would 'serve little, or no, practical purpose'. If the SCR would serve little or no practical purpose, the MHO need only complete parts 1 and 2 of the proforma and send a copy to the Commission.

**Section 3** provides a standardising framework for SCRs by way of headings. These headings are drawn from the Social Work Services Inspectorate's 1999 publication 'The Role of SCRs in Planning for the Care of People Detained in Hospital'. It is interesting to note that the Regulations Policy document seeks to amend this publication in line with the new Act, rather than to redesign the purpose of the SCR. In this sense experienced MHOs should be comforted that we are not looking to devise new policy or practice for SCRs.

#### **SCR Headings in relation to the 2003 Act:**

- The reasons behind the use of the powers to which the patient is currently subject;
- The views of the patient with respect to these current powers;
- The views of carers and family members on these powers;
- The patient's current state of mental health;
- The patient's current state of physical health;
- The patient's mental health history;
- An assessment of risk to patient and any other person;
- The patient's detailed personal history, including employment, financial and accommodation situation;
- The patient's family situation, including children, dependants and caring responsibilities;
- The patient's regular social contacts: e.g. supportive friends, involvement with voluntary organisations, attendance of religious group etc;
- The patient's ability to care for himself;
- The care being provided to the patient prior to detention taking place;
- Any matters which could prompt the local authority to inquire under section 33 of the Act;
- The alternatives to detention which were considered and ruled out;

- The patient's history of detention, including any consideration of victims and/or those affected;
- The patient's history of substance misuse;
- The care planning which has been put into place to deal with any/all of the above issues;
- Any ethnic, cultural and religious factors which need to be taken into account; and
- Any language or communication issues which need to be taken into account.

Clearly not all the items on this list will be required in every case. It may not be an exhaustive list either. For example, history of offending, where it exists may be extremely relevant.

#### **4. What next?**

As with other Readers, you are now directed to the self-assessed test of knowledge attached to this Reader, to assess your readiness to undertake session 4 of the training. As with previous Readers please read and reflect upon the case studies if you have spare guided study time. Take notes of your reflections and compare these with your thoughts after the study day.

#### **5. Last word**

Page 270 of the published Act contains **Schedule 5**, dealing with Repeals and Revocations. It displays a table of two columns. The left-hand side column lists legislation in chronological order and the right-hand one itemises the extent to which it is repealed by the 2003 Act. The second occurring item on the left is the Mental Health (Scotland) Act 1984, a piece of legislation which many practitioners know in intimate detail. Against it, on the right, under the heading 'extent of the repeal' is written 'The whole Act'.

This is a small detail in the 2003 Act, but its significance is huge. It means that it is time to embrace change, to put the new into practice according to our best skills.

#### **6. Training materials and exercises for session 4: self-assessed test of knowledge**

**In order to assess your preparedness for the final session of the transitional training, please answer the following questions based on the material from the Reader 4.**

- 1) List as many circumstances ('Relevant events') as you are able, in which the 2003 Act requires the designated MHO to produce an SCR.
- 2) Within what period must an SCR be completed?
- 3) Is it always the case that an SCR must be produced after a 'relevant event'?

- 4) At what stages of the process from being charged with an offence through to sentencing may a person be made subject to an Assessment or a Treatment Order?
- 5) How long does an Assessment Order last for?
- 6) What sorts of offences might a Court consider making an Interim Compulsion Order for?
- 7) What reports are required of an MHO for a Compulsion Order?
- 8) What medical evidence is required for a Compulsion Order?
- 9) When may a Restriction Order be made?
- 10) Once made by a Court, how do Compulsion Orders differ from CTOs made by the Tribunal in civil procedures?

**Answers are found in Annex A.**

### **Introduction to the case study**

By this point in the programme you should require little by way of instruction in how to approach the case study. Remember to appoint a note-taker to keep salient points of discussion for feedback to the larger group, if required.

Before you engage with the case study, here is the abbreviated list of principles again:

The principles place a requirement on those people who have what we have called a formal role to discharge any function under the Act. The requirement is that, in discharging his or her function, such a person has regard for:

- 1) The present and past wishes and feelings of the patient.
- 2) In so far as is practicable, the views of the patient's named person, carer and any guardian or welfare attorney.
- 3) The importance of the patient participating as fully as possible in the discharge of the function.
- 4) The importance of providing information and support for the patient, in the form that is most likely to be understood, to enable the patient to participate.
- 5) The importance of the range of options available in the patient's case.
- 6) The importance of providing the maximum benefit to the patient.
- 7) The importance of the patient's abilities, background and characteristics, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.

- 8) The importance of providing appropriate services and continuing care to the patient.
- 9) The needs and circumstances of the patient's carer, providing such information as might be needed to assist in the care of the patient.
- 10) The function must be discharged in a manner that involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances, encourages equal opportunities and if the patient is a child (under 18 years old) best secures his or her welfare.

## **The Scenario**

### **Past History:**

Karen Rae is in her early thirties. She has a history of criminal convictions ranging from breach of the peace and petty theft to assault and dealing in Class A drugs. Resulting from this, Karen has received two custodial sentences, one following repeated breaches of probation.

Karen also has a psychiatric history stemming from her adolescence. She attended an adolescent psychiatric unit because of self-harm and behavioural difficulties with which her mother could not cope. At that time Karen disclosed that, from the age of 12 to 13 she had been routinely sexually abused by one of her brother's friends. Her psychiatrist from the unit believed that her behaviour was a post-traumatic stress response to the abuse. However, as her behavioural problems have developed into adult life, Karen has acquired the diagnosis of personality disorder.

Karen has no contact with her family. She has had numerous partners but is single at present. Karen has two children aged 3 and 7. Both are being looked after by the local authority and she has had little contact with them.

When under stress Karen, still cuts herself and, while in prison, she made several attempts to hang herself. She has a number of physical health problems resulting from prolonged abuse of heroin and crack cocaine.

Karen leads a chaotic life and is often homeless. Both social work and psychiatric services struggle to keep regular contact with her. Karen maintains her most consistent means of support is through her GP, because this affords her access to supplies of various medications. She is currently in receipt of anti-depressive and anti-psychotic medication from her GP, but it is thought doubtful that she takes either with the necessary regularity.

### **Present circumstances:**

The local authority is in the process of obtaining a permanency order for both Karen's children, so that they may be placed for adoption. This is a source of considerable emotional stress for Karen. The tenancy of her council flat is also in jeopardy because she is in considerable arrears and her neighbours frequently complain about disturbances and fights in and around the flat.

## **The offence:**

When Karen failed to appear in Court on a charge of shoplifting she was arrested by warrant. On arrest she was found to be in possession of seven bags of heroin with a street value of £10 each. She claimed that they were for personal use in support of her heavy habit. However, the police attempted to strip-search Karen in custody.

While she was verbally abusive to the police up to this point, nothing in her bearing forewarned them of the force of her violent outburst when they attempted the search. She managed to fracture a woman police constable's cheekbone and it took several officers to restrain her until the police surgeon could administer tranquillising medication.

In the cells Karen was considered unmanageable. She made repeated attempts to harm or kill herself by throwing herself against the walls. Upon her appearance in Court, charged with both the original offence of shoplifting and with assault of a police officer and possession of a Class A drug, the Procurator Fiscal applied for an Assessment Order upon the evidence of the police surgeon.

Karen is now detained in the forensic unit of the local psychiatric hospital for assessment.

Upon the making of an Assessment Order by the Court, the MHO has 21 days to prepare an SCR.

## **Questions**

- 1) Were you the designated MHO, what issues would you wish to highlight from the above case in the SCR and why? (Make a list of these issues. In doing so it may be of help to consider the section 3.7 'A Template for SCRs' and the list under the title 'SCR Headings in Relation to the 2003 Act' in the Reader).
- 2) Assuming that, following from conviction of the offences, the RMO intended to request a Compulsion Order from the Court, what issues would you wish to highlight in your report to the Court?<sup>1</sup> In particular, what would be your assessment of Karen's needs, what would you devise as a care plan and (assuming reasonable availability of services must be underwritten by the local authority) what services would you propose to meet those needs? (Make a list of the various matters you would wish to collect in this report. In doing so it may be helpful to consider the list under the heading 'MHO Report for a Compulsion Order' under section 2.4 of the Reader).
- 3) In what ways do the issues gathered for your SCR list differ from the issues gathered in list for the report to the Court for the Compulsion Order?
- 4) What measures of compulsion would you wish to see contained in any order made by the Court?

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<sup>1</sup> In reality it would be most likely that the Assessment Order would be replaced by a Treatment Order upon expiry, before Karen approached the sentencing diet of the Court.

- 5) In addressing this last question please debate the merits of a Compulsion Order which seeks to enforce order in Karen's chaotic life, where the best informal attempts at service delivery have so far failed.
- 6) Finally, while issues of availability of medical treatment are matters for the RMO, how might the case differ if the result of the Assessment Order was that there is no available medical treatment would be likely to alleviate or prevent deterioration of the patient's condition?



## ANNEX A

### Answers to the fourth self-assessed test of knowledge (Reader 4)

1. **Q: List as many circumstances ('Relevant Events') as you are able, in which the 2003 Act requires the designated MHO to produce an SCR.**

**A:** After any of the following:

- A Short-term Detention certificate has been granted,

The making of:

- An interim CTO;
- A CTO by the Tribunal;
- An Assessment Order;
- A Treatment Order;
- An Interim Compulsion Order;
- A Compulsion Order;
- A Hospital Order; and
- A transfer for treatment direction, made by a Court.

Of course it would be unreasonable of us to expect you to be able to reel this list off, from the top of your head. However, we would expect you to have been able to identify some of the more central events that trigger an SCR: Short-term Detention, CTO and perhaps one or two of the criminal procedures orders.

2. **Q: Within what period must an SCR be completed?**

**A:** Within 21 days of the certificate being granted or the Order being made.

3. **Q: Is it always the case that an SCR must be produced after a 'relevant event'?**

**A:** No.

While you may still not be familiar with the technical term 'relevant event', we would hope that the term triggered your knowledge that the designated MHO need not compile a report if it 'would serve little, or no, practical purpose.'

4. **Q: At what stages of the process from being charged with an offence through to sentencing may a person be made subject to an Assessment or a Treatment Order?**

**A:** Either before conviction or before sentencing.

5. **Q: How long does an Assessment Order last for?**

**A:** Up to 28 days, non-renewable. But extendable once by 7 days, subject to certain grounds, and application to the court by a medical practitioner.

6. **Q: What sorts of offences might a Court consider making an Interim Compulsion Order for?**

**A:** More serious offences, where a custodial sentence would be considered (other than in the case of murder). More specifically, an Interim Compulsion Order is almost always required to secure a lengthy period of assessment before a Restriction Order is considered. Therefore, an Interim Compulsion Order may be considered where further assessment is required to investigate the conditions of serious risk to the public and the relationship between that risk and the mental disorder.

We would not expect you to get this answer perfectly correct. For example, we would not expect you to fully recall the complexities of Compulsion Orders in relation to restriction orders.

7. **Q: What reports are required of an MHO for a Compulsion Order?**

**A:** The MHO should be required to submit just one (Mental Health Officer) report but it should contain a care plan within it and, if the CO is to be requested alongside a restriction order, it must give consideration to the suitability of that order.

8. **Q: What medical evidence is required for a Compulsion Order?**

**A:** As with a CTO:

- The existence of mental disorder, about which both practitioners must agree;
- The availability of medical treatment likely to alleviate or prevent the disorder from worsening; and
- The risk factors (health, safety, welfare or risk to the safety of any other person), and the necessity of making the order.

Unlike a CTO, the test of impairment to the ability to make treatment decisions is missing from the list of similarities above.

There is an additional criterion for the Compulsion Order that the offender must have been convicted of an imprisonable offence other than murder.

This is another of those situations in which we cannot reasonably expect you to have the list of conditions for the order off pat. We would hope one of two things- that you either knew an approximation of the answer or (the MHOs fall-back position) that you knew where to look in the Act, to find the answer.

9. **Q: When may a Restriction Order be made?**

**A:** As discussed in question 6, a Restriction Order is required to investigate the conditions of serious risk to the public and the relationship between that risk and the mental disorder.

We would hope that you do have an approximation of answer fixed in your mind, if only to the extent that the seriousness of a Restriction Order is such that it must be viewed in relation to public protection.

**10. Q: Once made by a Court, how do Compulsion Orders differ from CTOs made by the Tribunal in civil procedures?**

**A:** Upon any extension or variation by the Tribunal, Compulsion Orders are the same as CTOs. However, before that point there is no right for the patient or the named person to apply for the order to be revoked and there is no right to advocacy.

Unlike a CTO, a Compulsion Order must be referred to the Tribunal by the RMO, at the point of its First Review.



### Summary of the duties of the MHO for Criminal Procedures Act provisions

#### Compulsion Orders

- Generally speaking, the duties placed upon MHOs and upon RMOs are the same after someone has been made subject to a Compulsion Order as they are after someone is made subject to a Compulsory Treatment Order.
- Under **Section 57C** a Mental Health Officer's report may be required by the Court. In such cases an MHO is required to interview the offender wherever practicable and prepare a report stating the name and address of the offender; if known, the name and address of the offender's primary carer; in so far as relevant for the purposes of this section of the Act, details of the personal circumstances of the offender; and any other information the MHO considers relevant for the purposes of that section.
- **Section 138** imposes a duty on MHOs as soon as practicable after a Compulsion Order is made to take such steps as are reasonably practicable to ascertain the name and address of the patient's named person.

#### Mandatory reviews of Compulsion Orders by RMO

- **Section 139** consultation with MHO by RMO required re first review of order.
- **Section 140** consultation with MHO by RMO required re further reviews.
- **Section 141** consultation with MHO by RMO required before making a determination during mandatory reviews that the patient no longer meets the criteria for continued Detention and revokes the order.
- **Section 144** notification to MHO of revocation of order required by RMO.
- **Section 145** consultation with MHO by RMO required re mandatory reviews of order.
- **Section 146** consultation with MHO by RMO required where there is a proposed extension of order at first review.
- **Section 147** imposes duties on MHO triggered by above. MHO must interview the patient wherever practicable and must, in any case, inform the patient of the RMO's proposal, of their rights in relation to the proposed application, and of the availability of independent advocacy services. They must also take appropriate steps to ensure that the patient has the opportunity of making use of those services. In addition, the MHO must inform the RMO as to whether the MHO agrees or disagrees with the proposed application and, if they disagree, the reasons why this is the case. They must inform them as well of any other matters that the MHO considers relevant. The RMO must inform the Tribunal in any subsequent application

under Section 149 of the MHO's views and why they disagree with the order if they do. They must also advise the Tribunal in the application where the MHO failed to comply with the duties imposed by **Section 147**.

- **Section 150** consultations with MHO by RMO required in respect of proposed extension of order at further reviews.
- **Section 151** imposes duties upon the MHO triggered by above which are the same as those imposed under **Section 147**.
- **Section 152** imposes a duty on RMOs to consult with the MHO during further reviews of the order before making a determination.
- **Section 153** requires that the RMO give notice to the MHO (as well as the patient, the patient's named person, the Tribunal and the MWC) of the determination that the order is to be extended. The RMO must also advise the Tribunal of whether the MHO agrees or disagrees with the determination and if they disagree, the reasons for this. They must also advise the Tribunal where the MHO failed to comply with their duties under **Section 151**. Where the MHO disagrees the Tribunal has a duty under **Section 165** to review the determination. Before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

#### **Extension and variation of Compulsion Order:**

- **Section 154** requires the RMO to give notice to and consult with the MHO where the RMO is proposing extending and varying the order.
- **Section 155** imposes duties on MHO triggered by above which are the same as under **Sections 147 and 151**.
- **Section 157** places a duty on RMOs to give notice to MHOs where an application is to be made extending and varying a Compulsion Order. The application must state whether the MHO agrees or disagrees that the application should be made and if they disagree, the reasons why they do.

#### **Variation of Compulsion Order:**

- **Section 159** imposes a duty on RMOs to consult with MHOs as soon as practicable but before deciding to make an application when it appears to them that the Compulsion Order should be varied by modifying the measures specified in it. Any subsequent application under **Section 161** must include a statement as to whether the MHO agrees or disagrees with the application, and if they disagree, the reasons for this. The application must also indicate where the MHO failed to comply with the duties imposed under **Section 159**. Before making a decision the Tribunal must afford the MHO the opportunity of making representation orally or in writing and of leading or producing evidence.

### **Reference to Tribunal by MWC re Compulsion Orders:**

- **Section 162** requires the MWC to give notice to the MHO when they refer a case to the Tribunal. In such circumstances the Tribunal may make an order varying the Compulsion Order in respect of which the reference is made, or revoking the order. Before making a decision the Tribunal must give the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Application to Tribunal by patient/named person for revocation of extension and/or variation of Compulsion Order:**

- **Section 163** relates to the Tribunal's duty to review a determination to revoke an extension of a Compulsion Order. Before making a decision, the Tribunal must afford the MHO the opportunity of giving evidence orally or in writing and of leading or producing evidence.
- **Section 164** relates to situations where the patient or the patient's named person applies to the Tribunal to revoke a Compulsion Order or vary it by modifying the measures specified in it. When this happens, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Application for Interim Order by person with interest in proceedings:**

- Under **Section 169**, an MHO would be considered to be a person with an interest in the proceedings under the above sections and as such could make an application to the Tribunal to make an Interim Order (for up to 28 days) varying the Compulsion Order by modifying the measures specified in it.

### **Provision of MHO reports required by Tribunal:**

- **Section 173** relates to Regulations that may be made in respect of the above considerations by the Tribunal specifying the circumstances where the Tribunal can require the Mental Health Officer (and/or the patient's RMO) to prepare and submit a report on such matters as may be prescribed.

### **Failure to attend for medical treatment when attendance requirement is specified in Compulsion Order:**

- **Section 177** effectively states that **Section 112** in respect of patients subject to Compulsory Treatment Orders and the consequent involvement of MHOs applies to same situation where patients are subject to Compulsion Orders.

### **Non-compliance generally with Compulsion Order:**

- **Section 177** effectively states that the civil provision sections of the Act relating to non compliance generally with Compulsory Treatment Orders and

the consequent involvement of MHOs applies to same situation where patients detained under Compulsion Orders.

### **Compulsion Orders and Restriction Orders:**

- **Section 181** applies where a person is subject to a Compulsion Order and a Restriction Order and imposes a duty on the MHO to take such steps as are reasonably practicable to ascertain the name and address of the patient's named person.

### **Review of Compulsion Order and Restriction Order:**

- **Section 182** requires the RMO to consult with the MHO in undertaking their mandatory annual review of patients subject to Compulsion Orders and Restriction Orders.

### **Reference to Tribunal by Scottish Ministers re Compulsion Order and Restriction Order:**

- **Section 185** relates to situations where an RMO has submitted a report to Scottish Ministers under **Section 183 (2)** that includes a recommendation that the Compulsion Order be revoked or has submitted a report under **Section 184**. In such circumstances Scottish Ministers must make a reference to the Tribunal and must as soon as practicable give notice to the Mental Health Officer that a reference is to be made.
- Under **Section 186** the MWC has authority to require Scottish Ministers to make reference to the Tribunal in respect of a person subject to a Compulsion Order and a Restriction Order. In such cases Scottish Ministers are required under **Section 187** as soon as practicable after receiving notice from the Commission to make reference to the Tribunal. When reference is made, Scottish Ministers must as soon as practicable give notice to the MHO that the reference is to be or has been made.
- Where an application is to be made to the Tribunal by Scottish Ministers under **Section 191**, Scottish Ministers must as soon as practicable after the duty to make the application arises give notice to the MHO that the application has been or is to be made.
- Before the Tribunal makes a decision in relation to any reference made to it under **Sections 185(1), 187(2) or 189(2)** or any application under **Section 191 or 191(2)** they must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Conditional Discharge of Person on Compulsion Order and Restriction Order:**

- **Where a patient has been conditionally discharged by the Tribunal under Section 193 and the Tribunal imposes conditions on that discharge, Scottish Ministers have the authority under Section 200, if satisfied that it is necessary, to vary any of the conditions imposed by**

the Tribunal and must in such cases notify the MHO as soon as practicable of that variation.

**Appeal to Tribunal by patient/named person against variation of conditions imposed on Conditional Discharge where patient was subject to Compulsion Order and Restriction Order:**

- When Scottish Ministers do vary conditions as stated above, the patient and/or their named person may appeal this decision to the Tribunal within 28 days. Before making a decision on this appeal, the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence

**Appeal to Tribunal against recall from Conditional Discharge where persons were subject to Compulsion Order and Restriction Order:**

- Where an appeal is made to the Tribunal under **Section 204** by the patient or their named person, before deciding on the appeal the Tribunal must afford the MHO the opportunity to make representation orally or in writing and of leading or producing evidence.

**Hospital Directions and Transfers for Treatment Directions:**

- **Section 205** requires the MHO as soon as practicable after the direction is made to take such steps as are reasonably practicable to ascertain the name and address of the patient's named person.

**Review of Hospital Direction and Transfer for Treatment Direction:**

- **Section 206** places a duty on RMOs to consult with the MHO as part of the review of Hospital Directions or Transfer for Treatment Directions.

**Reference to Tribunal by Scottish Ministers or the MWC re Hospital Directions and/or Transfer for Treatment Directions:**

- **Section 210** requires Scottish Ministers to give notice to MHOs as soon as practicable where, upon receipt of a report by the RMO following a review of a Hospital Direction or a Transfer for Treatment Direction the decision is taken not to revoke the direction and a reference is to be made, as required, to the Tribunal.
- **Section 211** outlines the process to take effect when a notice is given by the MWC to Scottish Ministers under **Section 209**. Scottish Ministers must make a reference to the Tribunal as a result and must give notice to the MHO as soon as practicable after receiving notice from the MWC.

**Reference to Tribunal by Scottish Ministers re Hospital Direction or a Transfer for Treatment Direction:**

- When no reference or application to the Tribunal has been made during a period of two years, **Section 213** requires Scottish Ministers to make

reference to the Tribunal. In doing so they must as soon as practicable give notice to the MHO that a reference is to be made.

**Application by patient/named person to Tribunal to revoke Hospital Direction or Transfer for Treatment Direction:**

- **Section 214** gives patients and /or their named person the right to apply to the Tribunal to revoke a Hospital Direction or Transfer for Treatment Direction. Before making a decision the Tribunal must afford the MHO the opportunity to make representation orally or in writing and of leading or producing evidence.

**Assessment Order: Suspension of measure authorising Detention:**

- Under **Section 221** the RMO may suspend the Detention requirement of a patient on an Assessment Order and may include conditions seen as necessary in the interests of the patient. These conditions may involve the MHO, e.g. a condition that the patient grants access to an MHO. If an MHO is authorised under this section, the RMO then has a duty under **Section 222** to give them notice when the order is revoked. Similarly, when Scottish Ministers revoke the order under **Section 223**, they must also notify the MHO if they had been authorised under **Section 221**.

**Suspension of measures authorising Detention after other relevant events:**

- **Section 224** relates to situations in respect of; Treatment Orders; Interim Compulsion Orders; Compulsion Order and a Restriction Orders; Hospital Directions; and, Transfer for Treatment Directions where the RMO grants a certificate specifying the suspension of the Detention requirement for up to three months. When the period for which Detention is to be suspended would exceed 28 days, the RMO must give notice of the proposal to the MHO. When the certificate is revoked under **Section 225**, the RMO must also give notice to the MHO. Similarly, where Scottish Ministers revoke this certificate, **Section 226** requires that they give notice to the MHO.

This pack is one of a series of Training Guides detailed below developed for local authority mental health officers and related health and social care staff commissioned from Robert Gordon University by the Scottish Executive.

Reader 1

Introductory training for mental health officers and other practitioners

Reader 2

Emergency and short-term detention and related matters

Reader 3

Compulsory treatment orders and related matters

Reader 4

Provision of social circumstance reports and provisions for people with mental disorder within the criminal justice system and other related matters

Trainers Guide for Readers 1-4

Briefing Paper

For health service and local authority managers

Briefing Paper

For local authority elected members

This material is also available on the Scottish Executive's mental health law website

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