PATIENTS CONCERNED IN CRIMINAL PROCEEDINGS - (date)

Introduction

1. The purpose of this paper is to summarise the initial deliberations and to collate some preliminary proposals from Sub Group 4 (the Group) of the Legal Issues Committee. The work of the Group could not have been completed in isolation as it was inextricably interlinked with the work of the other three Sub Groups. In producing this paper the Group has necessarily made assumptions about some of the proposals from the other Sub Groups. It is hoped that the production of this paper will stimulate further discussion among the subgroups and members of the Legal Issues Committee, thus facilitating progress towards a final composite set of proposals.

2. The remit of the Group was originally established as:

   - definitions and terminology, including inclusion or otherwise of personality disorder within the legislation;
   - dealing with offenders with mental health needs; and
   - transfers between jurisdictions (part).

3. The first of these points has been addressed by the other Sub Groups and this Group contributed to that process. This paper focuses primarily on the second and third points.

4. The paper is concerned primarily with mental health legislation (the Mental Health (Northern Ireland) Order 1986 (the 1986 Order) and what may replace it), but also refers to other relevant legislation such as the Police and Criminal Evidence (Northern Ireland) Order 1989 and the Criminal Justice (Northern Ireland) Order 1996.

5. The Group recognised that the existing legislative framework contains many excellent features and it sought to build upon that foundation. It has taken account of legal developments in other jurisdictions, particularly in other parts of the United Kingdom. It has made recommendations to update the legislation, for example by incorporating requirements of the Human Rights Act. It also considered the principles that should underpin new mental health legislation and has made recommendations to ensure that the new legal framework is compatible with those principles. These processes have resulted in a potentially substantial agenda for change.

Principles

6. The Group noted the proposals by Sub Group 1 that future mental health legislation in Northern Ireland should be based upon and should incorporate the following four high level principles:

   1. Respect for autonomy
   2. Justice
   3. Benefit
   4. Least harm.

7. The Group also noted the principles underlying the Review which are enunciated in the Adult Mental Health Strategic Framework Report. This states that services should:

- respect service users and carers as individuals – through openness and honesty in the providing of information, respect and courtesy in individual interactions with service users, partnership and empowerment in service planning and delivery – with Government, providers and wider society each accepting their respective responsibilities; and
- demonstrate justice and fairness – resources for services should be allocated and managed according to criteria which are transparent and which demonstrate equity.

The framework of the Review is based on the following principles:

- partnership with users and carers in the development, the evaluation and monitoring of services;
- partnership with users in the individual assessment process, and in the development of their programme of treatment and care and support;
- delivery of high quality, effective treatment, care and support;
- provision of services which are readily accessible;
- delivery of continuity of care and support for as long as is needed;
- provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;
- take account of the needs and views of carers, where appropriate, in relation to assessment, treatment, care and support;
- provision of comprehensive and equitable advocacy support, where required, or requested;
- promotion of independence, self-esteem, social interaction and social inclusion through choice of services and opportunities for employment in social activities;
- promotion of safety for service users, carers, providers and members of the public;
- staff provided with the necessary education, training and support;
- services subject to quality control, informed by the evidence.

8. The Forensic Services Committee has produced draft recommendations that people should be treated:

- under conditions of security no greater than is justified by the degree of danger they present to themselves or others;
- in such a way as to maximize rehabilitation and their chances of sustaining an independent life; and
- by services that are open, accountable and subject to external review.

9. The Forensic Services Committee also supported the Principle of Equivalence, which states that people who are subject to the Criminal Justice System should receive treatment, care and support for their mental disorder which is of an equivalent standard to that received by people in the rest of our society. This Principle of Equivalence relates closely to other principles proposed by Sub Group 1, such as justice, equality and non-discrimination. It has particular implications for mentally disordered people in police custody or in prison. In addition to a range of services equivalent to those available in the community, those individuals who are in police custody or in prison should expect access to treatment in hospital on a voluntary basis (that is, voluntary in relation to mental health legislation). When compulsory assessment and treatment in hospital is required the criteria for admission to hospital should be the same as for people in the community. The decision to admit should be

based on similar information in relation to the medical and social circumstances of the individual, admission should occur within equivalent timescales and the rights of the individual should be protected by equivalent safeguards.

10. The Forensic Services Committee recognised the complex needs of mentally disordered offenders, their carers, the victims, service providers and the public. It has advocated improved co-ordination between the Criminal Justice System and mental health and learning disability services to meet these needs effectively and efficiently. The Group took a similar approach, recognising that diversion to one agency or service seldom provides a full and adequate solution and that co-ordinated responses by a number of agencies and services are generally required to address the full range of issues raised by mentally disordered offenders such as their needs for treatment and care and their criminal responsibility and culpability.

The Legislative Framework

11. In Northern Ireland, most of the legislation in relation to patients concerned in criminal proceedings or under sentence is contained in Part III of the 1986 Order. Part IV of the Criminal Justice (Northern Ireland) Order 1996 makes amendments to the provisions contained in the 1986 Order in relation to insanity and unfitness to be tried. The Criminal Justice Order also contains provisions in relation to Probation Orders, including those with conditions of treatment.

12. The Richardson Committee [1] recommended "the provision of care and treatment for mental disorder in relation to offenders, or suspected offenders, should be dealt with under the same legislation as that which applies to non-offenders. Involvement with the criminal justice process should not alter the basis on which an individual enjoys access to healthcare." The Group supported this view.

Proposal

1. Future mental health legislation should include provisions for the care and treatment of all mentally disordered people including offenders or suspected offenders.

Provisions Relating to Mentally Disordered People in Police Stations

(a) The Appropriate Adult Scheme

13. Paragraph 1.5 of Code C of the Code of Practice for the Police and Criminal Evidence (Northern Ireland) Order 1989 (the PACE Order) states: "if an officer has any suspicion, or is told in good faith, that a person of any age, including a person called to a police station to act as an appropriate adult may be mentally disordered, or mentally incapable of understanding the significance of questions put to him or his replies, then that person should be treated as a mentally disordered person for the purposes of this Code." The Code requires the appropriate adult to advise and assist the person being questioned, facilitate communication and observe whether or not the interview is being conducted properly. The Code also requires the appropriate adult to be present when the person is being advised of their rights, when intimate searches are taking place, fingerprinting, photographing when samples are being taken, during identification parades and when and if the person is being charged. The appropriate adult may also be required to give evidence in any subsequent court proceedings.

14 The Appropriate Adult Scheme seeks to regulate police interventions in relation to juveniles and mentally disordered individuals and to encourage that they are not

disadvantaged during police investigations by nature of their mental disorder or age. While these aims are laudable, the scheme has raised a number of concerns including:

- the criteria for suspected mental disorder are potentially very broad and do not appear to be adequately targeted at those who are most vulnerable at the time of interview;
- research has indicated that in practice there is a failure by police to identify mental disorder and this implies that the interests of mentally disordered people may not have been demonstrably safeguarded;
- there are difficulties in finding people to act as appropriate adults. Social workers may perform this function, but Trusts have not been provided with the resources to meet these considerable potential demands;
- in Northern Ireland there is a lack of detailed guidance for those acting as appropriate adults; and
- there has been insufficient training for staff acting in the role of appropriate adult.

Proposal

2. The Appropriate Adult Scheme should be reviewed in consultation with all relevant stakeholders with a view to achieving a more effective and fully co-ordinated approach.

(b) Fitness for Interview

15. Paragraph 12.3 of Code C of the Code of Practice for the PACE Order states, "no person who is unfit through drink or drugs to the extent that he is unable to appreciate the significance of questions put to him in his answers may be questioned about an alleged offence in that condition, except in accordance with Annex D." Annex D is designed to avoid delay in gaining necessary information which otherwise is likely to lead to interference with or harm to evidence connected with an offence or interference with or physical harm to other people.

16. The Code of Practice does not refer in this section to people who may be unfit for interview by reason of any condition other than through drink or drugs, specifically it does not address the needs of people who may be unfit for interview on account of mental disorder.

17. The Association of Forensic Medical Officers of Northern Ireland and the Association of Forensic Physicians in England, Scotland and Wales have created operational definitions. However, there is a wish to see these placed on a formal basis.

Proposal

3. Following appropriate consultation, Code C of the Code of Practice of the PACE Order should incorporate guidance on fitness for interview.

Voluntary Treatment in Hospital of Persons Held in Prison

18. It is a principle underlying the [PACE or 1986] Order that people suffering from mental disorder should, where possible, receive treatment on a voluntary basis. Currently there is no system in routine use whereby an individual who is in prison, who is suffering from a mental disorder that warrants treatment in hospital and who consents to voluntary treatment in hospital may be transferred to hospital to receive

treatment on a voluntary basis. Such individuals who require inpatient hospital treatment should not receive treatment in prison healthcare centres, because these centres are not equivalent to hospitals. It seems inappropriate to continue with the current system of subjecting to compulsory powers of mental health legislation an individual who is capable of consenting to treatment on a voluntary basis.

19. There is a concomitant need to respect the requirements of the Criminal Justice System that the individual be held in conditions of security. It seems there may be an argument for future legislation to further separate the powers to compulsorily admit individuals to hospital for assessment and treatment from the powers to hold the individuals in conditions of security. Exercise of the latter powers could allow an individual to be transferred to an appropriate secure hospital setting where he or she could receive treatment on a voluntary basis.

Proposal

4. Future legislation should allow for individuals held in police custody or in prison to receive treatment in hospital on a voluntary basis while being held in conditions of appropriate security. Such legislation may fall outside the mental health legislative framework.

Remand to Hospital of Unsentenced Persons Suffering or Suspected to be Suffering From Mental Disorder

20. Article 42 of the 1986 Order makes provision for Magistrates Courts and Crown Courts to remand to hospital for report on the accused's mental condition and Article 43 makes provision for remand to hospital for treatment. A remand under Article 42 can be made on the basis of one medical opinion – the oral evidence of a Part II approved doctor. Article 42 does not evoke powers to treat without the patient's consent. At present the Court of Appeal has no specific power to remand an individual to hospital for a report or for treatment. The 1986 Order does not provide for the delegation of powers to the Responsible Medical Officer to grant temporary leave from the hospital.

21. For unsentenced individuals liable to be remanded to hospital, the Group favoured a process of admission to hospital for assessment followed by detention for treatment that is as similar as possible to the process available to individuals who are not subject to criminal proceedings. In complex forensic cases it may be difficult or impossible to complete a full assessment within the 2 week period that Part II of the 1986 Order currently allows. The option to extend the assessment period to a maximum of 4 weeks would seem appropriate and this may also prove relevant in the cases of certain patients subject to civil proceedings.

22. Once an individual no longer requires inpatient hospital assessment or treatment it should be possible to return him or her promptly to the Court so that an alternative and more appropriate placement may be found.

Proposals

5. There should be a single power available to Magistrates Courts, Crown Courts and the Court of Appeal to remand to hospital for assessment and treatment individuals who are charged with an offence punishable with imprisonment. This should be equivalent to the civil process of admission for assessment (Part II of the 1986 Order) followed by detention for treatment and should be based on evidence from similar sources in relation to the medical condition and social circumstances of the individual.

6. The period of admission for assessment for Part II and Part III patients should be capable of being extended from the current period of 2 weeks to a maximum of 4 weeks.

7. The procedures for treating without his or her consent a person who has been remanded to hospital by the Courts should be the same as for a person who has been compulsorily admitted to hospital from the community.

8. It should be possible for an accused person to appeal against an order for remand to hospital at any time during the period of remand.

9. When the Court remands an individual for assessment and treatment it should indicate whether the Responsible Medical Officer may give the person temporary leave from hospital or whether the decision to grant leave is to be reserved to the Court.

10. Once an individual no longer requires inpatient hospital assessment or treatment the new legislation should allow his or her prompt return to Court for alternative placement.

Mental Health Disposals by Courts (Hospital Orders, Interim Hospital Orders, Guardianship Orders, Hospital Directions, Probation Orders with Requirements as to Treatment for a Mental Condition or Dependency on Alcohol or Drugs)

23. Sentencing of mentally disordered people must be fair and be seen to be fair. This means not only that the convicted offender, the victim and the public should know what the sentence means in practical terms, but also the reason for the disposal should be made clear. The Criminal Justice Act 2003 in England and Wales requires that for a range of disposals including and extending beyond mental health disposals, the Court should make a statement detailing the options it has considered and its reasons for making the disposal. The remit of the Group is limited to mental health legislation, but such a practice would be entirely consistent with the principles of this Review.

Proposal

11. When making a mental health disposal the Court should make a statement detailing the options it has considered and its reasons for making the disposal.

Hospital Orders and Interim Hospital Orders

24. Currently the Magistrates or Crown Court may make a Hospital Order (Article 44) on the basis of two medical recommendations. The 1986 Order does not contain a requirement for a report into the social circumstances of the individual which has been prepared by an Approved Social Worker (ASW) or Probation Officer.

25. Part II of the 1986 Order requires that the medical practitioner who is making the recommendation for admission for assessment has examined the patient not more than two days before the date on which he or she signs the recommendation (Article 6 (a)). Similarly Article 5 (2) requires that an applicant for assessment (the nearest relative of the patient or an ASW) must have seen the patient not more than two days before the date on which the application is made. In accordance with the Principle of

Equivalence it seems appropriate that the mental health legislation should contain the same timescales whether or not an individual is involved in criminal legal processes.

26. A Court may impose a Hospital Order on a patient who has been convicted of an imprisonable offence if the Court is satisfied on the evidence of two medical practitioners that the necessary criteria apply. If the individual is acquitted (unless it is by reason of insanity), a Hospital Order cannot be made, however two medical practitioners have taken the view that the accused person requires detention. There is currently no process to allow such detention to proceed.

27. The Group noted the value of Interim Hospital Orders and other mechanisms whereby an individual may be admitted to hospital before the Court makes a Hospital Order. The Group considered it good practice for psychiatrists, lawyers and the judiciary to consider the full range of options available before making a Hospital Order with or without Restriction. The Mental Health (Care and Treatment) (Scotland) Act 2003 has extended the maximum period of an Interim Hospital Order from 6 months to 12 months. The Group supported similar provision in Northern Ireland.

28. An individual subject to an Interim Hospital Order cannot be transferred outside the Northern Ireland jurisdiction, for example to the State Hospital, Carstairs in Scotland. A similar situation is considered in greater detail below in relation to individuals on remand. It should be noted that this is a totally unsatisfactory situation that denies certain mentally disordered people in Northern Ireland access to the full range of legal provisions. It must be remedied as a matter of urgency.

Proposals

12. The mental health legislation should require that Courts receive information about both the medical condition and the social circumstances of the individual before making a Hospital Order or an Interim Hospital Order. The Courts may wish to receive additional information from other disciplines such as psychology.

13. When a mentally disordered offender or suspected offender is to be made subject to the powers of the mental health legislation, those who are making an application or recommendation must have seen the individual within a specified period of time. The same timescales should apply whether or not the individual is involved in criminal proceedings.

14. In the case of acquitted persons with recommendations for admission to hospital these recommendations should provide sufficient authority to permit the individual to be admitted to hospital for assessment.

15. The maximum period of an Interim Hospital Order should be extended to 12 months.

16. Mechanisms must be found to enable all people in Northern Ireland, including individuals subject to an Interim Hospital Order to have timely access to treatment in high security facilities.

Hospital Directions

29. Mental health disposals such as Hospital Orders allow for an individual to be transferred from the Criminal Justice System to a hospital where he or she may receive treatment for his or her mental disorder. In most cases the individual has been considered to have legal responsibility for his or her criminal behaviour, but on

transfer to hospital the requirement for treatment takes primacy over issues such as punishment and deterrence. In other jurisdictions, Hospital Directions have been introduced which allow, in certain situations, a Court to impose a sentence of imprisonment, including a life sentence for murder, and at the same time to authorise that the convicted person is admitted to and detained in hospital. Hospital Directions have been used infrequently in other jurisdictions, but may be appropriate disposals in situations where:

- there is not considered to be a strong association between the offender's mental disorder and the offence, and so punishment for the offence is appropriate, despite the current need for treatment; or
- the alleviation of those aspects of the person's mental state which are likely to respond to treatment may not substantially reduce the extent to which the offender presents a risk to the public.

30. The Group considered whether such an additional disposal may be appropriate in some cases or whether other disposals such as a combination of a sentence of imprisonment with a transfer direction order may adequately meet the needs. It has concluded that there may be a small number of cases where the availability of a Hospital Direction would provide additional benefits, for example, where an individual currently requires treatment in hospital and is unfit for imprisonment yet all the circumstances of the case require a prison sentence.

31. Appropriate appeal mechanisms are required to enable the individual to appeal against the hospital component of the disposal.

Proposals

17. A Hospital Direction should be introduced to the mental health legislation to provide a disposal option in certain cases such as where there is not considered to be a strong association between the offender's mental disorder and the offence or the alleviation of those aspects of the person's mental state which are likely to respond to treatment may not substantially reduce the extent to which the offender presents a risk to the public.

18. Appropriate appeal mechanisms are required to enable the individual to appeal against the hospital component of the disposal.

Guardianship Orders

32. Article 44 makes provision for the Crown Court or the Magistrates Court to make a person the subject of a Guardianship Order. The Group considered that any new arrangements should be consistent with and equivalent to the provisions for people who are not involved in criminal proceedings.

Proposal

19. The provisions for making Guardianship Orders or Community Treatment Orders in the cases of people involved in criminal proceedings should be consistent with and equivalent to the provisions for people who are not involved in criminal proceedings.

Insanity and Unfitness To Be Tried

33. The psychiatric defence of insanity serves to excuse an accused person from criminal responsibility for his or her actions. Previously the procedure in relation to the finding of insanity was addressed in Article 50 of the 1986 Order. A person who was found legally insane was made the subject of a Hospital Order with Restriction without limitation of time. That situation was amended by Articles 50 and 51 of the Criminal Justice (Northern Ireland) Order 1996 which introduced to the 1986 Order a range of disposals available to the Court including:

- a Hospital Order;
- a Hospital Order with Restrictions;
- a Guardianship Order;
- a Supervision and Treatment Order; and
- Absolute Discharge.

34. Criminal law also recognizes that an accused person may suffer from a mental disorder that renders them unfit to be tried. Previously the procedure in relation to unfitness to be tried was contained in Article 49 of the 1986 Order and this finding also resulted in the individual being made subject to a Hospital Order with a Restriction without limitation of time. The Criminal Justice Order amended those provisions by making available to the Court the same range of disposals as with the finding of insanity. In addition the Criminal Justice Order introduced the procedure referred to as "trial of the facts" as a safeguard that the jury could be satisfied that the accused did the act or made the omission charged against him/her.

35. The Group was concerned at the outmoded terminology of "insanity" which does not correspond to any clinical entity recognized by mental health professionals. There was concern that the term "insanity" is stigmatizing and promotes negative and unhelpful connotations of mental disorder. In 1975, the Butler Committee recommended that the insanity defence should be replaced by a finding that the accused is not guilty on evidence of serious mental disorder and that the phrase "serious mental disorder" should be defined. Thirty years later that recommendation still has much to commend it.

36. There is also concern that in cases of unfitness to plead or unfitness to be tried the range of disposals available to the Court may not adequately address the range of clinical conditions and circumstances that may present. For example, none of the disposals currently available may adequately address the circumstances of an individual with focal brain damage, who appears to have substantial responsibility for committing a serious offences and whose medical condition is not amenable to psychiatric treatment.

Proposal

20. The legal term "insanity" is replaced by a more appropriate expression such as "not guilty on evidence of serious mental disorder".

21. The disposals available in cases of unfitness to plead and unfitness to be tried are reviewed to take account of the range of clinical conditions and circumstances that may present.

Impaired Mental Responsibility

37. The plea of impaired or diminished responsibility is made only in murder cases. If it is successful it reduces the conviction from murder to one of manslaughter. Murder carries a mandatory life sentence, whereas the Court has a range of disposals available in cases of manslaughter.

38. Section 5(1) of the Criminal Justice Act (Northern Ireland) 1966 states:

> "Where a person charged with murder has killed or was a party to the killing of another, and it appears to the jury that he was suffering from mental abnormality which substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing, the jury shall find him not guilty of murder but shall find him guilty (whether as principal or accessory) of manslaughter".

39. From the viewpoint of the practising psychiatrist, this definition of impaired mental responsibility often causes profound difficulties because it is open to a wide range of interpretations. There is a yawning gulf between the legal definition and the realities of clinical classification and practice.

40. It can be argued that while a conviction for murder automatically attracts a life sentence, there will always be a need for a system such as impaired mental responsibility that recognizes reduced culpability and introduces a more flexible range of sentencing disposals. While recognizing such limitations, the Group considered that there would be substantial merit in reviewing the defence of impaired mental responsibility, particularly with a view to giving greater guidance to clinicians, lawyers and the Courts on the correlation between legal and clinical definitions and conditions.

Proposal

22. The defence of impaired mental responsibility should be reviewed, particularly with a view to giving greater guidance to clinicians, lawyers and the Courts on the correlations between legal and clinical definitions and conditions.

Transfer from Prison to Hospital

41. Article 53 of the 1986 Order makes provision for a person serving a sentence of imprisonment to be transferred to hospital after two written reports have been furnished to the Secretary of State. There is no requirement for a report on the social circumstances of the prisoner. Article 53 requires "that the person is suffering from mental illness or severe mental impairment". There is no provision for admission to hospital for assessment, and the transfer procedures do not conform to the tighter timescales under Part II of the 1986 Order that generally lead to prompt admission to hospital. Currently there may also be significant delays in returning from hospital to prison an individual who no longer requires treatment in hospital.

42. It is possible for the Secretary of State to refuse an application for transfer and the Order does not contain a right of appeal against such a refusal to transfer. The Group proposed the introduction of a right of appeal to the Mental Health Review Tribunal (MHRT).

43. The Group did not recommend that a specific provision is introduced to allow the treatment of mentally disordered people in prison against their will. It considered that those who meet the criteria for admission to hospital should be transferred there as a matter of urgency.

Proposals

23. The new mental health legislation should introduce provisions for transfer from prison to hospital for assessment, followed, if appropriate, by detention for treatment.

24. The decision to transfer to hospital should take account of the social circumstances of the individual as well as his or her medical condition.

25. Transfer to hospital from prison should occur within the same timescale as admission to hospital of an individual in the community.

26. Similarly, an individual should be returned immediately to prison once the Responsible Medical Officer is satisfied that the individual no longer meets the criteria for admission to or detention in hospital.

27. Where a prisoner has been assessed as meeting the criteria for admission to hospital under the mental health legislation there should be a right of appeal to a MHRT against a decision by the Secretary of State not to authorize a Transfer Direction. An individual should be able to appeal to a MHRT against a Transfer Direction in a similar fashion to a patient subject to civil detention.

Arrangements for Transferred Prisoners on Expiry of Sentence

44. Under Article 56 (2) a Restriction Direction in the case of a person serving a sentence of imprisonment ceases to have effect on the expiration of the sentence. When a person's sentence expires, therefore, he will simply be subject to a Transfer Direction which has the same effect as a Hospital Order. Under Article 56 (3) the date of the expiry of the sentence is calculated taking into account any remission of sentence to which the person would have been entitled if he had been transferred to hospital.

45. Under Article 46 (6) (a) a patient who is admitted to hospital in pursuance of a Hospital Order shall be treated for the purposes of the provisions of Part II mentioned in Part I of Schedule II as if he was detained for treatment and his date of admission was the date of the Hospital Order, subject to the modifications of those provisions specified in Part I of Schedule II. A patient admitted to hospital under a Hospital Order is treated essentially the same as a patient admitted to hospital under Part II of the 1986 Order. One major difference from a Part II patient is that the patient's nearest relative cannot discharge him from hospital. The effect is that the patient is detained beyond his release date as if he had been made subject to long-term detention under the civil procedures of the 1986 Order, but without there having been any prior approval by the MHRT.

Proposal

28. Where a person subject to a Transfer Direction or a Hospital Direction would be entitled to be released from prison, but the Responsible Medical Officer is satisfied that the prisoner requires continued detention under the mental health legislation, it should be necessary for the continued detention to be authorized by the MHRT (or to have the right of appeal to a MHRT) and the individual should be treated as if subject to normal civil procedures.

Restriction Orders

46. Article 47 of the 1986 Order provides powers to Crown Courts and Magistrates Courts to restrict discharge from hospital where

    (a) the Court makes a Hospital Order in respect of any person; and

    (b) it appears to the Court, having regard to the nature of the offence, the antecedents of the person and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm to do so.

47. The effects of a Restriction Order are that the provisions of Part II relating to the duration, renewal and expiration of authority for the detention of the patient do not apply. The day-to-day management of the restricted patient is the responsibility of the Responsible Medical Officer. However, any leave of absence or transfer requires the consent of the Secretary of State. The Responsible Medical Officer is also required to submit a report at least once a year to the Secretary of State. A MHRT may authorize:

    - Absolute Discharge;
    - Conditional Discharge; or
    - Variation or removal of Restrictions.

48. The Secretary of State may refer a case to the MHRT at any time if he or she is satisfied that there may be grounds for granting conditional or absolute discharge.

49. The Group recognised the importance of measures designed to protect the public from serious harm, but is concerned that Restriction Orders may discriminate against people suffering from mental illness or severe mental impairment. It would seem appropriate to incorporate future measures in relation to the risks posed by people suffering from mental illness or severe mental impairment within a wider risk management framework that addresses the full range of people who pose a risk of serious harm to the public. The Group noted the recent recommendations by Criminal Justice Inspection (Northern Ireland)[2] that the Multi-agency Procedures for the Assessment and Management of Sex Offenders (MASRAM) should be placed on a statutory footing, extended to include violent offenders and relate to those subject to Restriction Orders.

Proposal

29. New mental health legislation should continue to make provision for the imposition of Restriction Orders or similar that do not discriminate against individuals suffering from mental disorder and that are incorporated within a wider risk management framework.

The Role of the Secretary of State in Relation to Restricted Patients

50. The Secretary of State has a significant role in overseeing the management of restricted patients. The powers of the Secretary of State include:

    - to direct that a patient cease to be subject to special restrictions when satisfied that in the case of any patient a Restriction Order is no longer required for the protection of the public from serious harm;

- to discharge the patient from hospital, by warrant, if he thinks fit, either absolutely or subject to conditions;
- to refer a case to the MHRT at any time if he is satisfied that there may be grounds for granting conditional or absolute discharge; and
- that the Secretary of State is required to refer the case of any restricted patient detained in a hospital whose case has not been considered by the MHRT within the last two years.

51. The powers of the Secretary of State include not only the major decisions in relation to discharge but also more day-to-day management issues. The Secretary of State must approve leave of absence, even at the level of an escorted trip from hospital. The Secretary of State is also responsible for the authorization of transfers between hospitals and decisions to recall patients from Conditional Discharge.

52. It is sometimes mistakenly believed that only the Secretary of State has the power to discharge restricted patients whereas Article 78 of the 1986 Order empowers the MHRT to direct the absolute discharge of the patient and this is not subject to the approval of the Secretary of State. In practice the decision making authority of the Secretary of State is often delegated to Northern Ireland Office officials. Nevertheless, the question arises whether these responsibilities might more appropriately be placed elsewhere.

53. The Millan Committee[3] recommended that Scottish Ministers should no longer have responsibility for the management and discharge of restricted patients. This Committee suggested that these responsibilities should be transferred to the Risk Management Authority and to the Parole Board, the latter sitting as the Restricted Patients Review Board. However, these recommendations were not accepted by the Scottish Executive which decided that the MHRT should authorize all discharges of restricted patients and that Scottish Ministers should retain responsibility for authorizing leave of absence and transfers between hospitals of restricted patients.

54. The Richardson Report similarly commented on the role of the Home Secretary: "while we appreciate both the Home Secretary's proper interest in matters of public safety and the absolute need to protect the public from those patients who pose a real threat of violence, we cannot recommend that the current structure be continued unchanged." The Richardson Committee (the Committee) noted that the Human Rights Act required that an individual subject to detention on the grounds of his or her mental disorder must have the right to test the legality of that detention before an independent court. The Committee recommended that the final decision on transfer, leave, variation or discharge should rest with a MHRT, which had been specially constituted to hear restricted cases. The Committee recommended that the Home Office, as now, should have the right to make representations to the MHRT and the MHRT should be expressly obliged to consult the Home Office before making any decision.

55. The Committee also recommended the continuation of the power to impose a Conditional Discharge in the case of Restriction Order patients. However, it expressed concern at the fact that both community supervision and the power of recall could be applied to a discharged patient who was not, at the point of discharge, suffering from a mental disorder. The Committee recommended that aspects of the current provision be seriously reconsidered.

56. The Green Paper[4] noted that the Government was strongly of the view that the Restriction Order performed an indispensable function in the safe management of those offenders who posed a risk of serious harm to others. The Green Paper proposed that the power would be preserved in the new legislation and would continue to evoke scrutiny of the management of the restricted patient on behalf of the Home Secretary. It was also proposed that Restriction Orders should be limited in their availability to the higher courts although Magistrates Courts could commit an individual for sentencing in the higher courts where it was believed a Restriction Order was needed.

57. The Group appreciated that these are complex matters involving the human rights of the individual, the need to ensure that robust mechanisms are in place to consider relevant security issues and to safeguard the public and also the need to ensure practicable arrangements. It envisaged that the MHRT authorises the discharges and conditional discharges of all restricted patients. Patients who are subject to Conditional Discharge and who are recalled to hospital should be able to appeal to the MHRT. The Secretary of State should refer such cases to the MHRT within 7 days (the current provision under Article 80(1)(a) is for referral within 1 month).

58. The Group also noted that in England and in Scotland there are advisory mechanisms available to the Home Office and to Scottish Ministers. These allow for psychiatric advice to be given in the management of complex cases. There are no similar mechanisms available to the Secretary of State in Northern Ireland.

Proposals

30. The Secretary of State should retain responsibility for authorizing leave of absence and transfers between hospitals of restricted patients and the MHRT should authorize all discharges of restricted patients.

31. Consideration should be given to the appointment in Northern Ireland of a psychiatric advisor or advisory panel to the Secretary of State.

32. It is proposed that only the MHRT may authorize Conditional Discharge of a patient who is subject to a Restriction Order.

33. Patients who are subject to Conditional Discharge and who are recalled to hospital should be able to appeal to the MHRT against any such recall. The Secretary of State should refer such cases to the MHRT within 7 days.

Appeals Against Excessive Restriction in Hospital

59. The Millan Committee recommended that patients should have a Right of Appeal to be transferred from the State Hospital or from medium secure facility to conditions of lower security. The Scottish Executive believed there were a number of practical difficulties with these proposals and did not include this Right of Appeal in the Mental Health (Scotland) Bill. However, provisions were included in the Mental Health (Care and Treatment) (Scotland) Act 2003 to allow for appeal against detention in conditions of excessive security and patients from Northern Ireland who are detained inappropriately in conditions of excessive security at the State Hospital will be able to avail of these provisions when they come into effect in May 2006.

60. The Group strongly supported the principle of treating people under conditions of security no greater than is justified by the degree of danger they present to themselves

or others. There is particular concern that patients may be detained in locked or restricted environments with limited or inadequate access to appropriate ranges of therapeutic, educational, occupational, recreational and social activities. We advocate the introduction of measures to enable appeal against detention in excessively restrictive circumstances.

Proposal 34. Mechanisms to enable appeal against detention in excessively restrictive circumstances should be introduced.

Patients Removed To and From Northern Ireland

61. The authority to remove patients detained in hospital between Northern Ireland and England and Wales is contained in Part VI of the Mental Health Act 1983 and between Northern Ireland and Scotland in Part VI of the Mental Health (Scotland) Act 1984 and in Part 18 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Currently the main reason for the transfer of detained patients from Northern Ireland to England or Scotland is to receive treatment under conditions of greater security. A restricted patient detained in Northern Ireland may be transferred to England, Wales or Scotland if it appears the Secretary of State for Northern Ireland to be in the interests of the patient. Arrangements have to be in place to admit the patient to a hospital and, in practice, this means that the doctor is named at the receiving hospital as having agreed to take the patient.

62. At present, people who are remanded to prison and who are suffering from mental disorder which warrants transfer to a high security facility cannot be remanded to a hospital outside the Northern Ireland jurisdiction, and thus cannot receive appropriate treatment in conditions of high security until their case has been dealt with by the courts. There is no maximum security facility in Northern Ireland, so a prisoner who suffers from florid mental illness or severe mental impairment may have to remain on remand in prison for a prolonged period, perhaps a year or more, without adequate treatment.

63. Similarly, individuals whose circumstances may warrant an interim Hospital Order cannot be transferred outside the jurisdiction, for example to the State Hospital, Carstairs. Section 81 of the Mental Health (Scotland) Act 1984 (as amended by the 1986 Mental Health (Consequential Amendments) Northern Ireland Order) specifically excludes people subject to remand for assessment or treatment or to an interim Hospital Order (Articles 42, 43 and 45 of the 1986 Order from the arrangements for removal to Scotland of patients in Northern Ireland. This is a highly unsatisfactory situation that demands urgent resolution. The Group considered it imperative that a suitable solution to this problem is identified and implemented.

64. Once the Secretary of State authorizes the transfer of a patient from Northern Ireland he or she is required under Article 134 (6) of the 1986 Order to send notification of that authorization to the Mental Health Commission and to the nearest relative of the patient not less than 7 days before the date of the removal of the patient.

65. Under the current Scottish and English provisions, upon being transferred to England, Wales or Scotland the patient is treated as if, on the date of his or her admission to the receiving hospital, he or she had been detained under the corresponding enactment in England and Wales or Scotland. The same applies to transfers from most countries into Northern Ireland. The effect is that the detention “clock” resets itself. Thus a

patient could find that his or her period of detention without review (or a second opinion on his or her medication) lengthens.

66. Restricted patients being transferred from Northern Ireland should have a right to appeal to a MHRT at any time between notification to the patient and named person on the date of transfer, or within 28 days following transfer. However, these rights should not delay transfer where there are serious risks of harm to the patient or others.

67. The Group noted that there are maximum security facilities in the Republic of Ireland. There are occasions when there may be clinical benefit in transferring patients between Northern Ireland and the Republic of Ireland particularly in relation to patients requiring treatment in conditions of high security. Such transfers would require the formation of appropriate reciprocal legislation.

Proposals

35. Mechanisms must be found to enable all people in Northern Ireland, including prisoners on remand and those who may require an interim Hospital Order, to have urgent access to treatment in high security facilities when necessary.

36. The specific grounds for transfer should be recorded and made available to the Mental Health Commission and, where appropriate, the MHRT.

37. The requirement for 7 days notice prior to leaving Northern Ireland should be retained in a modified form, requiring notice to be given to the patient, the patient's named person as well as to the Mental Health Commission. However, it should also be possible for the notice of transfer to be waived in certain circumstances, for example where:
    - the patient agrees;
    - there are strong clinical reasons for an urgent transfer.

38. Restricted patients being transferred from Northern Ireland should have a right to appeal to a MHRT at any time between notification to the patient and named person on the date of transfer, or within 28 days following transfer.

39. Patients should be transferred under compulsion under the terms of the law of the receiving country, but that compulsion should be deemed to have started on the date of compulsion under the law of the previous jurisdiction.

Inspection of Prison Facilities and Services

68. In view of the very high psychiatric morbidity in prisons and the fact that people suffering from serious forms of mental disorder that warrant admission to hospital can remain in prison for prolonged periods without adequate treatment, the Group consider it was essential that provisions for mentally disordered people in prison are subject to internal governance and quality assurance and that they are open to external and independent inspection. The Group noted the new roles of the Criminal Justice Inspector, the Prison Ombudsman, the Health and Personal Social Services Regulation and Inspection Authority and the proposals by Sub Group 2 for the successor to the Mental Health Commission. It is essential that there is co-ordination among these and other bodies to ensure effective mechanisms for the independent inspection of services for prisoners suffering from mental disorder.

Proposal

40. There should be robust mechanisms with the necessary powers and resources to ensure the independent inspection of facilities and services for people in prison who may be suffering from mental disorder.

Discharged Prisoners

69. The Department of Health, Social Services and Public Safety issued guidance entitled "Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others" (May 2004).

70. There were substantial concerns about many aspects of the Discharge Guidance and these extend well beyond the remit of the Group. Here it is assumed that the Guidance will be replaced under the new mental health legislative framework and that approaches to risk assessment and management will be in accordance with the values and principles of this Review.

Probation Orders

71. Under the provisions of the Criminal Justice (Northern Ireland) Order 1996 a person may be made the subject of a Probation Order, Community Service Order, Combination Order, or Custody Probation Order at the direction of the Court, after being convicted of an offence. The legislation also provides for additional requirements in Probation Orders such as residence in an approved hostel, engagement in an offence prevention programme or treatment for a mental condition or for dependency on drugs or alcohol. The duration of a Probation Order is 6 months to 3 years and for a Community Service Order it is 40 to 240 hours.

72. In forming an opinion about the suitability of an offender for a community sentence, the Court is required to obtain a pre-sentence report from a Probation Officer and in the case of a Probation Order with an additional requirement as to treatment for mental condition, the Court is required to receive written or oral evidence from a registered medical practitioner who is approved under Part II of the 1986 Order. The Court must be satisfied that the mental condition of the offender requires and may be susceptible to treatment, that a Hospital Order is not warranted and that arrangements have been made to provide the treatment. For Probation Orders with additional requirements as to treatment for drug or alcohol dependency the Court does not require specific medical evidence before making these orders.

73. The Criminal Justice (Northern Ireland) Order 1996 also contains provisions in relation to individuals who are found to be legally insane or unfit to be tried. Such findings require the oral evidence of a medical practitioner approved under Part II and oral or written evidence from another registered medical practitioner. Individuals who are found to be legally insane or unfit to be tried may be made the subject of a Supervision and Treatment Order which may place the individual under the supervision of a probation officer for a period of up to 2 years.

74. Since the introduction of the Criminal Justice (Northern Ireland) Order 1996 the numbers of individual found legally insane or unfit to be tried has remained small. Courts have made limited use of additional requirements to Probation Orders for treatment of a mental condition or for treatment of drug or alcohol dependency despite the fact that a high percentage of clients supervised by Probation Board for

Northern Ireland are assessed as experiencing mental health and substance misuse problems. Possible reasons for these small numbers include:

- lack of developed forensic services;
- Government policies that mental health services should focus on severe mental illness;
- lack of psychotherapeutic training and services;
- lack of inter-agency training and co-working; and
- lack of research and evidence base to establish efficacy of treatments.

75. It seems likely that an inter-agency strategy is required to ensure that mentally disordered people who are the subject of probation orders receive the full range of services to address their mental health needs.

76. It has also been suggested that the requirement to receive evidence specifically from a Psychiatrist may be limiting the making of some probation orders with a requirement for treatment of a mental condition, particularly in those cases involving offenders with a personality disorder. In these cases it may be appropriate for the Court to receive evidence from a suitably qualified Psychologist or other mental health practitioner who is prepared to demonstrate to the Court that the condition requires and may be susceptible to treatment and that suitable arrangements for such treatment have been made. Nothing in the current legislative framework would appear to preclude such arrangements but it may be that changes to the legislation to specifically include them would facilitate the provision of appropriate treatment and care, as one component of a broader inter-agency strategy.

Proposal

41. Schedule 1 paragraph 4 of the Criminal Justice (Northern Ireland) Order 1996 should be amended to include an additional provision that, where the Court is proposing to make a Probation Order in relation to an individual suffering from personality disorder, the Court may receive evidence from a suitably qualified psychologist or other mental health practitioner who is prepared to demonstrate to the Court that the condition requires and may be susceptible to treatment and that suitable arrangements for such treatment have been made.

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