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VISIT AND MONITORING REPORT

CPSA 1995 monitoring - first contact with services

Individuals whose first formal contact with mental health services was through Criminal Procedure (Scotland) Act 1995 (CPSA) - a review of the Commission's files

Where an individual is charged and/or convicted of an offence and there is evidence of a mental disorder, whether at the time of the commission of the offence or at any point in the judicial process before or after conviction, then there are a variety of orders which Sheriffs or Judges can impose at the request of prosecutors, Scottish Ministers or following the findings of a jury. These are all covered under Part VI of CPSA as amended by Parts 8-13 of the Mental Health Act 2003 (MHA). In addition, convicted prisoners who subsequently develop or are found to have a mental disorder can be, with the approval of Scottish Ministers, transferred to hospital for appropriate treatment if it is not possible to treat them in prison.

In 2012-2013, we identified as a monitoring priority those individuals whose first formal contact with services was as a result of a conviction for an offence and disposal of the case using an order referred to in Part 10 of the Act. We also identified cases where there was clear evidence of mental disorder resulting in such an order being in place at some point in the criminal justice process. This includes those subject to the following orders: Compulsion Order with Restriction Order (CORO), Compulsion Order or Community Compulsion Order (CO/CCO), Temporary Compulsion Order or Interim Compulsion Order (TCO/ICO), Hospital Direction (HD), Transfer for Treatment Direction (TTD), and Treatment Order (TO).

We did not include those whose contact was only as a result of an assessment order (AO) and where there was no immediately subsequent CPSA disposal.

Our main reason for identifying this group was to determine if there was any evidence that better risk assessments or contact with mental health services might have prevented the need for compulsory care and treatment as a result of an offence being committed. Our underlying concern is that an individual may be left with a criminal record, unless they are acquitted as a result of the special defence of insanity (Sec 51A CPSA).

Background

Where there is no evidence of mental disorder, the court process is fairly straightforward.

An individual is charged with an offence, there may be a number of preliminary hearings held and then a trial date is fixed. The trial takes place and, if convicted, the person is sentenced. There are rules governing the maximum length of time between a first court appearance and the start of the trial.

The process can be more complex where there is a suggestion, or evidence, of mental disorder. It is still governed by timescales to ensure that there is no undue delay to the justice process.

At any point before conviction, the Procurator Fiscal or Scottish Ministers can request that the court impose an assessment order (AO). The court can also take this decision without such a request but based on the evidence before it.

An AO provides for the admission of an individual to hospital to assess their mental health. The order can last for up to 28 days, with a single extension period of seven days if necessary. Following this, the individual must return to court and the process continues, with the additional information gained from the period of assessment now available.

The psychiatrist who has been assessing the individual may provide a report which recommends a period of treatment, or indicates that the mental disorder is sufficiently serious such that the individual is unfit to plead. If the psychiatrist does not do this, then the individual continues through the usual justice process and no further mental health input is required.

If the psychiatrist is of the view that a mental disorder is present and treatment is required, or that the individual is unfit to plead, there are a number of options open to the court. The court may grant a treatment order (TO). A TO allows for an individual to be compulsorily admitted to hospital for treatment if the psychiatrist indicates that further assessment and treatment is required. This order can only be used prior to conviction and is not a disposal order. There is no time limit other than that laid down for the justice process generally. In other words, any time spent on a TO will count towards the maximum period of custody on remand.

If, however, the psychiatrist indicates that the individual is unfit to plead, the court may impose a temporary compulsion order (TCO) and then hold an “examination of the facts”. Alternatively, if the individual is acquitted on the grounds of insanity, the court can impose an interim compulsion order (ICO) pending an appropriate disposal.

Final disposal of the case may or may not result in an order being imposed. Where an order is imposed, this will either be a compulsion order (CO), compulsion order with restrictions on discharge (CORO) or a hospital direction (HD). A HD is rarely used and only in those circumstances where an individual has a mental disorder which requires treatment, but that does not appear to be related in any way to the offences for which they have been convicted.

Previous research has indicated that there is a strong relationship between childhood disruption and subsequent offending behaviour. It is also known that children who have been through care have a higher incidence of mental ill health. In

addition, the impact of substance misuse on the likelihood of aggressive behaviour in people with mental illness has been previously well reported.

Summary of findings

- We did not find any evidence that people were being inappropriately placed in a prison setting.
- The misuse of drugs and alcohol is noted in a significant minority of cases (38%)
- Whilst it is clear that there is significant variation in the amount of information that the Commission receives in respect of individuals who are subject to these orders, the lack of a Social Circumstances Report or any similar report in 50% of cases is very concerning.

Method

We identified from our database all those who met our criteria between the implementation of the 2003 Act in October 2005 and 31st December 2011. Of the 353 files we had to review, 328 were used in the data analysis.

The 25 files that were omitted included people on transfer for treatment directions (TTDs) from Dungavel Removal Centre, which accommodates failed asylum seekers. Dungavel Removal Centre is regarded as part of the prison estate, despite the fact that people held there have committed no criminal offence. A number of other individuals, on closer inspection, did not meet the criteria so it was not appropriate to include them in the analysis.

Our original intention had been to review all the files and note anything of interest including previous contact with psychiatric services. We intended then to use this information to visit all those who remained on orders, to examine whether there was anything which may have alerted people to issues prior to the index offence. However, our review of the files revealed that in many cases, there was very little information regarding previous contact. For many of those where it was noted, there was evidence of significant contact.

In just over half of the cases we noted no pertinent issues, usually because there was no information on file. Of these, 91 were no longer on any order. In total, two thirds of people were not on any order at the point of review.

Over half the individuals reviewed were noted as having had previous contact with psychiatric services (52% of females and 55% of males). In most cases this was in the recent past; 40 individuals appeared to be in contact with services at the time of their offence.

A minority were recorded as having difficulties at some point with drugs or alcohol, or other illicit substances. In many cases these difficulties were still present at the time of the offence. However, it was difficult to ascertain whether the drug or alcohol misuse was specifically related to the offence.

Detailed tables showing the diagnostic and offence related data are available in the appendix. As the numbers are small, and a lot of the information will be in the public domain, numbers quoted in respect of some parameters within the text exclude those where only very small numbers are reported - for example, in the outcomes of Treatment Orders as noted below.

Special Groups

There are 3 specific sub groups in the data. These are:

- Individuals subject to a transfer for treatment direction,
- Individuals who have not yet been convicted and
- Individuals who have been convicted and who are awaiting a decision about how their case will be dealt with.

Individuals subject to a transfer for treatment direction (TTD)

Individuals subject to a TTD are sentenced prisoners who have developed or had a recurrence of a mental disorder to the extent that they cannot be safely treated in a prison setting. The approval of Scottish Ministers is required before the transfer can be authorised and has to be supported by two medical opinions, one of whom must be a Section 22 approved doctor.

A prisoner on a TTD may be returned to prison following a period of treatment if his/her condition no longer justifies treatment in hospital. If the individual is still in hospital and receiving treatment at the point when his/her sentence reaches the "earliest date of liberation", arrangements for further treatment under the civil proceedings of the MHA have to be made in most circumstances. We therefore decided to look at this group on its own as their mental disorder is clearly separate from any offence.

Ninety-three people (87 men and 6 women) were on a TTD. Twenty-three of these individuals appeared to still be on the order at time of monitoring. In a number of these cases we should have received copies of reports etc, however, there was nothing on the file. A close examination of the files revealed that only 12 people remained on the TTD which had been in place as their first formal contact. A small number had transferred to civil orders, which had subsequently been revoked, and some had been returned to prison. Four people remained on civil orders at the time of the file review.

Diagnoses were available for most individuals; the majority (72) had a diagnosis of schizophrenia or other psychotic illness.

Five individuals who were subject to TTDs were noted to have a diagnosed learning disability. This provides some reassurance that there may not be a large number of people with a definite learning disability being inappropriately sent to prison. There was one individual with a diagnosis of Autism Spectrum Disorder.

Of the 26 files where pertinent issues were noted, the majority made reference to the abuse of drugs and, occasionally, alcohol prior to imprisonment. Seven had clear evidence of previous contact with psychiatric services.

Assessment Orders and Treatment Orders

For many people, their contact with mental health services via the criminal justice system is limited to AOs, sometimes followed by a TO which is then revoked by the court. Some individuals become subject to Mental Health Act orders, or agree to remain in hospital informally. Others may be returned to prison to await further court process or to be acquitted and freed. Some are dealt with other than by a custodial sentence.

We excluded from the study all those whose only formal contact with mental health services had been an assessment order. All those that are in the study either had a subsequent TO or received treatment under the Mental Health Act.

We were not able to identify the numbers of people who remained in hospital on an informal basis. The forms used to notify the Commission about the revocation of an order do not usually provide much detail regarding the reasons for the order being revoked or what happened afterwards. In some cases it was clear that the charges were dropped. In a few cases, it appeared that the court determined that the individual had spent enough time in “custody” and no further disposal was made. One or two people were noted as having been returned to prison.

Of those who were initially placed on Assessment Orders (160 out of 328), the majority were noted as having had previous contact with mental health services. The majority also had previous convictions. Diagnostically, the largest group were those with schizophrenia or another psychotic illness. Drug and/or alcohol abuse was noted as a contributing factor in a minority of cases; interestingly, 60% of these cases had a diagnosis of psychosis. Very few of the 160 individuals were noted as having had difficulties in childhood. About half had “pertinent issues” noted, although many of these consisted of further detail about previous offences, about final disposal of the criminal case, or clarification of the extent to which drugs/alcohol or childhood issues had been relevant. We have provided some examples below.

“25 yr history of schizophrenia and psychosis”

“Problems with behaviour and drug abuse since childhood. Evidence of possible mental illness from early teenage years”

“Was well known to psychiatric service at time of offences. Psychiatric history for many years with several admissions to hospital due to non-compliance with medication. He was placed on probation following conviction for firing airgun at police officer. Had several outpatient appointments in the months before his index offence. At court despite 2 psychiatric reports indicating he should be further detained the court revoked the Treatment Order. He was then an informal patient.

He absconded and attempted to kill .....He was charged with Attempted Murder, placed on Compulsion Order and Restriction Order and admitted to a medium secure facility".

Thirty-seven people were placed directly on to TOs, indicating that either they were already known to services and had clear evidence of active mental illness or that their presentation either in police custody or in court was such that treatment rather than assessment was indicated. The majority were noted to have had previous contact with mental health services and of those who did not (12 individuals), 10 had a diagnosis of schizophrenia or other psychosis. Drugs and/or alcohol were noted as factors in 17 cases. Twenty one people received a final disposal under CPSA, the majority being placed on COROs.

Of the 160 people who were initially placed on an assessment order 98 individuals progressed to further compulsory treatment as a disposal of their case. Thirty-two of these individuals are currently on an order, eleven on COROs and two on a Hospital Direction. The outcomes for people on treatment orders varied: 20 people were subsequently placed on a compulsion order, 13 of which were with additional restrictions (CORO). Fourteen people were either acquitted or had all charges dropped, some were then subject to civil orders such as a short term detention certificate (STDC) or a compulsory treatment order (CTO). In total for those placed on AO or TO (197), 60% received a CPSA disposal of their case.

One hundred and eight individuals had text in the "pertinent issues" field. As noted above, this was often further detail about the offence and subsequent disposal. However, in 88 cases there was evidence of previous contact with mental health services and a lack of engagement. We have provided some examples below

"Family had been seeking help prior to offence".

"Was being seen at out-patients for treatment of depression. ? was there any risk assessment carried out prior to his offence- attempted murder of ..... due to severe psychotic depression".

"Attended GP with anxiety, drug and alcohol dependence and auditory hallucinations. GP sought advice from psychiatrist re treatment options".

"Previous alcohol and illicit drug misuse. 14 year history of schizophrenia with several hospital admissions"

"Long history, appears to have been minimised to some extent both by him and by professionals until serious assault".

There is further discussion of relevant "pertinent issues" later in the report.

Post Conviction Orders (CO/CORO/TCO/ICO)

Thirty-four people had a first mental health order granted, either as a final disposal post conviction or as an interim or temporary order whilst the final mental health disposal was agreed. The majority of these individuals had evidence of previous contact with psychiatric services.

"Several very brief contacts with psychiatric services over a 30 year period -always disengaged from services. Living in marital home at time of offence, but effectively he and his wife living in separate parts of the home".

Twelve people were identified as having drug/alcohol problems in addition to a diagnosed mental illness, 8 of whom had schizophrenia.

A quarter of those where the first formal contact was post conviction apparently had a learning disability. This amounted to a third of the total number of people recorded as having a diagnosis of learning disability.

There was some evidence that there had been previous convictions for some individuals but the information held by the Commission was generally very limited.

Pertinent Issues

File reviewers were asked to note any pertinent issues relating to the individual and the offence committed.

This may have been –

- evidence of ongoing or previous contact with mental health services
- noted failures to engage or comply with services offered
- care gaps which may have had an impact on the subsequent actions of the individual
- any historical evidence such as being a looked after child
- having significant problems on childhood which may have been of relevance

Two significant and often interrelated themes emerged; non engagement with services and problems with drug and alcohol abuse.

Further examination of the files in cases where a CPSA disposal was made showed that 91 had some text in the pertinent issues field. Seventy-four indicated that there had been previous contact with mental health services and of these 44 were noted to have significant problems with drug and alcohol abuse.

We decided to look in more detail at cases with a CPSA disposal where the index offence was classified as murder, culpable homicide, attempted murder or serious assault.

Thirteen individuals were identified as having pertinent issues which warranted further review. When we looked at the files further, five contained additional information which indicated that the issues noted had been dealt with or were not in

fact supported by the evidence. The remaining eight were known to the Commission and we had carried out further investigation or were awaiting receipt of a critical incident review from the services involved. Only one has resulted in a published investigation report to date.

Social Circumstances Reports (SCRs)

Although we did not specifically ask about whether an SCR was completed at the time of the initial order, we are able to access this data from our information management system, IMP. About half (170 individuals) did not appear to have an SCR completed in respect of the imposition of a CPSA order. As all the orders are regarded as relevant events, this is very concerning.

In very few cases was there any indication that the mental health officer (MHO) had determined under Section 231(2) that the production of an SCR "would serve little, or no, practical purpose".

Many of the file reviews were annotated with "no SCR on file", some of which would appear, at least from the information that was available, to have been appropriate for the production of such a report. Even for service users with extensive histories there was a dearth of SCRs available. The following two extracts are from file reviews where no SCR was found.

"Very limited information on file -no final disposal, only details re assessment order and treatment order. Adult has a learning disability -brief background report on file indicates that he was assessed as being very vulnerable himself during his period in hospital, and would require considerable support making transition from child care to adult care services. Offences involved lewd and libidinous practices against two 6 year old children".

"Concerns raised by neighbours with MWC re risks not being taken seriously - neighbours reporting concerns re his behaviour. Communication with local services and copies of an ASP meeting received -this acknowledged that there could have been a more assertive approach taken to trying to engage with the adult, prior to the incident which led to contact under the CPSA. Also copy of Critical Incident review minute received -this indicated that there was a difference of opinion between the RMO and MHO re whether detention of the adult could have been considered prior to the incident. Also issues on file re extension of the CO in June ... -MHTS deemed extension to be invalid, and he was subsequently detained on a CTO, which he remains subject to".

When we looked at the percentage of SCR's available for people who were on CO/COROs in 2010, 73% had no SCR on file. In this report we are looking at a broader range of orders and at first formal contact with mental health services. One could expect that an SCR would be routinely available for the responsible medical officer (RMO) particularly as it should address issues which are not usually covered in great detail in social enquiry reports(SER) for the court.

However, the figure of 120, which is just over half of those in the study (231excluding those on TTD) is still worryingly high. The Act and its accompanying code of practice makes it clear that an SCR should be provided unless the MHO determines that it would "serve little or no purpose". In these circumstances, the MHO should notify both the RMO and the Commission, in writing, of their reasons for reaching this conclusion.

There is a helpful distinction noted in the code of practice between the SCR, which is prepared for the RMO and should inform the mental health assessment and for CPSA cases inform the consideration of appropriate mental health disposals, and the SER which is prepared for the court to inform sentencing and may be prepared by a practitioner other than the designated MHO. Whilst the information contained within the two reports may overlap, they are performing separate functions.

Of the 120 occasions where no SCR is on file the Commission and therefore, presumably, the RMO, were only notified of the reasons why an SCR was not required five times. This appears to us to be unacceptable.

Our good practice guidance on the preparation of SCRs[1] contains the following recommendations which are of relevance to this report:

- For a person who has no previous SCR on file, an SCR should always be completed within 21 days of initial relevant event. This is irrespective of whether or not the person is already known to mental health/learning disability services. In the exceptional – and unforeseen – circumstances where this does not happen, reasons must be clearly recorded in the SCR1 form.

- Local authorities should develop protocols with local Sheriff Courts to ensure that requests for SCRs by the court are made directly to a specified person within the local authority.

- An annually updated SCR should be provided by the designated MHO for all people subject to long term detentions. Exceptions to this would be where there are agreed alternative review arrangements in place, e.g. Care Programme Approach reviews that involve MHOs or MHO reports prepared to support decisions to extend/vary orders" (MWC 2009). Even in this situation, an updated SCR may be helpful.

  And from our previous monitoring report[2] for people subject to CPSA orders:

- Managers of services should identify a named MHO for each individual and audit the completion of social circumstance reports to make sure they meet the requirements of the 2003 Act

[1] Social Circumstances Reports. Good practice guidance on the preparation of Social Circumstances Reports for mental health officers and managers. (MWC 2009)
[2] A Question of Balance: Report from our visits to people given compulsory mental health care after committing an offence in Scotland (MWC 2011)

Whilst it would appear that for this group at least there has been some improvement in the availability of Social Circumstances Reports, it is clear that MHO services and their employing Local Authorities have some considerable way to go in meeting the recommendations made over 3 years ago.

This is a significant issue and counter to the principles embodied in the Act which are no less important for this group of individuals than those who have not been in contact with the criminal justice system.

General Conclusions

Our principal concern when we undertook this exercise was to establish whether there was any evidence that people with mental disorder were not receiving appropriately proactive care, and subsequently ending up receiving treatment through the criminal justice route rather than the civil proceedings route.

The information we were able to gain from our files did not allow us to draw any conclusions about this. However, we identified some instances where it appears that communication between services and professionals may have resulted in speedier action and reduced the possibility of the individual being dealt with through criminal justice procedures.

We did not find any evidence that people were being inappropriately placed in a prison setting. However, we are only notified of those that are transferred, and not those for whom a transfer to hospital is deemed appropriate by prison staff but is not approved by psychiatrists and/or Scottish Ministers. Nevertheless, our visits to prisons have not resulted in us identifying significant numbers of people who should be more appropriately cared for in a hospital setting.

The misuse of drugs and alcohol is noted in a significant minority of cases (38%)

Whilst it is clear that there is significant variation in the amount of information that the Commission receives in respect of individuals who are subject to these orders, the lack of an SCR or any similar report in 50% of cases is very concerning. Such reports are required by the Act whenever there is a “relevant event”. This includes all the orders that are the subject of this report.

Recommendations:

1. The Commission should agree on a minimum data set which should be provided by RMO/Medical Records with regard to individuals placed on a mental health order by virtue of the CPSA
2. Local authorities should take note of the findings in this report and in our previous reports and guidance with regard to the requirement for an SCR to be provided in all relevant circumstances and, if deemed to serve no useful purpose at the time, then the appropriate notifications should be made. The Commission will continue to monitor the provision of SCRs and the relevant notifications.

APPENDIX

Table 1: Type of Offence

Offence	Female (n=25	Male (N=303)	Total (N=328)	%
Murder/culpable homicide/serious assault	6	85	91	28%
Other assault	8	67	73	23%
Sexual offence	0	31	31	9%
Fire raising	3	9	12	4%
Theft	1	35	36	11%
Breach of the Peace	9	106	115	35%
Other	4	85	89	27%
Total	31	418	447	

NB Totals will be more than the number of individuals due to multiple offences

Table 2: Diagnoses

Diagnosis	Female (N=25)	Male (N=303)	Total (N=328)	%
Schizophrenia and psychoses	13	209	222	68%
Learning Disability	2	23	25	8%
Bipolar disorder	2	22	24	7%
Dementia	0	2	2	1%
Depression	4	23	27	8%
ASD	0	7	7	2%
Drug/alcohol abuse	3	121	124	38%
Personality disorder	5	9	14	4%
Other	0	15	15	5%
Total	29	431	460	

NB Totals will be more than the number of individuals due to multiple diagnoses


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