



Guidance for working with MAPPA and mentally disordered offenders

Introduction

The responsibility for identifying MAPPA-eligible offenders falls to each agency that has a statutory role in their supervision or care, i.e. the police, probation service, prison service, youth offending services and mental health services. These agencies must have robust internal management procedures in place to identify all MAPPA eligible offenders under their supervision in order to facilitate the lawful exchange of information for the protection of the public.

Public protection does not rest with any single agency. MAPPA exists to promote joint working. The collaborative nature of MAPPA should not, however, undermine the role of the lead agency to manage the offender in the community, but should assist in ensuring a robust risk management plan.

Under section 325(3) of the Criminal Justice Act 2003, health services have a duty to co-operate with the MAPPA responsible authorities in assessing and managing the risk of MAPPA-eligible mentally disordered offenders. Section 327 of the Criminal Justice Act 2003 identifies offenders who are MAPPA-eligible who have a mental disorder.

This guidance seeks to:

1. Identify which mentally disordered offenders are MAPPA-eligible and which agency has lead responsibility for supervising them.
2. Offer advice to mental health service providers on the internal identification process.
3. Provide advice to mental health services on the notification process to MAPPA.
4. Provide advice to mental health services on communication processes with MAPPA.
5. Recommend a referral process to level 2 and 3 for mentally disordered offenders.
6. Provide detailed advice on the Mental Health Act 1983 (the 1983 Act) and its implications for managers. (This more detailed advice is for those practitioners who would benefit from a more detailed understanding of the 1983 Act)
7. Describe the involvement of victim contact officers with patients subject to hospital orders, with or without restrictions. (The parts which deal with victims' statutory rights will be of particular importance to all Victim Liaison Officers – see 7.1 to 7.7 and 8.6 of Section 2.)

It does not introduce any new requirements.

This document comes in three parts.

- **Section 1** – Multi-agency public protection arrangements to manage offenders identified as mentally disordered.
- **Section 2** – Advice on the Mental Health Act powers and implications for agencies, including for victim contact.
- **Section 3** – A list of relevant Mental Health Act powers.

Section 1

1. MAPPA-eligible mentally disordered offenders

1.1 Mentally disordered offenders (MDOs) who are MAPPA-eligible are those who are:

- **convicted of a specified sexual or violent offence – Schedule 15 to the Criminal Justice Act 2003 (the 2003 Act) - and sentenced to twelve months or more imprisonment, or**
- **detained in hospital subject to powers of the 1983 Act.**

This means:

- those sent direct to hospital by a court, to be detained under a Hospital Order (section 37 of the 1983 Act), with or without a Restriction Order (section 41 of the 1983 Act). (A Restriction Order imposes, as its name suggests, certain restrictions upon the patient, which are considered necessary in order to protect the public from serious harm.) This group includes those who are sexual offenders subject to the notification requirements or found not guilty by reason of insanity or unfit to plead (having done the act);
- prisoners whose detention in hospital was directed by the sentencing court (section 45A of the 1983 Act) or by the Secretary of State (section 47 of the 1983 Act);
- other dangerous offenders – assessed as presenting a risk of serious harm and detained under either section 3 of the 1983 Act or a “notional section 37” of 1983 Act at the end of a prison sentence, with a past conviction for a violent or sexual offence, and indicators of potential increase in risk of serious harm to others that requires management at level 2 or 3.

1.2 Relevant MAPPA-eligible mentally disordered offenders in the community subject to powers of the 1983 Act are:

- offenders who are subject to a conditional discharge under sections 37 and 41;
- offenders under a community treatment order made under section 17A;
- sexual or violent offenders who are required to register with the police; and

- offenders who are simultaneously subject to Mental Health Act powers and to registration requirements for a sexual offence.

2. Identification of MAPPA-eligible mentally disordered offenders

2.1 All MAPPA-eligible offenders should be identified within three days of sentence or admission to hospital. The link below provides additional information on local facilities for mentally disordered offenders. <http://www.rcpsych.ac.uk/quality/quality accreditationaudit/forensicmentalhealth/cycle4memberunits.aspx>

Health Service

2.2 It is recommended that, at the first Care Programme Approach (CPA) meeting or equivalent, a designated member of the care team should be nominated as responsible for ensuring that the offender is marked as MAPPA-eligible on the internal management system. At this stage formal notification to the MAPPA coordinator is not required, but additional information can be requested from MAPPA agencies e.g. police, probation service, prisons.

Probation Service

2.3 For all prisoners detained in hospital who are MAPPA-eligible, the probation service will mark the offender as MAPPA-eligible on the internal management systems. Formal notification by the probation service to the MAPPA co-ordinator is not required, but additional information can be requested by the offender manager from MAPPA agencies e.g. police, health service providers, prisons.

3. Notification of MAPPA-eligible mentally disordered offenders

Mental Health Service

3.1 The MAPPA Co-ordinator needs to be aware of all MAPPA-eligible offenders who are being managed in the community. It is recommended that at the first CPA meeting where a discharge or a community treatment order is considered, a designated member of the care team should be tasked with completing the appropriate notification form at appendix A and sending it to the MAPPA Co-ordinator. This will provide the opportunity both to share clinical information with the criminal justice agencies and to request information from the police and probation services to inform risk assessment.

Probation Service

3.2 The Probation Service are not required to complete a notification form but must ensure that the MAPPA coordination unit has direct access to the probation service internal management systems.

4. Communication between mental health service providers and MAPPA

4.1 For detained patients, the responsible clinician has discretion to communicate significant events to the MAPPA coordinator at each stage of care that may involve a move outside the secure perimeter e.g. leave out of the hospital grounds or transfer to a different hospital. This applies also to clinicians treating patients on trial leave away from the hospital where they are liable to be detained. It is strongly recommended that the Co-ordinator should be informed by the care team of any occasion when the patient will be unsupervised in the community.

5. Referral process to level 2 and 3 MAPPA

5.1 When planning discharge arrangements for a MAPPA-eligible offender, bearing in mind that discharge is at the discretion of the First-tier Tribunal (Mental Health) or the Secretary of State and that

discharge cannot be certain until after the event, the CPA meeting should consider whether active multi-agency management is required. If so, a designated member of the care team should refer the offender to the MAPPA co-ordinator for a level 2 or 3 meeting. Such a meeting will enable information sharing, the preparation of an inter-agency risk management plan and access to specialist resources.

5.2 Most cases will be managed at MAPPA level 1, which is ordinary agency management, but this does not preclude information-sharing in order to manage the risks to the public appropriately.

5.3 If the responsible clinician assesses that referral to level 2 or 3 MAPPA is appropriate, a designated member of the care team should complete the referral form in the MAPPA guidance 2009 and send to the MAPPA coordinator.

6. Exit from MAPPA

6.1 The responsible clinician or offender manager should ensure that the MAPPA co-ordinator is informed when the patient / offender is no longer MAPPA-eligible.

Section 2

Further advice on the Mental Health Act 1983 and its implications for relevant agencies managing offenders

Introduction

1.1 This advice is offered to members of MAPPA responsible authorities and duty to co-operate authorities to supplement the national MAPPA guidance by giving more detail about arrangements for managing offenders who are detained, or have been detained, under powers of the Mental Health Act 1983 (the 1983 Act).

1.2 It indicates the difference between four types of disposal available to the courts when sentencing mentally disordered offenders:

- unrestricted hospital orders (see 2.1 to 2.4 below), where the NOMS role is limited to giving effect to victims' rights (see section 7), and the police service role in respect of Category 1 offenders;
- restricted hospital order patients (see 2.5 to 2.7 below), where risk management is the responsibility of Mental Health Casework Section (MHCS) in MoJ;
- determinate prison sentences (see 3.3 below), where MHCS's involvement lapses on the release date; and
- indeterminate prison sentences (see 3.4 below), where release will be on licence, and determined by the Parole Board.

1.3. It discusses the powers and functions of the Secretary of State for Justice under the 1983 Act, delegated to MHCS, a part of Public Protection and Mental Health Group (PPMHG). It advises where MAPPA authorities are likely to be in contact with MHCS, and with the First-tier Tribunal (Mental Health).

1.4. All except the first category in 1.2 are restricted patients for as long as they are liable to be detained in hospital, except for determinate sentence prisoners, where restrictions lapse on the release date. All are MAPPA-eligible under the terms of section 327 of the Criminal Justice Act 2003, if they have been convicted of a Schedule 15 offence and, in the case of prisoners, sentenced to 12 months or more. MHCS is not a duty to co-operate authority. It performs its functions under powers delegated by the Secretary of State under Part 3 of the 1983 Act.

⇒ Implications for Probation Service offender managers

- **Find out whether the sentence is:**
 - **an unrestricted hospital order**
 - **a restricted hospital order**
 - **a prison sentence with a hospital direction or a transfer direction.**

Sections 2 to 4 describe the disposals and their effects in greater detail.

See also *Mental Health Act 2007, Guidance for the Courts on remand and sentencing powers for mentally disordered offenders.*

2. Hospital orders

2.1 On conviction for any imprisonable offence, except murder, the Court may order admission to hospital under Part 3 of the 1983 Act. The Court will usually have convicted for the offence charged on the basis of the full criminal standard of proof and full criminal intent (but see section 4 below). In these circumstances, it can always make the appropriate prison sentence. But if it has heard evidence from at least two doctors that the offender is mentally disordered and needs admission to hospital for treatment, it may dispose of the case by making a hospital order under the 1983 Act. The offender with a hospital order has no tariff to serve, because he is not being punished. He will be detained for as long as his responsible clinician (RC) (the clinician in charge of his case) considers it necessary for him to receive medical treatment which is necessary to protect his own health and safety or that of others. An unrestricted hospital order lapses after six months unless renewed on the application of the RC. Otherwise the patient may be discharged at any time back into the community when his RC assesses that it is clinically appropriate to do so.

2.2 The patient has the right to have his detention reviewed by the First-tier Tribunal (Mental Health), or the Mental Health Review Tribunal in Wales (the Tribunal) if the order is renewed beyond six months, and once in every twelve month period thereafter.

2.3 These are entirely clinical disposals, subject to review by the Tribunal. There is no necessary correlation between the seriousness of the offence convicted and the making of a hospital order. For example, the Crown Court has made unrestricted hospital orders following conviction for manslaughter. An unrestricted hospital order indicates that the sentencing Court found treatment more appropriate than punishment, and was persuaded that purely clinical risk management would suffice to protect the public.

2.4 The RC also has a power to treat the patient in the community subject to conditions, intended to ensure that he continues to receive the treatment he needs. This is under a community treatment order (CTO). The CTO can only be made by the RC, who has sole power to recall the patient to hospital, if necessary to reinstate treatment. The Tribunal can order the patient's discharge from hospital, or from liability to be readmitted from a CTO, if it is not satisfied that detention for treatment is, or is likely to be justified.

⇒ Implications for the police

- **Police officers managing those convicted of a Category 1 qualifying offence, or where the offender is subject of a Violent Offender Order, will need to be made aware of plans to manage unrestricted patients on a CTO.**

⇒ Implications for probation service offender managers

- **None unless a qualifying victim has been identified. See section 7 below.**

Restriction orders

2.5 In about half of the cases where the Court makes a hospital order, it also concludes that special restrictions are necessary for the protection of others from serious harm. A magistrates' court cannot make restrictions, but will commit the case to the Crown Court if it thinks restrictions necessary. The restriction order has no existence independent of the hospital order, but it converts the hospital order into an effective risk management structure. The hospital order becomes indefinite in duration, and decisions on the patient's access to the community are no longer purely clinical. The RC cannot give the patient permission to leave the hospital, cannot transfer him to another hospital, and cannot discharge him into the community without the express agreement of the Secretary of State. Those decisions are all taken by caseworkers in MHCS

under the Secretary of State's delegated powers. The RC is required to provide MHCS with the information necessary to conduct an informed risk assessment in respect of each of the above proposals, as well as reporting comprehensively on the patient's progress at least once a year. The sole exception to the Secretary of State's exclusive control is that the Tribunal has the duty to review the detention of restricted patients and to direct their discharge if it is not satisfied that it remains appropriate to detain the individual for treatment.

2.6. The most significant risk management benefit of the restricted hospital order is that when the patient is discharged from hospital, whether on the direction of the Tribunal or with the agreement of the Secretary of State, discharge can be conditional. The patient will normally be subject to supervision by clinical and social supervisors, reporting directly to MHCS. A conditionally discharged restricted patient remains liable to detention in hospital and his detention can be reinstated at any time by the Secretary of State, through the power of recall. That power is exercised by officials in MHCS. There is always a duty officer available to direct recall out of office hours.

2.7. As a structure for the protection of the public, the restricted hospital order is as effective as any criminal disposal. Fewer than 2% of restricted patients commit a further serious sexual or violent offence within two years of discharge.

⇒ **Implications for the police**

- **For restricted patients, MHCS will inform the police force for the area where the patient will be situated of decisions to grant leave, transfer or discharge to that area. That includes orders of discharge by the Tribunal.**

⇒ **Implications for offender managers**

- **The statutory role of offender managers in respect of hospital order patients is limited to liaison with victims (see section 7).**

3. Prisoners

3.1 Alternatively, mentally disordered offenders may be given prison sentences, either determinate or indeterminate. They may additionally be detained in hospital under Mental Health Act powers, for all or part of their sentence. This can happen in two ways. The Crown Court when passing a prison sentence may add a hospital direction, requiring the offender's immediate admission to hospital. Or, the Secretary of State may direct the transfer of a sentenced prisoner to hospital at any time during his sentence (but see paragraphs 5.6 to 5.8).

3.2. The effect of these two routes into hospital for prisoners is similar. They may remain detained in hospital for as long as their RC considers it appropriate, after which they will be remitted to prison to complete their sentence, if they have not already passed their release dates.

3.3. A determinate sentence prisoner who is still detained in hospital under Mental Health Act powers on his release date (i.e. the date on which he would have been entitled to release from prison) will become what is called a notional section 37 patient. That is to say, his continuing detention in hospital will be entirely at the discretion of his care team, based on his clinical needs, and subject to review by the Tribunal. It is important that offender managers are in touch with the care team at this stage, as they will need to plan for the offender's management in the community. The offender may be treated in the community under a community treatment order (see 2.4) but that is at the discretion of the RC. Restrictions lapse automatically

on the offender's release date. There is in practice no equivalent to conditional discharge for transferred prisoners.

3.4. A life sentence prisoner, or prisoner subject to an indeterminate sentence for public protection, may be detained in hospital irrespective of his tariff for as long as his RC believes it necessary to give him medical treatment. That is subject to review by the Tribunal, which may find that the criteria for his detention in hospital under Mental Health Act powers are no longer met. Where that happens, he will be remitted to prison unless the Tribunal additionally recommends that he remain in hospital. If he has passed his tariff date he will have automatic access to the Parole Board, whether he remains in hospital or is remitted to prison. His release can only be ordered by the Parole Board and will be on life licence subject to probation supervision. The life sentence prisoner will be on licence for life, whereas the IPP prisoner, whilst his sentence is technically indefinite, may apply to the Parole Board after ten years on licence for the lifting of the licence.

⇒ **Implications for the police**

- **For purposes of managing Category 1 and VOO offenders, police officers will need to liaise with the prison service or the detaining hospital to be informed of arrangements for the offender's discharge or treatment on a CTO, once restrictions have lapsed (see implications for offender managers below).**

⇒ **Implications for offender managers**

- **It is important to know what is the underlying sentence for any prisoner who has been directed to hospital. That is what will determine his release date. The life or indeterminate sentence prisoner can only be released by the Parole Board. The determinate sentence prisoner, by contrast, if still in hospital on his release date, ceases to be subject to restrictions. It is essential to establish contact with the clinical team, so that any licence arrangements can be co-ordinated with plans for his discharge from hospital.**

4. Criminal Procedure (Insanity) legislation (CPI)

4.1 In a small number of cases, the Court finds offenders unfit to plead or not guilty by reason of insanity. In unfitness cases, the Court is required to satisfy itself, by way of a "trial of the facts", that the defendant actually did the offence charged. This must be done to the full standard of criminal proof, but does not amount to a conviction because the defendant's criminal intent cannot be established. A finding of insanity establishes a lack of criminal responsibility.

4.2 Admission to prison is therefore never an option in these cases. The Court's options following one of these findings include making a hospital order, with or without restrictions, if the conditions for making such an order are met. Exceptionally in these cases the Court does not need an offer of a hospital bed in order to make a hospital order, because prison is not a sentencing option. If it does not make a hospital order, the Court may otherwise make a supervision order or an absolute discharge. Neither carries any criminal justice sanction.

4.3 Where a hospital order, with or without restrictions, is made, the effect is the same as if the order followed a conviction, except that the Secretary of State has power to order the remission to court for trial of a restricted patient found unfit to plead. He can do so for as long as the defendant remains detained in hospital, if he is advised by the RC that the defendant can now properly be tried. Where that happens, the trial proceeds afresh.

⇒ **Implications for the police**

- **Registration periods under Part 2 of the Sex Offenders Act 2003 apply to qualifying offenders after a CPI finding.**

⇒ **Implications for offender managers.**

- **It is important to establish what finding and disposal has been made where proceedings happen under the Insanity legislation. Only where a hospital order with restrictions is made is there any outstanding criminal justice sanction (except under Sex Offender or Violent Offender arrangements). With restrictions the offender may be remitted to court for trial when he becomes fit. Without restrictions, he will not be remitted.**

5. Extent of offender manager role

5.1 All categories of sentenced offender, if sentenced for a MAPPA-qualifying offence, and those dealt with under the Insanity legislation, who are detained under Mental Health Act powers, are eligible for MAPPA information-sharing arrangements. To inform the decision on the right level of management, this section discusses the responsibilities of the offender manager, depending upon which of the above disposals is in place. Sex Offender and Violent Offender Order arrangements, if relevant, cannot come into force while the person is detained under Mental Health Act powers, but may apply on discharge.

5.2. If the Court makes a hospital order without restrictions, there is no statutory role for the probation service, unless victim interests are identified, either on the making of the order or subsequently (see section 7). The offender becomes a patient to be managed at the discretion of his RC. He will be discharged into the community as soon as the RC, or the Tribunal, is satisfied that detention in hospital for medical treatment is no longer necessary, or that no further appropriate medical treatment is available for him in hospital. That decision will be taken on the basis of the patient's clinical needs. The RC has discretion to treat the patient in the community subject to a community treatment order (see 2.4).

5.3. If the Court adds restrictions to a hospital order, the statutory role of the probation service is similarly limited to liaison with victims (see section 7). These offenders are also managed primarily by their RC, but reporting to MHCS. MAPPA agencies and offender managers may be able to share information about these offenders, who will include some of the most serious, but it will be unusual that they require anything above Level 1 review, which is provided by MHCS. See section 8 for liaison with the Tribunal.

5.4. Where the offender has received a prison sentence, his management remains with the criminal justice system and the offender manager, even if he is also a restricted patient (see section 3). Unless he has been granted technical lifer status (see paragraph 5.10), his management on release will be the responsibility of the offender manager. Close liaison with the medical care team is called for, to establish whether the offender is likely to be released directly from hospital, in which case licence conditions need to be co-ordinated with his CPA plan. While he remains a restricted patient, decisions on his leave from hospital or transfers between hospitals are for MHCS. The offender manager can advise, but cannot override the Secretary of State's decision. Remission to prison and release from hospital are options. That is primarily a decision for the RC, on whose advice MHCS will direct remission to prison if appropriate. Where that happens, all 1983 Act powers end.

5.5. The principal risk management difference from the hospital order patient is that the Tribunal cannot order his discharge into the community. If the Tribunal finds that he is no longer lawfully detained in hospital under Mental Health Act powers, it can recommend his discharge, which the Secretary of State will not normally agree if the prisoner has not completed his sentence (but see 5.10) . The result is that he will be

remitted to prison to complete his sentence. The Tribunal has a further power to recommend in those circumstances that he should remain in hospital. It will often use that power, with the result that the offender remains in hospital until the next Tribunal review, or until his release date is reached.

5.6. Offender managers should understand that sentenced prisoners who may need transfer to hospital for treatment must be assessed for transfer at the earliest possible point in their sentence. On no account should they defer concerns about a perceived need for treatment simply because the offender is detained in prison.

5.7. The above guidance is given because the notional section 37 is not a suitable power for managing the risk posed by a prisoner after his release date. Hospitals may not readily accept a dangerous offender where restrictions do not apply. The prisoner will have been anticipating release and is likely to be angry if his liberty is further curtailed. He is unlikely to co operate with medical treatment, and he may pose a risk of serious harm to other vulnerable people in the hospital.

Admission to hospital late in sentence

5.8. The Court of Appeal ruled in December 2008 that prisoners should not be transferred to hospital at the end of sentence unless there is clear evidence that hospital admission is necessary on clinical grounds. Where that is the case, assessment and admission under civil powers is to be preferred, a procedure which demonstrates that the decision is clinically-led, and is not a misuse of the powers of the Mental Health Act to extend the sentence of the Court. In these circumstances, mental health professionals can assess prisoners in prison to determine whether they might be admitted to hospital under section 2 or 3 of the 1983 Act on their release date.

Life and indeterminate sentences

5.9. Where the prisoner has an indeterminate sentence with a direction to hospital, offender managers can rely on the safeguard that release can only ever be ordered by the Parole Board. Irrespective of tariff, an indeterminate sentence prisoner has no right of access to the Parole Board for as long as he remains lawfully detained in hospital under Mental Health Act powers. He can be remitted to prison by the Secretary of State on the recommendation of his RC. Remission will immediately restore his right of access to the Parole Board if he is past tariff. Alternatively, the Tribunal may make a recommendation as in paragraph 5.5 above. Such a recommendation immediately restores access to the Parole Board. Release may be direct from hospital if remission to prison has not occurred. Any release ordered will be subject to licence.

“Technical lifers”

5.10. The exception to the process of release described in paragraph 3.4 and 5.9 is the small number of life sentence prisoners who were designated “technical lifers” between 1985 and 2005. In essence, these are prisoners whom the Secretary of State undertook to manage as if the Court had made a restricted hospital order instead of a life sentence. This means that, exceptionally, if the Tribunal recommends their discharge under Mental Health Act powers, he will agree, and subsequent risk management will be conducted under Mental Health Act powers and not on licence.

Summary of sentence categories

5.11. The above descriptions are intended to provide an indication of where offender managers, as opposed to MHCS, have the lead on the risk management of patients dealt with under Mental Health Act powers. All these offenders are eligible for MAPPA management, if convicted of a Schedule 15 offence, but there should be a clear demarcation between those cases where Mental Health Act powers, operated by MHCS should suffice, and where criminal justice powers prevail. This is without prejudice to the police service’s responsibilities in respect of sex offender and violent offender arrangements on discharge. In sum:

- Unrestricted hospital order: probation service role is limited to VLO statutory role in respect of victims and police powers in respect of Category 1 offenders.
- Restricted hospital order: risk management the responsibility of MHCS. Offender managers may be consulted in case of problematic discharges or high profile victim concerns, and sex offender registration is for an indefinite period.
- Determinate prison sentence: Offender manager will manage following release on licence. Will need to liaise with hospital in preparation for arrangements after his release date.
- Indeterminate prison sentence: Offender manager will supervise on life licence after release. Release will always be by the Parole Board after tariff is served.

6. Information sharing

6.1 As a matter of course, MHCS will inform the police force for the area where a restricted patient is detained when:

- the patient is sentenced and admitted to hospital;
- he is exceptionally given a one-off leave from hospital;
- his RC is given discretion to give escorted or unescorted leave;
- he transfers to a different hospital;
- he is discharged into the community, whether by the Secretary of State or the Tribunal;
- he is recalled to hospital from the community;
- he receives an absolute discharge and is no longer liable to detention.

Where the patient is transferred to a hospital in a different force area or discharged to live in a different force area from the detaining hospital, MHCS will also inform the police force in the receiving area.

6.2 The hospital managers are responsible for informing the police whenever a restricted patient:

- escapes from the hospital in which he is detained;
- absconds from an escort, or from the hospital grounds where he has leave to be in the grounds;
- fails to return from leave for which he had permission.

This information should be passed immediately to the local police force in accordance with local protocol. Hospital managers should be ready to inform the police in the same circumstances as in paragraph 6.1 in respect of unrestricted patients who are category 1 offenders.

7. Victims

7.1 Victims of sexual or violent offences committed by mentally disordered offenders have certain statutory rights to know about the patient's presence in the community. Those rights are tightly circumscribed in law because of the requirements of medical confidentiality and the [Data Protection Act 2018](#). Responsibility for liaising between the victim and the relevant decision-maker falls to the Victim Liaison Officer (VLO) where restrictions are in place, and to the hospital managers where they are not.

7.2. The victim's rights are provided by the Domestic Violence, Crime and Victims Act 2004 (DVCVA). They were extended by the Mental Health Act 2007 to include victims of unrestricted patients. Statutory rights apply only where the sentence was passed on or after 1 July 2005. Where the sentence was passed before that date, the victim has no statutory rights. MHCS practice in such cases is to give victims who contact us the information to which they would be entitled if the DVCVA had been in force. VLOs approached by victims of offences committed by restricted patients who were sentenced before 1 July 2005 should liaise with MHCS so that responses can be co-ordinated. Where the patient is unrestricted, the VLO must inform the hospital managers of any qualifying victims who wish to exercise their rights. It is important to understand the constraints on what victims are entitled to know, since they are inclined to press for more than the statute provides.

Victims' entitlements

7.3. Where the DVCVA applies, the Probation Service is responsible after the sentence for establishing whether there are any victims who would be eligible under the 2004 Act. An eligible victim is entitled to know:

- Whenever discharge is being considered, either by the Secretary of State, the Tribunal (restricted patients), the RC or the hospital managers (unrestricted patients.)

The victim has the right to make representations to the decision-maker, but not about whether discharge is appropriate. The representations should be about conditions to be added to any discharge, or CTO, to protect the victim or the victim's family.

The victim is further entitled to know;

- whether discharge, or CTO, took place and, if so,
 - what conditions, if any, are in place for protection of the victim or the victim's family; and
 - when those arrangements end, either because the offender has been recalled to hospital, because he has been absolutely discharged or the CTO has been lifted.

7.4. It should be noted that the victim has **no** statutory right to know:

- when the patient is allowed out of hospital on leave;
- where he is being detained;
- if he transfers to another hospital;
- where he must live in the event of discharge.

7.5. Whilst the VLO, or hospital managers in unrestricted cases, have discretion to give more information than the statutory entitlement, care must be taken to manage the victims' expectations. For example, it will usually be a breach of the [Data Protection Act 2018](#) to let the victim know the offender's address. It will usually be counterproductive to tell the victim when the patient has leave in the community. If in doubt about a restricted patient, the VLO should discuss with MHCS.

7.6. Where the victim concerns are high-profile and local or national media have been involved, coordination of the response at MAPPA level 2 or 3 may be advisable.

7.7. Where the offender is subject to an unrestricted hospital order, the decision-makers are the hospital managers, the RC and the Tribunal. Victims have the same entitlement to information as when a restricted hospital order is made, provided the conviction is for a qualifying offence. In unrestricted hospital order

cases, it is the hospital managers who are responsible for providing the information about discharge decisions, and relevant conditions made in the event that the offender becomes subject to a community treatment order.

8. The First-tier Tribunal (Mental Health) (Mental Health Review Tribunal for Wales) (the Tribunal)

8.1 Restricted patients are at present about four times more likely to be discharged into the community by the Tribunal than by the Secretary of State. The Tribunal has broad discretion to discharge unrestricted patients but this section deals primarily with restricted cases.

8.2. The RC can ask the Secretary of State at any time to agree to the discharge of a restricted patient into the community. If MHCS is content with proposed arrangements to manage the patient in the community, he will agree to a conditional discharge. He will not, however, agree to discharge the patient absolutely unless he is satisfied either that:

- the patient no longer poses any risk of harm to others, or that
- if he is dependent on medical care and treatment to ensure that he poses no risk of harm to others, that continuing care and treatment are guaranteed for as long as he may need them.

8.3. Detained restricted patients have the right to apply to the Tribunal once a year. The Tribunal is required by law to discharge the patient from hospital if it is not satisfied that:

- he remains sufficiently mentally disordered to require medical treatment in hospital;
- the medical treatment is necessary for his health and safety or for the protection of others; and
- appropriate medical treatment is available for him.

8.4. A restricted patient subject to conditional discharge in the community has the right to apply to the Tribunal for an absolute discharge once every two years. It is the Tribunal which orders nearly every absolute discharge.

8.5. The Tribunal is entirely independent of Government, as its human rights role requires. MHCS's role in respect of Tribunal hearings is limited to making a statutory statement on behalf of the Secretary of State explaining why he has not used his own power to discharge the applicant. He cannot challenge a Tribunal decision unless he has reason to believe it has acted unlawfully. Offender managers should bear in mind the criteria considered by the Tribunal described at paragraph 8.3. It may be that MAPPA will have information about a patient's current risk which would be of assistance to the Tribunal, and that information should be offered to the Tribunal or to MHCS, who can incorporate it in the Secretary of State's statement. But the only persons who have a right to make representations, other than the parties, are victims under the DVCVA provisions (see paragraph 7.3).

8.6 The Tribunal has its own arrangements to give effect to victims' statutory rights under the 2004 Act, which will be implemented when it is informed about qualifying victims. Victims have no rights to attend Tribunal hearings. In particular, they have no rights to make representations about the decision whether to discharge the applicant from hospital. The President of the Tribunal has discretion to invite victims to attend but will normally only do so where the victim has up-to-date information which is relevant to the decision on discharge.

⇒ **Implications for VLOs**

- **Where qualifying victims have been identified, the VLO must notify the Tribunal, MHCS, and in unrestricted cases, the hospital managers. Those bodies are then responsible for notifying the VLO of**
 - **applications for discharge made by the patient, or**
 - **proposals by the RC to discharge.**

(In unrestricted cases, the hospital managers are responsible for informing the victim of proposals to manage the patient on a community treatment order.)

The VLO (or hospital managers) are responsible for

- **facilitating the consideration of representations from the victim,**
- **notifying the victim of decisions on discharge or CTO and, if relevant,**
- **of any conditions put in place for the victim's protection.**

⇒ **Implications for police service and probation service offender managers**

- **It is the VLO who has statutory responsibility for managing the statutory flow of information to qualifying victims. It is almost invariably counter-productive for any MAPPA agency to advise victims without reference to the VLO.**

For further information about the matters described in this guidance, contact:

Shelley Scott, Head of MAPPA policy, PPMHG, on 0300 047 4529

Lindsay McKean, Head of Mental Health Casework Section, on 0300 047 4205

Section 3

MAPPA-eligible offenders

Part 3 of the Mental Health Act 1983: powers of the courts (responsible agency is the mental health service provider)

Part 3 of the Act contains the sentencing options for the court dealing with a mentally disordered offender. Part 3 disposals relate to offences punishable with imprisonment (except murder). The courts have the power to:

- inform their sentencing decision by remanding in hospital for a medical report or treatment, or by making an interim hospital order;
- divert the offender from punishment by ordering detention for treatment in hospital in lieu of prison;
- combine hospital treatment with a prison sentence by making a hospital direction.

Section 37 Hospital Order – responsible agency is the mental health service provider

Detention in hospital for as long as the Responsible Clinician (RC) thinks necessary to receive treatment. The unrestricted hospital order lapses at six months unless it is renewed by the hospital managers: for a further six months, and thereafter at twelve monthly intervals.

- offence punishable by imprisonment;
- mental disorder as defined in the 1983 Act;
- disorder is of a nature or degree requiring detention in hospital for treatment;
- appropriate medical treatment is available;
- evidence from two doctors;
- hospital place available within 28 days.

Section 37 may be accompanied by a “restriction order”.

Section 41 Restriction Order – responsible agency is Mental Health Casework Section (MHCS) in the Public Protection and Mental Health Group in the National Offender Management Service.

Section 41 enables the Crown Court to add special restrictions to a hospital order, where the Court concludes it is necessary to protect the public from serious harm.

Restrictions have the effect of giving the Secretary of State for Justice a veto over clinical discretion to increase the patient’s access to the community. The patient can be allowed leave from hospital, transferred between hospitals or discharged, only with the authority of the Secretary of State, except that the Tribunal must order his discharge, if not satisfied that the criteria for detention are met. The Secretary of State has no power to veto the decision of the Tribunal.

Conditional Discharge

The discharge of restricted patients will normally be subject to conditions and liability to recall. The conditions are generally of residence and compliance with the directions of supervisors. Breach of a condition is not a ground for recall. Rather, recall is at the discretion of MHCS, subject to the availability of medical evidence of mental disorder. Recall will generally be ordered if the patient displays dangerous behaviour in the community related to his mental disorder.

Community Treatment Orders

The Responsible Clinician for an **unrestricted** hospital order patient has discretion to direct continuation of treatment in the community whilst retaining the power to readmit compulsorily to hospital. This is called a Community Treatment Order (CTO). CTO patients cannot be compelled to have treatment in the community but may be readmitted to a hospital (or to a clinical setting which is part of that hospital) if they need treatment subject to compulsion without which there would be a risk to themselves or others. The CTO is intended to address the “revolving door syndrome” of patients who refuse treatment after discharge from hospital, relapse and threaten further harm to themselves or others.

The criteria for the use of a CTO include that:

- the patient is suffering from a mental disorder;
- the patient is in need of medical treatment, without which there is risk to the patient's health or safety, or that of others
- appropriate medical treatment is available;
- the patient does not need to be in hospital to receive treatment but does need to be liable to recall to hospital to ensure that the risk can be managed; and
- it is necessary for the patient's health or safety or the protection of others that the patient remains liable to recall.

A restricted patient may be absolutely discharged if his mental condition no longer justifies liability to detention in hospital, in which case there are no continuing sanctions.

An unrestricted patient discharged without a CTO is similarly free from any sanction.

Section 42 – Powers of Secretary of State in respect of patients subject to restriction orders

- Power to lift restrictions
- Discharge from hospital absolutely
- Discharge from hospital with conditions – patient can be recalled at any time
- A supervising clinician and a social supervisor, normally an approved mental health professional, are usually appointed. The Clinician is usually a psychiatrist, but will not necessarily be a forensic practitioner.

Role of Social Supervisor

The social supervisor must visit the person at least monthly and furnish the MHCS, acting for the Secretary of State, with a progress report at regular intervals. The supervisors must consult over the care and treatment of the patient to ensure mutual understanding of the current risk management in place.

Mentally disordered offenders who are prisoners

– responsible agency is probation service

Section 45A – Hospital direction

In order to be able to add a hospital direction to a prison sentence, the Court will need the following conditions to be satisfied:

- medical evidence of mental disorder for which appropriate treatment is available;

- the Court should have considered making a Hospital Order (Section 37);
- evidence from two doctors, one of whom must give oral evidence; and
- a hospital bed is available within 28 days.

Section 47 – Secretary of State’s power to transfer sentenced prisoners for treatment

A transfer direction can be made for an offender who is serving a prison sentence if two doctors certify that

- the offender is mentally disordered; and
- the disorder is of a nature or degree that requires detention in hospital for medical treatment.

The patient may be returned to prison to continue serving his sentence on completion of the treatment. Or detention in hospital may continue after his release date, as an unrestricted patient. A prisoner may not be discharged by the Tribunal during his sentence.

Section 48 – Secretary of State’s power to remove other prisoners

The Secretary of State may similarly direct the transfer to hospital of unsentenced prisoners, where the need for treatment is urgent. Such prisoners remain liable for detention in hospital until discharged or until the Court otherwise disposes.

Section 49 – Secretary of State’s power to impose restrictions order on discharge of patients

The Secretary of State will normally apply restrictions when directing transfer of a prisoner, and always with an unsentenced prisoner. Restrictions have the same effect as when added to a hospital order.

Section 117 Aftercare

Applies to those detained under Sections 3, 37, 45A, 47 and 48. Gives a duty to health and local social services authorities to provide aftercare services for any person who has been detained for compulsory treatment, until they are satisfied that the person is no longer in need of such services.

Appendix A

Initial notification of MAPPA offender (mental health)

→ Responsible clinician:

If you are planning discharge for this patient as part of his long-term rehabilitation into the community, please complete sections 1 to 6 of this form and send it to your local MAPPA co-ordinator.

→ MAPPA co-ordinator:

If you have any relevant information about this patient, please complete section 7 of this form and send it to the referring agency.

1. Category of offender

The patient must fall into one of the MAPPA Categories summarised below. Please state which one applies.

1. Registered sexual offender	YES / NO
2. Violent or other sexual offender who has been sentenced to 12 months or more custody for an offence under Sch.15 of the Criminal Justice Act 2003 and is transferred to hospital under s.47/48 MHA 1983 or is detained in hospital under s.37 with or without a restriction order under s.41.	YES / NO
3. Other dangerous offender – has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm AND which requires multi agency management. This might not be for an offence under Sch.15 of the Criminal Justice Act 2003	YES / NO

2. Offender information

Last name:	
First name:	
Date of birth:	
Aliases:	
Last known address before sentence:	
Gender:	
Ethnicity:	

3. Detained in hospital

Name of responsible clinician:	
Responsible funding authority:	
Hospital:	
Earliest possible release date (determinate sentence prisoner):	
Date of next CPA:	
Date of next tribunal:	

Please indicate the basis for detention from the options below:

Guardianship order under s.7 MHA 1983	YES / NO
Hospital order under s.37 MHA 1983	YES / NO
Restriction order under s.41 MHA 1983	YES / NO
Transfer from prison under s.47 MHA 1983	YES / NO

4. Conviction / caution information

Index offence:	
Date of conviction / caution:	
Sentence:	

5. Victim concerns

Has the victim of an unrestricted patient asked to be kept informed of relevant dates and decisions by the Hospital Managers?	YES / NO
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If YES:	
Please state what information has been provided	
6. Notifying agency information	
Agency:	
Name:	
Grade:	
Office:	
Telephone number(s):	
Email address:	
Date sent to MAPPA Co-ordinator:	
7. Information held by MAPPA co-ordinator	
Is there any information known to MAPPA, including information held on ViSOR regarding this patient, to help manage the risk he presents to the public?	YES / NO
If YES:	
Please confirm that the information has been passed to the referring agency	
Date information sent	