This study was undertaken to monitor and assess the operation and impact of the provisions contained within the Crime and Punishment (Scotland) Act 1997, which introduced a new disposal, the Hospital Direction, and extended the maximum duration of Interim Hospital Orders from 6 to 12 months. The Hospital Direction was introduced to allow the court to simultaneously detain in hospital and impose a prison sentence to be completed on discharge on offenders who are suffering from a treatable mental disorder and deemed in need of psychiatric care but who are fit enough to stand trial. The fieldwork was carried out over a period of 2 years from January 1998.

**Main Findings**

- During the research period two Hospital Directions were imposed and an additional request for a Hospital Direction was refused. Shortly after the conclusion of the research a third Hospital Direction was made and a fourth was expected in an on-going case.

- Transfers from prison to hospital within 2 months of conviction were unaffected to any significant degree by the introduction of the Hospital Direction.

- Although there was no single reason to explain the low use of Hospital Directions, interviews with legal and psychiatric personnel suggested that sentencers’ lack of familiarity with the provisions and psychiatrists’ reluctance to explicitly recommend Hospital Directions in the light of guidance from the Scottish Executive may have been contributory factors.

- 22 Interim Hospital Orders were made in the two-year period following the legislation coming into force. In respect of 11 of these, the order was not renewed at all beyond the initial period. 4 of the 22 Interim Hospital Orders utilised the new provisions and lasted in excess of 6 months.

- 12 of the 22 Interim Hospital Orders were located in the State Hospital with the remaining 10 being in a local hospital.

- The final disposals were known in 20 of the 22 cases where there was an Interim Hospital Order. These include 15 Hospital Orders (3 with restriction orders), 2 probation orders and 3 admonishments.

- The numbers of Interim Hospital Orders and the subsequent disposals do not vary greatly from those in the 3 years prior to the introduction of the legislation.

- In interviews conducted both legal and psychiatric personnel universally welcomed the extended Interim Hospital Order and the majority welcomed the Hospital Direction.
Introduction

The main aim of this research was to assess the operation and impact of the provisions contained within the Crime and Punishment (Scotland) Act 1997 which introduced a new disposal, a Hospital Direction (by inserting section 59A into the Criminal Procedure (Scotland) Act 1995) and extended the time limit for Interim Hospital Orders from 6 to 12 months (by amending section 53 of the said 1995 Act).

The key objectives of the research were to:
• monitor the use of Hospital Directions and explore the characteristics of the cases in which they were used in the two years from 1st January 1998 to 31st December 1999;
• monitor the outcomes for those given Hospital Directions in terms of where they served their sentence;
• assess the impact of the Hospital Direction on the admission of mentally disordered offenders to prison through a ‘before’ and ‘after’ study of people transferred from prison to hospital within two months of being imprisoned;
• monitor the use of Interim Hospital Orders;
• compare the disposals made following Interim Hospital Orders granted from 1st January 1998 to 31st December 1999 with disposals made in the 3 years prior to the legislation being introduced;
• explore the views of relevant practitioners on the new provisions.

The research period was 1st July 1998 to 31st May 2000. A notification procedure in respect of cases where a Hospital Direction or Interim Hospital Order was granted was established with the Sheriff Clerks in all Sheriff Courts across Scotland and also the Justiciary Office of the High Court. The Interim Hospital Orders were thereafter monitored, through correspondence and telephone, until disposal. The court records of those cases where a Hospital Direction was granted were consulted. In two cases prior notification of the possibility of a Hospital Direction facilitated attendance at court.

Problems identified by the Solicitor to the Scottish Office prohibited access to any files containing medical information. This necessitated alternative cross-checking procedures to be put in place. The Scottish Prison Information Network (SPIN) held by the Scottish Prison Service (SPS) provided data on prison transfers. This information was cross-checked by sending data to the Scottish Executive Public Health Policy Unit who confirmed any discrepancies in SPIN records to the researchers via SPS.

Due to the same access problems the Mental Welfare Commission could only confirm whether the data on the extended Interim Hospital Orders was accurate without correcting errors. For the same reasons they could only provide the researchers with numbers of individuals who had received Interim Hospital Orders in the three years prior to the legislation coming into force. Scottish Courts Service assisted by identifying the final disposal received by these individuals and provided related court papers.

These access problems, which had not been anticipated prior to the commissioning of the research, were problematic. While they do not appear to have affected the quality of the research findings, the inaccessibility of information and the reliance on third parties to provide and check information was onerous on all parties.

Interviews were conducted with Judges, Sheriffs, defence and prosecution agents/counsel and psychiatrists.

The Use and Impact of the Hospital Direction

During the research period only two Hospital Directions were imposed. In the first case, which involved charges of assault to injury and assault to danger of life, the accused lodged a special defence of insanity which was unsuccessful. This defence was supported by the psychiatrists who gave evidence during the trial. The jury’s verdict of ‘guilty’ was viewed as perverse and the Hospital Direction was regarded as remedying this perverse verdict. A sentence of 12 months imprisonment with a Hospital Direction was imposed, however, as the accused had spent time on remand. After two months he required to be detained under s.18 of the Mental Health (Scotland) Act 1984.
to enable further treatment and supervision. The accused had no documented psychiatric history and two minor previous convictions dating back several decades.

In the second case, which involved assault and armed robbery, the accused offended hours after absconding from a local psychiatric hospital. He had an extensive list of previous convictions and a documented psychiatric history. He pled guilty and was remanded in the State Hospital to allow further psychiatric assessment. A sentence of 9 years with a Hospital Direction was imposed.

In both cases the prisoner remained in hospital for the duration of the research project.

Personality disorder was not present in either offender, and the two cases involved circumstances quite different to those envisaged by the Scottish Office Circular (No. HD 19/1997), which offers two examples where a Hospital Direction might be appropriate: i) an offender being entirely well at the time of the offence who subsequently becomes ill; and ii) where there are co-accused and the court takes the view that one offender should not escape the punishment passed on to others merely because he is ill at the time of sentence.

It had been anticipated by the Scottish Office that there would be twelve cases involving Hospital Directions per annum, so the small numbers were somewhat surprising. There is little sign, however, that use of Hospital Directions will increase.2

There is no single reason to explain why there have been so few Hospital Directions in Scotland. Possible contributing reasons for under-use may be lack of awareness of the new disposal (a view held by some legal practitioners), uncertainty about the basis for identifying those offenders for whom a Hospital Direction would be appropriate, and an unwillingness on the part of medical personnel to recommend it (see interviews with Legal and Psychiatric Personnel). There was early opposition from psychiatrists in Scotland to the introduction of the Hospital Direction. Scottish Office Circular (no. HD 19/1997) explicitly states that “a psychiatrist may not recommend a hospital direction as it is attached to a custodial sentence.” This recognises that such action would inevitably involve psychiatrists in recommending a sentence of imprisonment. If sentencers are relying on psychiatrists to either alert them to the existence or suitability of the disposal, this restriction on psychiatrists may account for some of the under-use.

Transfer Prisoners

One of the objectives of this study was to monitor the impact of Hospital Directions on the numbers of prisoners, convicted on indictment, who were transferred from prison to hospital within two months of sentencing. This was undertaken in an attempt to ascertain if large numbers of offenders requiring treatment in the early stages of their custodial sentence had in the past been imprisoned and then transferred to hospital to receive treatment.

Transfer of prisoners from prison to hospital within two months of sentence do not appear to have been affected by the introduction of the Hospital Direction disposal. The largest number of prison to hospital transfers occur outwith the two month period, and for those prisoners convicted on indictment most occur after a substantial part of the sentence has been served.

Interim Hospital Orders

22 extended Interim Hospital Orders were made during the research period. Duration and renewal periods are variable. 11 of the Interim Hospital Orders were not renewed at all beyond the initial period, and the court granted disposal at this point; 7 were renewed but disposed of within 6 months duration; 4 were renewed in excess of 6 months, with the longest in operation for 8 months and 10 days prior to a disposal being made. Rarely do psychiatrists find it necessary to request renewals beyond six months. There is also an eagerness on the part of sentencers to reach a final disposal.

12 of the 22 Interim Hospital Orders named the State Hospital with the remaining 10 being spent in a local hospital.

Final disposals in 20 of the 22 cases are known and include 15 Hospital Orders (3 with restriction orders), 2 probation orders and 3 offenders were admonished. The numbers of Interim Hospital Orders and the subsequent disposals do not vary greatly from those in the 3 years prior to the introduction of the legislation.

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2 There have been a similarly small number of cases in England and Wales using the equivalent legislation, ss45A and B of the Mental Health Act 1983 as amended by the Crime (Sentences) Act 1997.
By and large, the individuals in receipt of Interim Hospital Orders tend to be problematic, both for the courts and the psychiatric services. Most have multiple personal and social problems which have, at one time or another, brought them into contact with state agencies. Almost all had lengthy psychiatric histories and all but five had past offending histories. Several had served custodial sentences. In six cases, the index offence was committed whilst the accused was on bail for other offences.

Whilst most past offending was relatively minor albeit persistent (e.g. breach of the peace, shoplifting), in some the past offending was of a serious violent nature (e.g. assault to severe injury).

In over half of the cases (12), the index offences included some form of assault which in some cases was of a very serious violent nature (e.g. murder, attempted murder, assault to severe injury, rape).

The term ‘personality disorder’ was applied in 3 cases. Other diagnoses included schizophrenia, learning disability, depression, hypochondria and mania.

Reaching a satisfactory psychiatric diagnosis is often problematic as many of those given Interim Hospital Orders have complex needs. Interim Hospital Orders are used by psychiatrists as a means of ‘buying more time’ in order to, for example, be able to settle on a firm diagnosis; ascertain whether offending was due to mental ill-health or other reasons; establish whether and how a patient was responding to new treatment or medication (or the withdrawal of medication); allow further neuro-psychological testing; or as a means to allow consideration of appropriate disposal. The assessment of ‘treatability’ remains a key reason for the request of Interim Hospital Orders.

**Appeal Proceedings**

In one of the cases where a Hospital Direction had been imposed there was an appeal. However, this was against the length of sentence and not against the Hospital Direction. In another case the offender appealed against the Hospital Order made by the court and sought a Hospital Direction to be substituted therefor. This was unsuccessful. In respect of Interim Hospital Orders, one such order was appealed against by way of a Bill of Suspension on the grounds that only one psychiatric report had been considered by the Sheriff. This Interim Hospital Order was revoked, as two psychiatric reports are required before such an order can be made.

**Interviews with Legal Personnel**

Whilst some legal practitioners welcomed the new disposal, others had ‘mixed feelings’ and felt that the availability of other sentencing disposals was adequate without the introduction of a new one with limited applicability. However, the fact that the Hospital Direction allowed for a punitive element to a disposal, unlike a Hospital Order, was largely approved by sentencers.

That the Hospital Direction could apply for all mentally disordered offenders, and not just those suffering from psychopathic disorder as in the equivalent English/Welsh legislation, was welcomed.

The Hospital Direction was felt by sentencers to balance the needs of the offender with public safety. This was achieved by the disposal providing both therapeutic treatment and also incarceration. Sentencers offered further case examples of the possible applicability of Hospital Directions, in addition to the two examples outlined in Scottish Office Circular (No. HD 19/1997) cited above. These were cases where the offender committed the offence whilst unwell, although mental illness was not the cause of offending; and cases where the individual committed an offence whilst unwell, but where it was difficult to separate out the offending behaviour, which could be partly due, for example, to drug addiction and the need for money and partly due to impaired judgement resulting from psychotic symptoms.

It was suggested by some that the small number of Hospital Directions is due to lack of awareness amongst sentencers, and that this could be remedied by relevant cases being reported.

Interim Hospital Orders in the new extended form were also welcomed as they were seen to facilitate appropriate psychiatric assessment prior to a disposal being made.

While psychiatric reports were generally deemed to be of a high quality and useful, the lack of psychiatric recommendation of the Hospital Direction was felt to be partially responsible for the low numbers. Both legal personnel and psychiatrists located the root of
this reluctance to recommend the disposal in the 1997 Scottish Office Circular (HD 19/1997). This restriction on psychiatric recommendation combined with the ethical issues if a psychiatrist or defence agent recommend a custodial disposal was highlighted in the interviews with both groups. Sentencers, in particular, felt that one way of addressing this would be for them to provide more explicit requests for information on specific issues regarding the offender’s mental condition and, in particular, on appropriate disposal.

**Interviews with Psychiatrists**

Psychiatrists find themselves caught on the horns of an ethical dilemma in relation to the Hospital Direction. Whilst it is broadly welcomed as a ‘clinically useful option’, they find themselves unable to recommend it. The ethical considerations centre on, first, whether psychiatrists should recommend a disposal that has imprisonment as an integral part of it. Second, Hospital Directions not only imply ethical issues at the sentencing stage, but also earlier, in assessing an individual for the court with a view to supplying information on their suitability for a therapeutic option, or not. A third concern relates to the decision to remit a patient on a Hospital Direction to prison, following ‘recovery’. Some spoke of a possible reluctance to transfer patients back into prison where treatment is proving successful. Further, psychiatrists are wary that some individuals may get to a stage where their presenting symptoms have remitted but they may be vulnerable to relapse once in prison. There was a general expectation amongst psychiatrists that the new disposal would not impact on the use of psychiatric defences at trial.

Echoing earlier concerns, psychiatrists also raised objections concerning the introduction of the Hospital Direction for all mental disorders, on the grounds that the broad application to all legal categories of offender was inappropriate. The small number of Hospital Directions however had allayed fears that this may lead to resource problems. Another concern cited was the potential for an increase in the number of mentally disordered offenders being sent to prison due to the reluctance of psychiatrists to recommend a Hospital Direction.

On the whole, it was felt that offenders to whom the term ‘personality disorder’ could be applied would be appropriate recipients of Hospital Directions, although it would be most appropriate in cases where mental illness was also present. Some interviewees gave specific examples, such as offenders suffering from severe personality disorder where there were issues of treatability, or those who offended while suffering from drug or alcohol induced psychosis, which might be relatively short-lived after hospital treatment. It was viewed as a suitable disposal for those offenders ‘who did not fit neatly’ into either the mental health or criminal justice system, who required medical intervention but who at the same time were culpable.

The extended Interim Hospital Orders, however, were universally welcomed by psychiatrists, although it was suggested that these should be reviewed every 3 months rather than monthly as is currently the case. One month is often not long enough to monitor change or effectiveness. It was felt that renewals beyond 6 months were rare (a view borne out by the research findings), although having the possibility of extension for up to 12 months was deemed clinically necessary.

**Conclusion**

The professional view on the low use of Hospital Directions is that this is due to a combination of sentencers’ lack of familiarity with the provisions and psychiatrists’ reluctance to explicitly recommend Hospital Directions because of the nature of the guidance available. Clearly, the dissemination of information or the circulation of specific guidance concerning the intention behind the Hospital Direction and the circumstances for its use to both professions would be desirable.

Given the discretionary and uncertain basis for identifying offenders who are deemed to be suitable...
candidates for Hospital Directions, it is likely that the disposal will continue to be little used. It certainly does not seem likely that it will recruit from those who are currently receiving Hospital Orders, or from those offenders who, by whatever means, are given custodial sentences. Similarly, it is unlikely that the new disposal will impact on the use of psychiatric defences at trial.

The restriction on psychiatrists recommending a Hospital Direction may be some way overcome if sentencers request that particular issues regarding disposal be addressed in the preparation of psychiatric reports. Although, strictly speaking, criminal responsibility is determined by the court in the finding of guilt, one way forward may be for the court to specifically request that the psychiatric report addresses the question of the link between the mental disorder and the behaviour.

Although little used, the impact of the Hospital Direction on sentencing principles and on forensic psychiatric practice should not be underestimated. It signals a different way of thinking, with potential for impact on both the exchange and relationship between the courts and psychiatrists, as well as between psychiatrists and their patients.

Given the small number of Hospital Directions it would be useful to continue to monitor the legislation to ascertain whether lack of knowledge or lack of psychiatric recommendation is the reason for the limited use of this disposal. The impact of the recommendations of the MacLean Committee on Serious Violent and Sexual Offenders which have been embodied in the White Paper, ‘Serious Violent and Sexual Offenders’, may also result in wider knowledge of the disposal’s existence and more use. Published after the completion of this research, both the MacLean and the Millan Reports support a greater use of Hospital Directions (and Interim Hospital Orders), particularly for offenders with complex needs.

This research has not highlighted any particular issues around transfers from prison to hospital within two months of sentence. It did, however, reveal that a large number of transfers occur late in longer custodial sentences. As there is no information to explain this, more research in this area would be useful.