Sentencing Council

Sentencing Council meeting:	**14 December 2018**
Paper number:	**SC(18)DEC03 – Mental Health**
Lead Council member:	**Rosa Dean**
Lead official:	**Mandy Banks** **0207 071 5785**

1 ISSUE

1.1 This is the last meeting to agree the draft guideline ahead of the consultation in Spring next year. The changes discussed at the last meeting have been made, and any major changes made to the draft since the last meeting have been highlighted in the attached draft at **Annex A.**

2 RECOMMENDATION

2.1 At this meeting the Council are asked to note the revised draft and in particular:

- To note the changes that have been made to the wording following the last Council meeting, and in particular, the revised **Annex A**
- To note the proposed plan for the draft resource assessment for the guideline
- To consider the questions regarding the objectives for the guideline
- To sign off the draft guideline ahead of consultation

3 CONSIDERATION

Applicability of guidelines

3.1 At the last meeting the Council agreed that the guideline would only be for offenders aged over 18, but that there should be some text to explain why the guideline was not applicable to under 18s. This has been done and can be seen at the top of page 3 **of Annex A.** It is suggested that the explanation should be brief, as it is quite difficult otherwise succinctly to explain the complex issues around differences between adult and adolescent psychology as it relates to offending behaviour.

3.2 There is also a link now to the Children and Young People guideline, and it is proposed that this guideline may alone be sufficient in terms of providing guidance on sentencing under 18s. This guideline outlines the principle that courts must have regard to the welfare of the young person, specifically that the court must be alert to any mental health problems or learning difficulties/disabilities, or brain injury, and that that the approach to sentencing must be individualistic, as set out in the extracts from the guideline below:

While the seriousness of the offence will be the starting point, the approach to sentencing should be individualistic and focused on the child or young person, as opposed to offence focused. For a child or young person the sentence should focus on rehabilitation where possible. A court should also consider the effect the sentence is likely to have on the child or young person (both positive and negative) as well as any underlying factors contributing to the offending behaviour.

In having regard to the welfare of the child or young person, a court should ensure that it is alert to:

- *any mental health problems or learning difficulties/disabilities;*
- *any experiences of brain injury or traumatic life experience (including exposure to drug and alcohol abuse) and the developmental impact this may have had;*
- *any speech and language difficulties and the effect this may have on the ability of the child or young person (or any accompanying adult) to communicate with the court, to understand the sanction imposed or to fulfil the obligations resulting from that sanction;*
- *the vulnerability of children and young people to self harm, particularly within a custodial environment; and*
- *the effect on children and young people of experiences of loss and neglect and/or abuse*

Question 1: Are the Council content with the proposed wording relating to the age applicability of the guideline? And does the Council agree that there doesn't need to be any new guidance for under 18s, that the existing Children and Young People guideline is sufficient?

Section One: General Approach:

3.3 The minor changes to wording agreed at the last meeting to this section have been made. In addition, as requested at the last meeting the last bullet point in paragraph 2 has been reworded, and can be seen in highlighted text at the bottom of page 4.

3.4 In relation to paragraph 4, at the last meeting the Council agreed to ask the Criminal Procedure Rules Committee, to add a requirement that sentencers should ensure that reports follow an offender to custody. The Rules Committee secretariat has confirmed that a rule amendment will be proposed to the Rules Committee at its December meeting. With rule amendments only being made twice a year, this amendment would be made in June 2019, to come into effect on the 1st of October 2019. It is therefore proposed that the wording is left as it is in paragraph 4, but the situation is outlined in the consultation paper.

3.5 Following the last meeting the Council commented on and agreed a revised draft of paragraph 6 via email. This paragraph relates to private treatment and hospitals, and can be seen highlighted on page 5.

3.6 At the last meeting the Council discussed whether there should be a glossary of mental health terms appended to the guideline. A search has been conducted to see if a glossary could be found, but there doesn't appear to be anything suitable. It is suggested that the document mentioned during the meeting, '*Defining Mental Health Services',* isn't really suitable for the purposes of the guideline. It discusses different mental health services available, and their definitions, e.g. 'acute inpatient bed'. Charities such as Mind do provide a glossary of common mental health terms on their website, which the guideline could link to, but the risk with this is it could become out of date. Therefore, it is recommended that the guideline doesn't include a glossary. The consultation paper could ask a question around this, to see if respondents think there should be something and, if so, ask for suggestions.

Question 2: Are the Council content with the changes made to section one? Does the Council agree to not including a glossary of mental health terms?

Section Two- Assessing Culpability

3.7 The minor changes to wording agreed at the last meeting to this section have been made. In addition, as requested at the last meeting the last lines of paragraph 8 relating to when it may not be appropriate to follow expert opinion have been reworded and can be seen highlighted on page six.

Question 3: Are the Council content with the changes made to section two?

Section Three – Determining the Sentence and Section Four – Sentencing Disposals

3.8 At the last meeting the Council discussed paragraph 10, which refers to the purposes of sentencing, and the new wording which had been proposed to deal with when the requirement to have regard to the purposes of sentencing may not apply. The Council requested that this paragraph be reworded. This has been done and can be seen in highlighted text on page 7. This was the main change to this section, other than minor changes to wording agreed at the last meeting. Similarly there has only been one minor change to section 4, the text regarding sentencing disposals.

Question 4: Are the Council content with section three and four of the guideline? Are the Council content with the reworded paragraph 10?

Annex A

3.9 Since the last meeting Professor Pamela Taylor, Chair of the Forensic Psychiatry Faculty at the Royal College of Psychiatrists has reviewed Annex A, the information on conditions and disorders. She has substantially revised this information, which can be seen at page 10 onwards. The previous version was perhaps too simplified an overview of what are very complex conditions. Professor Taylor's amendments rectify this and also correct some erroneous information at the same time. Soundings of reactions to this revised version were taken with Maura and Rosa, who both felt that the information contained would be very useful to courts. Although presented in a more descriptive style than previously, this is only supplementary information and is contained within an annex to the main guideline.

Question 5: Are the Council content with the revised Annex A?

Annex B - reports

3.10 The minor changes to wording agreed at the last meeting have been made to this section. The only other change concerns a suggestion made by Sophie Marlow, that as well as the guideline containing a link to the Criminal Procedure Rules, there should also be a link to the new Criminal Practice Directions on commissioning psychiatric reports, as they supplement the rules and provide guidance on how to request reports. A link has been inserted to this effect on page 16, and signposts the user to which are the relevant sections.

Question 6: Is the Council content that the guideline contains a link to the Criminal Procedure Rules?

Annex C – sentencing disposals

3.11 At the last meeting the Council asked that the legislation be checked regarding MHTRs, for the text within the box at the top of page 19. This has been done and the wording is correct. The Council also discussed the bullets points under the table, relating to the custody threshold and when a MHTR might be appropriate, and asked that they be amended, into three separate bullet points. This has been done and can be seen highlighted towards the end of page 19. A link to the Imposition guideline has also been included, as requested at the last meeting. There were no other changes to Annex C since the last meeting.

Question 7: is the Council content with the changes made to Annex C?

Purpose/Objectives for the guideline

3.12 At this stage it would be very helpful, not least for the draft resource assessment, and the communications/press strategy for consultation, if the Council confirmed what the purpose/objective of the guideline is. For example:

- Is the guideline intended to change sentencing practice in any way? Perhaps by increasing awareness of MHTRs and thereby driving up their usage?
- Or, is the purpose of the guideline awareness raising? Providing details of conditions/disorders which perhaps courts had not previously given as much thought to how they might affect sentencing?
- Or is the guideline to encourage courts to give greater consideration to the treatment of a condition in order to prevent further offending, which may increase hospital orders?
- Or, is the guideline simply consolidating useful information in one place to provide assistance in areas courts are already increasingly grappling with, in which case it won't radically change sentencing practice?
- Or is there another objective/purpose for the guideline not listed above?

Question 8: What is the purpose of the guideline?

Independent Review of the Mental Health Act

3.13 The final report into the Review was published on the 6 December. As this was on the same day this paper was circulated to Council it has not been possible to study the 300 odd page report in depth. It may be helpful to recall at this stage that the Review was set up to look at how MHA legislation is used, and how practice can improve. The stated purpose of the Review was to understand the reasons for:

- rising rates of detention under the Act;
- the disproportionate number of people from black and minority ethnic groups detained under the Act; and
- processes that are out of step with a modern mental health care system

3.14 The final report makes a number of recommendations, which the Government will now take time to consider. The Government has only thus far committed to accept the principle of 2 of the review's proposals on 'nominated person' (alternative to nearest relative) and 'advanced directives' (allowing patients to set out their wishes in advance for consideration by health professionals). The relevant recommendations the review makes for the Criminal Justice System are set out below:

• Magistrates' courts should have the following powers, to bring them in line with Crown Courts:

- remand for assessment without conviction under section 35 of the Mental Health Act (MHA)
- remand for treatment under section 36 of the MHA
- the power to commit a case to the Crown Court for consideration of a restriction order following an ‘actus reus’ finding
- the power to hand down a supervision order following an ‘actus reus’ finding (where a person is not fit to enter a plea, but has been found to have committed the offence) under S1a of the Criminal Procedure (Insanity) Act

• Prison should never be used as ‘a place of safety’ for individuals who meet the criteria for detention under the Mental Health Act

• A new statutory, independent role should be created to manage transfers from prisons and immigration removal centres

• The time from referral for a first assessment to transfer should have a statutory time limit of 28 days. It is suggested that this could be split into two new, sequential, statutory time limits of 14 days each: i) from the point of initial referral to the first psychiatric assessment; ii) from the first psychiatric assessment until the transfer takes place (this incorporates the time between the first and second psychiatric assessment and the time to transfer).

• Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according risk and complexity. Straightforward and / or low risk decisions should be taken by the responsible clinician. The Ministry of Justice would have 14 days to override this decision.

• The new statutory Care and Treatment Plan should include a plan for readmission and consider what factors should be taken into account concerning use of informal admission, section 2 and recall;

• The powers of the Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave or transfer.

- The Government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards

- There should be an automatic referral for people on conditional discharge to the tribunal after 12 months and at regular intervals after that for patients who have not applied directly.

- The Government should consider giving the Parole Board Tribunal status and combining hearings where appropriate. At the very least the Government should streamline processes so that hearings could be convened back to back

- There should be a common framework for assessment of risk across criminal courts, clinicians and the Justice Secretary. The assessment needs to be regularly reviewed (at least annually and before every Tribunal hearing). Every patient should have written in to the Care and Treatment Plan what their risk levels are.

3.15 In anticipation of the publication of the report, thought had been given to the possible impact of the review on the draft guideline, and the forthcoming consultation. Any changes to legislation (if they happen at all) will clearly be some way away. The main body of the draft guideline only deals with general principles and the approach to sentencing in this area. The main areas that refer to legislation are contained within annexes: primarily Annexes B and C. Accordingly, the Council could consider taking a similar approach to the one taken in the Guilty Plea guideline[1], where in the appendices at the back of the guideline, which contain flowcharts, it states: '*this flowchart is provided as an illustration of the operation of the guideline as at 1 June 2017. It does not form part of the guideline'.*

3.16 There could be similar wording inserted in annexes B and C, regarding references to legislation, to the effect of: '*This information provided is correct as of xx/xx/xx (date guideline comes into force). It does not form part of the guideline.'*

The position would be outlined in the consultation paper: that the recommendations of the Review have been noted, and that the Council will continue to monitor developments while it consults on a draft guideline. On the current timetable the definitive guideline will not be

[1] https://www.sentencingcouncil.org.uk/publications/item/reduction-in-sentence-for-a-guilty-plea-definitive-guideline-2/.

published until Spring 2020, which gives plenty of time to see what the position is with regards to legislation, and make any changes as appropriate. The link to the report is:

https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review.

Question 9: Are the Council content with the approach outlined with regards to the Review? Does the Council want to include a form of words within Annex B/C as suggested?

Consultation paper

3.17 The draft consultation paper and final version of the guideline will be sent around to Council members for comment via email. As the Council are aware officials have worked with a number of groups who have an interest in the area, academics, charities and the medical profession, to try to ensure the draft guideline is as robust and thoroughly researched as possible, in advance of consultation. We know that there is demand for such a guideline, so it is hoped that the reaction to the draft guideline will be a positive one, with it being seen that the Council is responsive to calls for a guideline in this area. The title of the guideline has been reworded, following the discussion at the last meeting.

4 IMPACT/RISK

4.1 A draft resource assessment, considering the likely impact of the guideline on sentencing practice, will be published alongside the consultation. The resource assessment will set out the purpose of the guideline and include statistics related to mental health, where available. Officials are maintaining close links with officials in the MoJ and other government departments to keep up to speed with the latest available data, which includes current volumes of mental health treatment orders and numbers of offenders sentenced to hospital orders.

4.2 Analysis of the Sentencing Council's Crown Court Sentencing Survey data and other data collections has also been undertaken to look at how often mitigating factors such as 'Mental health issues' were ticked, and the Ministry of Justice have shared figures, which are for internal use only, relating to the proportion of OASys assessments in prison which are marked as 'severe' mental health problems (see **Annex B).**

4.3 However, there remains a lack of data about how mental health is currently treated by the courts and therefore what the precise impact of the guideline may be. It is therefore expected that the resource assessment will take a narrative form, setting out the expectations of the guideline but without quantifying its expected impact. There is a risk that this approach may be criticised by the Justice Select Committee, who have previously called for more robust resource assessments, especially given that a large number of offenders may potentially be affected by the guideline. Officials will make contact in advance with the Committee to explain

why the assessment has been conducted in this way, to try to head off any criticism by the Committee of the approach taken.

4.4 To address the risks and to improve Council's understanding of what the impact of this guideline is likely to be, the A&R team plan to conduct interviews with experts in this field to help inform the draft resource assessment. It is also planned to carry out interviews with sentencers to further help inform the definitive guideline and final resource assessment.

4.5 There is also a risk that, if the guideline affects the use of hospital orders, this could disproportionately affect BAME groups. Statistics relating to detentions under the MHA suggest that rates of detention for the 'Black or Black British' ethnic group are four times that of the 'White' group, while the proportion of offenders sentenced to hospital orders is about 70% higher for Black offenders, compared to White offenders (see **Annex B).** The Council will be aware of the sensitivity around BAME issues post Lammy, and as noted in para 3.13 above, the Review into the MHA stated that higher rates of detention amongst BAME groups was an area of concern. Officials will look into these issues, but the general lack of data in this area, as discussed above, may mean that this is a risk that cannot fully be overcome.

4.6 A draft resource assessment will be cascaded for comment to the Analysis and Research subgroup, followed by all of Council, in spring 2019.

Question 10: Are the Council content with the proposed plan for the draft resource assessment? Are the Council content that the impact/risks have been sufficiently considered at this stage?

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Annex A

Sentencing Council

Overarching Principles:

Sentencing offenders with Mental Health conditions or disorders

Contents

Applicability of guideline

In accordance with section 120 of the Coroners and Justice Act 2009, the Sentencing Council issues this definitive guideline. It applies to all offenders aged 18 and older, who are sentenced on or after xxxx, regardless of the date of the offence. This guideline does not apply to offenders under the age of 18 as the considerations for these offenders in this regard are substantially different from those of adult offenders. Courts should instead use the Sentencing Children and Young People guideline, a link to which is attached below.

https://www.sentencingcouncil.org.uk/publications/item/sentencing-children-and-young-people-definitive-guideline/

Section 125(1) of the Coroners and Justice Act 2009 provides that when sentencing offences committed after 6 April 2010:

"Every court -

(a) must, in sentencing an offender, follow any sentencing guidelines which are relevant to the offender's case, and

(b) must, in exercising any other function relating to the sentencing of offenders, follow any sentencing guidelines which are relevant to the exercise of the function,

unless the court is satisfied that it would be contrary to the interests of justice to do so."

This guideline applies only to the sentencing of convicted offenders: it does not address issues of fitness to plead or disposals for those found unfit to plead.

Section one: General approach

1. The guidance given in this guideline will assist sentencers when sentencing offenders who have any of the conditions or disorders outlined in **Annex A**. The mere fact that an offender has such a condition or disorder does not necessarily mean that it will have an impact on sentencing.

2. There are a wide range of mental health conditions, neurological impairments and developmental disorders, and the level of any impairment will vary between individuals. Accordingly, in assessing whether the condition or disorder has any impact on sentencing, the approach to sentencing should be individualistic and focused on the particular issues relevant in the case concerned. In particular:

- care should be taken to avoid making assumptions, as unlike some physical conditions, many mental health conditions, neurological impairments or learning disabilities are not easily recognisable
- no adverse inference should necessarily be drawn if an offender had not previously been formally diagnosed, or had not previously declared a condition (possibly due to a fear of stigmatisation or because they are unaware they have a condition)
- it is not uncommon for people to have a number of different conditions, 'co-morbidity', and for drug and/or alcohol dependence to be a factor,
- difficulties of definition and classification in this field are common, there may be differences of expert opinion and diagnosis in relation to the offender, or it may be that no specific condition can be identified
- sentencers should be wary of acting on the basis of self- diagnosis or on diagnosis from those unqualified, which alone will rarely be sufficient

3. In any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law, unless, in the circumstances of the case, the court is of the opinion that it is unnecessary (s.157 Criminal Justice Act 2003). There is more information on s.157 at **Annex B.** It may be unnecessary if existing sources of information can be used, such as from probation, defence representatives, prison, police or court mental health teams, or family members. In addition, s.39 of the Mental Health Act (MHA)1983 provides that a court may request information about a patient from local health services if considering making a hospital

or interim hospital order. Further information about requests for reports can be found at **Annex B** of this document.

4. Where a custodial sentence is passed the court should forward psychiatric, medical and pre-sentence reports to the prison, to ensure that the prison has appropriate information about the offender's condition and can ensure their welfare.

5. Courts should always be alive to the impact of a condition on an offender's ability to understand and participate in proceedings. To avoid misunderstandings, which could lead to further offences, it is important to ensure that offenders understand their sentence and what will happen if they reoffend and or breach the terms of their licence or supervision. Courts should therefore consider putting the key points in an accessible way. Further information can be found at Chapter Four of the Equal Treatment Bench Book:

   https://www.judiciary.uk/publications/new-edition-of-the-equal-treatment-bench-book-launched/

6. In all cases where the court is considering a mental health disposal, the court must be satisfied that treatment is and will continue to be available. If the treatment proposed is not within a NHS hospital, courts should take particular care to confirm the proposed hospital/ treatment centre has the appropriate level of security and specialist staff able to address the offending behaviour in addition to treating the mental health condition. In all cases, courts should consider whether a restraining order or other ancillary order may be appropriate. In addition, if the court is considering making a mental health treatment requirement, sentencers should first seek assurance that the proposed treating psychiatrist is aware of the duty to the court to inform the court of any non- compliance with the order.

Section two: assessing culpability

7. Courts should refer to offence specific guidelines to assess culpability, in conjunction with this guideline. If an offender has any of the conditions or disorders listed in **Annex A**, it is possible that it may affect their level of responsibility for an offence. The relevance of any condition will depend on the nature, extent and effect of the condition on an individual and whether there is a causal connection between the condition and the offence. It is for sentencers to decide how much responsibility the offender retains for the offence, given the particular disorder or condition and the specific facts of the case at hand.

8. In some cases the condition may mean that culpability is significantly reduced, in others, the condition may have no relevance to culpability. Assessments of culpability will vary between cases due to the differences in the nature and severity of conditions, and the fluctuation of some conditions; it is not possible to be prescriptive in this regard. Careful analysis of the evidence is required to make this assessment, which the sentencer, who will be in possession of all the relevant information, is best placed to make. Expert evidence, where offered and relevant, should be taken into account, but sentencers must make their own decisions and should not feel bound to follow expert opinion. Examples of when it may not be appropriate to follow expert opinion include, but are not limited to, where there is conflicting expert advice or where experts suggest a diagnosis without a clear indication of how it affects culpability.

9. Courts may find the following list of questions to consider helpful, to assist in deciding the level of culpability:

- Did the offender's condition mean it impaired their ability to exercise appropriate judgement?
- Did the offender's condition impair their ability to make rational choices, or to think clearly?
- Did the offender's condition impair their ability to understand the nature and consequences of their actions?
- Did the offender's condition have the effect of making them disinhibited?
- Were there any elements of premeditation or pre-planning in the offence, which might indicate a higher degree of culpability?
- Were there attempts to minimise their wrongdoing or to conceal their actions, which might indicate a higher degree of culpability?
- Did the offender have any insight into their illness, or did they lack insight?
- Did the offender seek help, and fail to receive appropriate treatment or care?
- If there was a lack of compliance in taking medication or following medical advice, was this influenced by the condition or not?
- If the offender exacerbated their condition by drinking/taking drugs, were they aware of the potential effects of doing so?

This is not an exhaustive list.

Section three: determining the sentence

10. Courts should consider all the purposes of sentencing during the sentencing exercise: the punishment of offenders, reduction of crime, rehabilitation of offenders, protection of the public, and reparation. Although the statutory requirement to have regard to the purposes of sentencing does not apply when making a hospital order, a hospital order with restrictions, or a hospital and limitation direction, consideration of the purposes of sentencing may still be relevant in such cases. Just because an offender has a mental health condition, neurological impairment or disability, it does not mean they should not be punished, and in the case of serious offences protection of the public may be paramount. For offenders whose condition has contributed to their offending the effective treatment of their condition should in turn reduce further offending and protect the public.

11. Decisions will need to be made on a case by case basis. For example, in a case where an offender's culpability was high, the sentence **may** be more weighted towards punishment. In a case where an offender's culpability was low, the sentence **may** be more weighted towards rehabilitation.

12. An offender's condition at the point of sentence could have a bearing on the type, length or nature of sentence that is imposed, including or whether a disposal under the Mental Health Act is appropriate. Some points to consider are:

- The existence of a condition at the date of sentencing, or its foreseeable recurrence, could mean that a given sentence could weigh more heavily on the offender than it would on an offender without that particular condition
- Custody can exacerbate poor mental health and in some cases increase the risk of self-harm
- Some requirements of community orders may be impractical, consideration should be given to tailoring the requirements of orders, as necessary in individual cases. An offender should not receive a more severe sentence, such as custody, because they would be unable to do unpaid work as part of a community order, for example

13. In deciding on a sentence, courts should also carefully consider the criteria for, and regime on release. It should not be assumed that one order is better than another, or that one order offers greater protection to the public than another. Careful analysis of all the facts is required in each case, including what is practically available, before deciding on the appropriate disposal. The graver the offence and the greater risk to the public on release of the offender, the greater

emphasis the court must place upon the protection of the public and the release regime. Further details are given at **Annex C,** but in summary:

- A **s37 hospital order** lasts initially for six months but can be renewed for a further six months and then for a year at a time. Discharge from a hospital order can be made by the responsible clinician (RC) or the hospital at any time. The RC can also make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The patient can apply to the tribunal (First Tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal in Wales) for discharge after six months and annually thereafter.
- A **restriction order under s41** lasts indefinitely and does not need to be renewed. The Secretary of State for Justice (SoS) can lift the restriction order at any time if satisfied that it is no longer necessary to protect the public from serious harm. A patient who is still in hospital when the restriction order is lifted is treated as if admitted under a hospital order on the day the restriction order ended.
- A **limitation direction under s45A** ends automatically on the patient's 'release date'. The effect of this is that the limitation direction will end at the halfway point of a determinate sentence. If the patient is serving a life sentence, or an indeterminate sentence, the release date is the date (if any) on which the person's release is ordered by the parole board. Although the limitation direction ends on the release date, the hospital direction does not. So a patient who is still detained in hospital on the basis of the hospital direction on their release date, remains liable to be detained in hospital from then on as an unrestricted hospital order patient. While the limitation direction remains in effect, if the patient no longer requires treatment in hospital for a mental disorder, the SoS may direct that the patient be removed to prison (or equivalent) to serve the remainder of their sentence, or else release them on licence.

Section four: sentencing disposals

14. The following is a non- exhaustive list of available mental health disposals/orders and relevant guidance (further details on each are at **Annex C).**

Magistrates' courts

- Community Order with a Mental Health Treatment Requirement (MHTR)
- Section 37 Hospital order
- Section 37 Guardianship order
- Section 43 Committal to the Crown Court (with a view to a restriction order)

Crown Court

- Community Order with a Mental Health Treatment Requirement (MHTR)

- Section 37 Hospital order
- Section 37 Guardianship order
- Section 41 Restriction order
- Section 45A Hospital and limitation direction

The following guidance applies in the Crown Court only:

Where:

(i) the evidence of medical practitioners suggests that the offender is currently suffering from a mental disorder,

(ii) treatment is available, and

(iii) the court considers that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case,

the court should consider **all sentencing options** including a section 45A direction and consider the importance of a penal element in the sentence taking into account the level of culpability assessed at section two above.

Section 45A hospital and limitation direction

a. Before a hospital order is made under s.37 MHA (with or without a restriction order under s.41), consider whether the mental disorder can appropriately be dealt with by custody with a hospital and limitation direction under s.45A MHA. In deciding whether a s.45A direction is appropriate the court should bear in mind that the limitation direction will cease to have effect at the automatic release date of a determinate sentence.

b. If a penal element is appropriate and the mental disorder can appropriately be dealt with by a direction under s.45A MHA, then the judge should make such a direction. (Not available for a person under the age of 21 at the time of conviction).

Section 37 hospital order and s41 restriction order

If a s.45A direction is not appropriate the court must then consider whether, (assuming the conditions in s.37(2) (a) are satisfied), the matters referred to in s. 37(2)(b) would make a hospital order (with or without a restriction order under s.41) the most suitable disposal. The court should explain why a penal element is not appropriate.

Annex A

MAIN CLASSES OF MENTAL DISORDERS AND PRESENTING FEATURES

Mental disorder is a catch-all term for illnesses and developmental disorders. Mental disorder is a collection of symptoms (the sufferer's experiences) and signs (features that may be observed by an outside observer). For categorisation as a disorder, these problems should be associated with distress and/or interference with personal functions.

Broadly the concept of ***illness*** is used for disorders with onset after a sustained period – often a lifetime – of health or average/normal psychological function e.g. schizophrenia, depression.

Developmental disorders are conditions which may be apparent at birth, but always have early enough onset that the individual never quite fitted within the average behavioural range. Behaviour has three main components – thinking (cognitions), feeling (emotions, affect) and actions. Autism, generalised or specific intellectual (learning) disabilities, and personality disorders are examples.

Other disorders which may be relevant in court lie at the interface between psychiatry and neurology. Epilepsy in its various forms is an example.

Brief descriptions of some of the more common disorders likely to be relevant in court

Psychotic illnesses

These too affect cognitions, emotional capacities and actions.

There are two main groups – those which are associated with more generalised illness or bodily problems, often called 'delirium', and those which are not – often referred to as 'primary psychosis', which include schizophrenia and bipolar disorders.

Delirium is likely to present with some impairment in consciousness. It may occur as an acute phase of a dementing process, but also with serious infections or generalised problems with bodily functions, such as hormonal disturbances. They may also occur in the context of drug (including alcohol) taking or withdrawal from such substances.

Sufferers may misinterpret sensory input in any of its main forms (sight, hearing, smell, taste, touch), thus having 'illusions'; their sensory experiences may be so disturbed that they see or hear or smell or taste or feel things which are not there at all to the external observer (hallucinations). Their thinking may be disturbed in its own right, or following from these perceptual problems, such that they have pathological beliefs (delusions).

Delirium is likely to resolve as the underlying condition is treated.

Schizophrenia and bipolar disorders are disorders in which consciousness is unimpaired, but sensory (illusions, hallucinations) and cognitive (delusions, formal thought disorder) disturbances occur.

In ***schizophrenia***, serious disturbances of emotion also occur in which the person either cannot experience or express emotions accurately, or both, and may be unaware of the difficulty. Terms like – 'incongruous affect', when the emotional experience or expression is the opposite from what a healthy observer might expect for the situation, or 'flattened affect', when the person seems to have little or no emotion at all, are quite common. Tests for empathy may show that this is reduced.

People may also present with 'formal thought disorder' – when the form of thought, and thus speech is hard to follow and may include nonsensical, made-up words. Hallucinations most commonly take the form of 'third person hallucinations' when the person hears others talking about them, but when no-one is doing so.

Delusions are beliefs which, in full form, are wholly impervious to reason, generally, but not always based on a false premise. Persecutory/paranoid delusions are probably the most common. Passivity delusions – when the individual 'knows' that his/her thoughts, feelings or actions are controlled by another person or an external system – may be particularly associated with violence. If hypochondriacal delusions occur, they tend to be bizarre and may be dangerous to the sufferer – for example a belief in a machine causing all the problems implanted in his/her eye. Many aspects of schizophrenia are treatable, but 'cure' is unlikely and deterioration over years quite common. Nevertheless, sufferers can attain a good quality of life and safety if a full range of relevant treatments can be sustained.

Delusional disorder is sometimes diagnosed when the only abnormality appears to be the presence of a single delusion. Vexatious litigants sometimes have this disorder.

Bipolar illness – also referred to by the older, now less used term 'manic depression' – is characterised by repeated episodes of depression (low mood and low activity levels) and (hypo)mania (high mood and high activity levels). Psychotic symptoms are not invariably present at either extreme, but depressive psychotic symptoms include hypochondriacal delusions of a kind that the person believes his/her body is rotting away, or delusions of catastrophe; suicidal ideas are common and the rare situation of family killings with suicide of the perpetrator may occur in such states. In a manic phase, the individual may have grandiose or omnipotent delusions, accompanied by reckless and/or disinhibited acts.

Unipolar affective illnesses - people may have recurrent depressions or recurrent manic episodes, but not both.

Schizoaffective illness looks like a hybrid of schizophrenia and bipolar disorder; it may not be a distinct disorder.

Non-psychotic illnesses

These include 'simple' depression (seriously low mood and perhaps suicide related behaviours, but without delusions) and anxiety disorders. The latter include a range of conditions; the more common include phobic disorders (sufferers recognise that their fear is not well founded in fact), obsessive compulsive disorders (again, the fear recognised for what it is, but still thoughts and fears intrude and maybe rituals must be performed), panic attacks and post-traumatic stress disorders [PTSD]. PTSD can only be diagnosed if it follows a seriously traumatic event – the condition must emerge within six months of this. As well as mental and physiological symptoms and signs of anxiety, and often some depressive features, extremely distressing intrusions of memories or experiences of the event – disrupt sleep and/or waking life.

Developmental disorders

Intellectual disability [ID] (learning disability, mental retardation) – names for these conditions keep changing over time in a constant effort to reduce stigma. Problems may be generalised (probably most relevant in court) or specific – for example relating to a particular language function. As the labels suggest, the core problem is cognitive – sufferers have a lower than average ability to learn at all and to acquire language. Inevitably, this is an over-simplification as there are often problems with emotions and actions too, and it is hard to distinguish the extent to which these are part of the primary condition and the extent to which they follow from difficulties in learning. A tested 'intelligence quotient' (IQ) is often used to indicate severity – mild, moderate, severe. Average intelligence is taken as 80-120. A person with severe generalised intellectual disability mental will have a tested IQ under 35, and cannot live independently. In varying degrees those with moderate (IQ 35-49), mild (IQ 50-69) or borderline ID (70-80) can live independently, but are particularly vulnerable if they enter the criminal justice system.

Autism and autistic spectrum disorder (the latter sometimes known as Asperger's syndrome) are pervasive developmental disorders in which intelligence may or may not be impaired, but emotional and relationship capacities, often with aspects of speech development, are. Generally, parents are always aware that their child is 'different', but this will certainly be clear by the age of 3 years.

Attentional deficit hyperactivity disorder [ADHD] is similarly apparent from a very early age, although may not be completely recognised until the individual starts school. It is not uncommonly associated with other developmental disorders, but also occurs alone, when it is characterised by profound difficulties in concentrating in ordinary social situations or on tasks (many can focus on computer based activities) and very high levels of physical activity. Children are seen as 'disruptive' and can easily be made worse under conventional behavioural control efforts. As with all developmental disorders, it may persist into adult life.

Substance misuse disorders

Substance misuse *per se* is widespread – although evidence on safe drinking limits is not finite. Substances which are illegal are, by definition, legally abused if consumed. Substance misuse disorders, however, arise when the individual no longer has significant personal control over intake and/or s/he has signs and symptoms of secondary disease. Substances of abuse affect the nervous system, often altering its activity so that the experience of the consumer is that when they do not have the substance they have very unpleasant symptoms or signs ranging, from intense anxiety through to psychotic symptoms (withdrawal symptoms/signs), and so they have to keep taking the substance in order to feel almost normal. Secondary disease may affect any part of the body, although most commonly those areas that process the substances – like the gut or the liver – and the brain.

Conduct disorders, if unresolved, are the childhood precursors of personality disorders. Emphasis is on repeated patterns of extreme dissocial, aggressive or defiant behaviours, persistent through childhood, which cannot be completely explained by one of the other developmental disorders.

Personality disorders. The personality is not considered to be fully formed until adulthood, so, by definition these are conditions which can affect only adults. Although adulthood is often taken as 18 years old, there isn't a set time threshold when the brain and physiology is one day that of a child and the next of an adult. For a diagnosis of personality disorder, there must be evidence of continuity with problems such as conduct disorder throughout childhood and adolescence. Similar conditions may arise in adulthood after, say, brain injury or disease, but this would be *personality change*.

Specific personality disorder labels are generally descriptive, following from their most prominent characteristics. Treatment needs mean that is probably most helpful to think of the personality disorder clusters rather than specific disorders – thus

Cluster A – the paranoid, eccentric, schizoid

Cluster B – the emotionally unstable, histrionic, narcissistic, antisocial

Cluster C – the anxious, avoidant, obsessional (anankastic), dependent.

'Psychopathic disorder' is not a recognised diagnosis; its use should be avoided as pejorative and unscientific. 'Psychopathy' is similarly not a diagnosis, but rather a term that has been introduced to indicate whether a person had crossed a threshold on one of a number of possible psychopathy scales. Generally, these scales measure two things – the extent to which antisocial behaviours are widespread and have been repeated through the life course, and the extent to which the individual have capacity for variants of empathy.

Both these elements have, correctly, been used as indicators of risks or repetition of unwanted behaviours. It is obvious that established behaviour patterns are likely to continue that way unless deliberately disrupted; on the other hand, it is always easier to tell if progress has been made when a previously repeated behaviour ceases over a substantial period of time under a range of circumstances.

If empathy is severely impaired – for example the capacity to recognised distress in others and make appropriate use of that information – this may severely impair capacity to desist from harming others.

Risk of harm to self is very high among people with personality disorder.

The dementias

Dementia follows from brain damage. Each aspect of behaviour may be affected. The most obvious is the cluster of cognitive problems, with forgetfulness, difficulties in following a train of thought and making judgements prominent. There are commonly also directly related emotional problems, as the brain can no longer control emotions, and also secondary emotional problems when the sufferer retains insight and is aware of progressively losing his or her mental abilities. Capacity for control of actions may also be impaired, resulting in what is often referred to as 'disinhibited behaviour'.

Evidence for dementia will come in several forms – the clinical examination, which should include asking the affected person about his/her experiences and for a history of the development of the condition; for obvious reasons it is more than usually important to get a history from relatives and friends too. People with dementia may retain the capacity to give a long and fascinating account of their problems which has little basis in reality (referred to as confabulation).

Simple tests of memory and other cognitive functions may be enough for basic diagnosis and to help the court, but it is generally best to map cognitive functions with detailed psychological testing, and there may be some very specific deficits which are relevant in

court – for example difficulties in recognising people or experience of perceptual distortions. Brain imaging techniques may have particular value in verifying the nature and extent of the brain damage underpinning the problems.

The dementias are progressive. People may be helped to manage their difficulties, sometimes the progress may be slowed, and sometimes worsening of some aspects of the condition may render other aspects less problematic or risky, but these are not conditions from which people recover.

The most common dementias are a function of unhealthy aging. There has been an increase in offending among older people, so these are conditions increasingly likely to be seen in the courts. A few have a clear genetic cause; there is evidence that there is a genetic contribution to most. Dementias may also, however, follow from brain damage from external causes, for example a serious head injury, in relation to other disorders affecting the whole body, like diabetes, or from having taken noxious substances – especially excessive alcohol, but a range of other drugs too.

Multi-morbidity and comorbidity

These terms are often used interchangeably to mean that the individual has more than one disorder although, strictly, comorbidity means that the conditions arose simultaneously. This is a very common situation among people who have a disorder of mental health. The truth is that it is generally very hard to disentangle which disorder came first or whether they did arise simultaneously.

It is not clear that it matters clinically, except insofar as the idea that a psychotic condition is 'drug induced' may, in the context of scarce service resources, be used to deny services. In addition to having several mental disorders – for example schizophrenia, personality disorder, cannabis use disorder and reactive depression – an individual is likely to be multiply disadvantaged socially – for example homeless or disconnected from family – and some clinicians will include these social disadvantages in the sum of comorbidities. They are certainly relevant to outcomes.

Annex B

Where the court considers a report is necessary, it should make the request specific, so that the report writer is clear as to **what** is required, and **when** the report is required by. Examples of information that might be requested are:

- background/history of the condition
- diagnosis, symptoms, treatment of the condition
- the level of impairment due to the condition
- how the condition relates to the offences committed
- dangerousness
- risk to self and others
- if there has been a failure of compliance (e.g not attending appointments, failing to take prescribed medication) what is thought to be driving that behaviour
- the suitability of the available disposals in a case
- if a particular disposal is recommended, the expected length of time that might be required for treatment, and details of the regime on release/post release supervision
- the impact of any such disposals on the offender
- any communication difficulties and/or requirement for an intermediary
- and any other information the court considers relevant.

Further information on requests for reports can be found within the Criminal Procedure Rules (part 28.8 Sentencing Procedures in Special Cases), and within the Criminal Practice Directions (I General Matters 3P Commissioning Medical Reports and VII Medical Reports for Sentencing Purposes R) both of which can be found here:

https://www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015#Anchor8.

https://www.judiciary.uk/wp-content/uploads/2018/08/crim-pd-amendment-no-7-consolidated-oct-2018.pdf.

When requested by clinicians wanting to undertake an inpatient assessment, for offences punishable with imprisonment, courts may wish to consider making an interim hospital order (s.38 MHA). Before making a s.38 order the court must be satisfied a bed is available, and that a s.38 order is necessary in the circumstances of the case.

Where appropriate, assessments can also be made in the community.

Power to order reports- magistrates courts

There are limited powers to order reports in the magistrates' courts. s.11 Powers of Criminal Courts (Sentencing) Act 2000[1] provides for the ordering a report, but it is only post- conviction or a finding under s.37 (3) Mental Health Act 1983 that the defendant did the act or made the omission charged. However, the court can request a report and a duly qualified medical practitioner who provides such a report can be paid out of central funds, using s.19 Prosecution of Offences Act 1985[2] plus Regulation 25(1) Costs in Criminal Cases (General) Regulations 1986[3].

Additional requirements in case of mentally disordered offender (s.157 Criminal Justice Act 2003)

(1) Subject to subsection (2), in any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law.

(2) Subsection (1) does not apply if, in the circumstances of the case, the court is of the opinion that it is unnecessary to obtain a medical report.

(3) Before passing a custodial sentence other than one fixed by law on an offender who is or appears to be mentally disordered, a court must consider—

(a) any information before it which relates to his mental condition (whether given in a medical report, a pre-sentence report or otherwise), and

(b) the likely effect of such a sentence on that condition and on any treatment which may be available for it.

(4) No custodial sentence which is passed in a case to which subsection (1) applies is invalidated by the failure of a court to comply with that subsection, but any court on an appeal against such a sentence—

(a) must obtain a medical report if none was obtained by the court below, and

(b) must consider any such report obtained by it or by that court.

[1] https://www.legislation.gov.uk/ukpga/2000/6/section/11
[2] https://www.legislation.gov.uk/ukpga/1985/23/section/19
[3] https://www.legislation.gov.uk/uksi/1986/1335/regulation/25/made

(5) In this section “mentally disordered”, in relation to any person, means suffering from a mental disorder within the meaning of the Mental Health Act 1983 (c. 20).

(6) In this section “medical report” means a report as to an offender's mental condition made or submitted orally or in writing by a registered medical practitioner who is approved for the purposes of section 12 of the Mental Health Act 1983 by the Secretary of State [or by another person by virtue of section 12ZA or 12ZB of that Act] [1] as having special experience in the diagnosis or treatment of mental disorder.

(7) Nothing in this section is to be taken to limit the generality of section 156.

Annex C

Mental Health Treatment Requirement (section 207 CJA 2003)	
May be made by:	A magistrates' court or Crown Court
In respect of an offender who is:	Convicted of an offence punishable with imprisonment
If the court is of the opinion	That the mental condition of the offender is such as requires and may be susceptible to treatment but does not warrant detention under a hospital order. The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order— (a) treatment as a resident patient in a care home an independent hospital or a hospital within the meaning of the Mental Health Act 1983, but not in hospital premises where high security psychiatric services within the meaning of that Act are provided; (b) treatment as a non-resident patient at such institution or place as may be specified in the order; (c) treatment by or under the direction of such registered medical practitioner or registered psychologist (or both) as may be so specified; but the nature of the treatment is not to be specified in the order except as mentioned in paragraph (a), (b) or (c).
And the court is satisfied	That arrangements have been or can be made for the treatment to be specified in the order and that the offender has expressed a willingness to comply with the requirement.

- MHTRs provide a useful option for offenders who would otherwise not qualify for treatment under the Mental Health Act 1983, to receive treatment
- Use of MHTRs attached to court orders for those offenders with identified mental health issues may result in reductions in reoffending, compared to the use of short term custodial sentences.
- Courts may also wish to consider a drug rehabilitation requirement and/or an alcohol treatment requirement in appropriate cases.
- A community order with a MHTR may be appropriate where the offence is not serious enough to cross the custody threshold,
- Where the defendant's culpability is substantially reduced by their mental state at the time of the commission of the offence, and where the public interest is served by ensuring they continue to receive treatment, a MHTR may be more appropriate than custody.
- Even when the custody threshold is crossed, a community order with a MHTR may be a proper alternative to a short or moderate custodial sentence
- A MHTR is not suitable for an offender who is unlikely to comply with the treatment or who has a chaotic lifestyle.

See also the Imposition of Community and Custodial Sentences definitive guideline:

https://www.sentencingcouncil.org.uk/publications/item/imposition-of-community-custodial-sentences-definitive-guideline/

<table>
<tr><th colspan="3">Hospital order (section 37 Mental Health Act 1983)</th></tr>
<tr><td>May be made by:</td><td colspan="2">A magistrates' court or Crown Court</td></tr>
<tr><td rowspan="2">In respect of a defendant who is:</td><td>Where made by a magistrates' court:</td><td>Where made by the Crown Court:</td></tr>
<tr><td>Convicted by that court of an offence punishable on summary conviction with imprisonment,
or
Charged before that court with such an offence but who has not been convicted or whose case has not proceeded to trial, if the court is satisfied that the person did the act or made the omission charged</td><td>Convicted before that court for an offence punishable with imprisonment (other than murder)</td></tr>
<tr><td>If the court is satisfied</td><td colspan="2">On the written or oral evidence of two doctors, at least one of whom must be approved under section 12, that
• the offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment, and
• appropriate medical treatment is available.</td></tr>
<tr><td>And the court is of the opinion</td><td colspan="2">Having regard to all the circumstances, including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with the offender, that a hospital order is the most suitable method of dealing with the case</td></tr>
<tr><td>And it is also satisfied</td><td colspan="2">On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case, or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the period of 28 days starting with the day of the order.</td></tr>
</table>

A hospital order is, an alternative to punishment. The court may not, at the same time as making a hospital order in respect of an offender, pass a sentence of imprisonment, impose a fine or make a community order, a youth rehabilitation order, or a referral order. Nor can the court make an order for a young offender's parent or guardian to enter into a recognizance to take proper care of and exercise proper control over the offender. The court may make any other order which it has the power to make, eg a compensation order.

A hospital order made **under s37** (without a restriction order) authorises the detention of the patient in hospital for medical treatment

- Discharge from the order can be made by the responsible clinician (RC) or the hospital at any time. The order initially lasts for six months but can be renewed by the hospital for a further six months and then for a year at a time if the conditions for making the order are still satisfied. There is no limit to the number of times that the order can be renewed.
- The patient can apply to the tribunal[4] for discharge after six months and annually thereafter.

[4] First Tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal in Wales

- The RC can authorise a leave of absence for a limited period or indefinitely; such leave can be subject to conditions and the patient can be recalled at any time if the RC considers it necessary in the interests of the patient's health or safety or for the protection of other people (the order can be renewed during a period of absence if hospital treatment remains necessary).
- The RC can make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The CTO lasts for an initial six months and can be extended for a further six months and annually thereafter.

Restriction Order (section 41 Mental Health Act 1983)	
A restriction order (section 41) may be imposed by the Crown Court where a hospital order has been made and:	
If	At least one of the doctors whose evidence is taken into account by the Court before deciding to give the hospital order has given evidence orally
And, having regard to	• the nature of the offence • the antecedents of the offender, and • the risk of the offender committing further offences if set at large
The Court thinks	It necessary for the protection of the public from serious harm for the person to be subject to the special restrictions which flow from a restriction order

A restriction order lasts until it is lifted by the Secretary of State under section 42, or the patient is absolutely discharged from detention by the responsible clinician or hospital managers with the Secretary of State's consent under section 23 or by the Tribunal under section 73.

While the restriction order remains in force, the hospital order also remains in force and does not have to be renewed.

- The Secretary of State for Justice (SoS) can lift the restriction order at any time if satisfied that it is no longer necessary to protect the public from serious harm. A patient who is still in hospital when the restriction order is lifted is treated as if admitted under a hospital order on the day the restriction order ended. A patient who has been conditionally discharged from hospital will be automatically discharged absolutely on that date.
- A restricted patient may not be discharged, transferred to another hospital or given leave of absence by the responsible clinician (RC) or hospital without the SoS's consent. Either the RC or the SoS can recall a patient from leave.
- The SoS has the power to discharge the patient conditionally or absolutely.
- The Tribunal has no general discretion to discharge restricted patients but must discharge patients who are subject to a restriction order (other than patients who have been conditionally discharged and not recalled to hospital) if it is not satisfied that the criteria for continued detention for treatment under a hospital order are met.
- The discharge must be conditional, unless the Tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment, i.e. to be made subject to conditional discharge.

- Where the Tribunal is required to discharge a restricted patient conditionally it may, but does not have to, impose conditions with which the patient is to comply. The SoS may impose conditions and vary those imposed by the Tribunal.

Hospital and limitation directions (section 45A Mental Health Act 1983)	
May be given by:	Crown Court
In respect of a person who is	Aged 21 or over and convicted before that court of an offence punishable with imprisonment (other than murder)
If the court is satisfied	On the written or oral evidence of two doctors, at least one of whom must be approved under section 12, and at least one of whom must have given evidence orally, that: • the offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment, and • appropriate medical treatment is available
And the Court	Has first considered making a hospital order under section 37, but has decided instead to impose a sentence of imprisonment
And it is also satisfied	On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the 28 days starting with the day of the order.

This so-called 'hybrid order' enables the court to combine a hospital order with restrictions with a prison sentence. A hospital direction is a direction for a person's detention in hospital. A limitation direction is a direction that they be subject to the special restrictions in section 41 of the Act which also apply to people given restriction orders. A hospital direction may not be given without an accompanying limitation direction (although, as described below, a hospital direction may remain in force after the limitation direction has expired).

- A limitation direction ends automatically on the patient's 'release date'. The patient's release date is the day that the patient would have been entitled to be released from custody had the patient not been detained in hospital. Discretionary early release such as home detention curfew is not taken into account. For these purposes, any prison sentence which the patient was already serving when the hospital direction was given is taken into account as well as the sentence(s) passed at the same time as the direction was given. The effect of this is that the limitation direction will end at the halfway point of a determinate sentence.
- If the patient is serving a life sentence, or an indeterminate sentence, the release date is the date (if any) on which the person's release is ordered by the parole board.
- Although the limitation direction ends on the release date, the hospital direction does not. So if patients are still detained in hospital on the basis of the hospital direction on their release date, they remain liable to be detained in hospital from then on like unrestricted hospital order patients. This includes patients who are on leave of absence from hospital on their release date, but not those who have been conditionally discharged and who have not been recalled to hospital.
- Unlike hospital order patients, hospital and limitation direction patients are detained primarily on the basis of a prison sentence. While the limitation direction remains in effect, the Secretary of State may direct that they be removed to prison (or equivalent) to serve the remainder of their sentence, or else release them on licence.

This is only possible where the SoS is notified by the offender's responsible clinician, any other approved clinician, or by the Tribunal, that:
  - the offender no longer requires treatment in hospital for mental disorder, or
  - no effective treatment for the disorder can be given in the hospital in which the offender is detained.
- When notified in this way by the responsible clinician, or any other approved clinician, the SoS may:
  - direct the offender's removal to a prison (or another penal institution) where the offender could have been detained if not in hospital, or
  - discharge the offender from the hospital on the same terms on which the offender could be released from prison.
- If the Tribunal thinks that a patient subject to a restriction order would be entitled to be discharged, but the SoS does not consent, the patient will be removed to prison. That is because the Tribunal has decided that the patient should not be detained in hospital, but the prison sentence remains in force until the patient's release date.

Committal to the Crown court (section 43 Mental Health Act 1983)	
A magistrates' court may commit a person to the Crown Court with a view to a restriction order if (s43(1))	
The person	Is aged 14 or over, and
	Has been **convicted*** by the court of an offence punishable on summary conviction by imprisonment
And	The court could make a hospital order under section 37
But having regard to	The nature of the offence The antecedents of the offender, and The risk of the offender committing further offences if set at large
The court thinks	That if a hospital order is made, a restriction order should also be made.

*Note: there is no power to commit to the Crown Court for a restriction order where a magistrates' court has made a finding that a defendant has done the act/made the omission charged under s 37(3) MHA.

The Crown Court is required to inquire into the circumstances of the patient's case and either:

- make a hospital order (with or without a restriction order), as if the offender had been convicted before the Crown Court, rather than by the magistrates' court, or
- deal with the offender in some other way the magistrates' court would have been able to originally.

Guardianship order (section 37 Mental Health Act 1983)		
May be made by	a magistrates' court or the Crown Court	
	where made by a magistrates' court	where made by the Crown Court
	convicted by that court of an offence punishable (in the case of an adult) on	convicted before that court for an offence punishable with

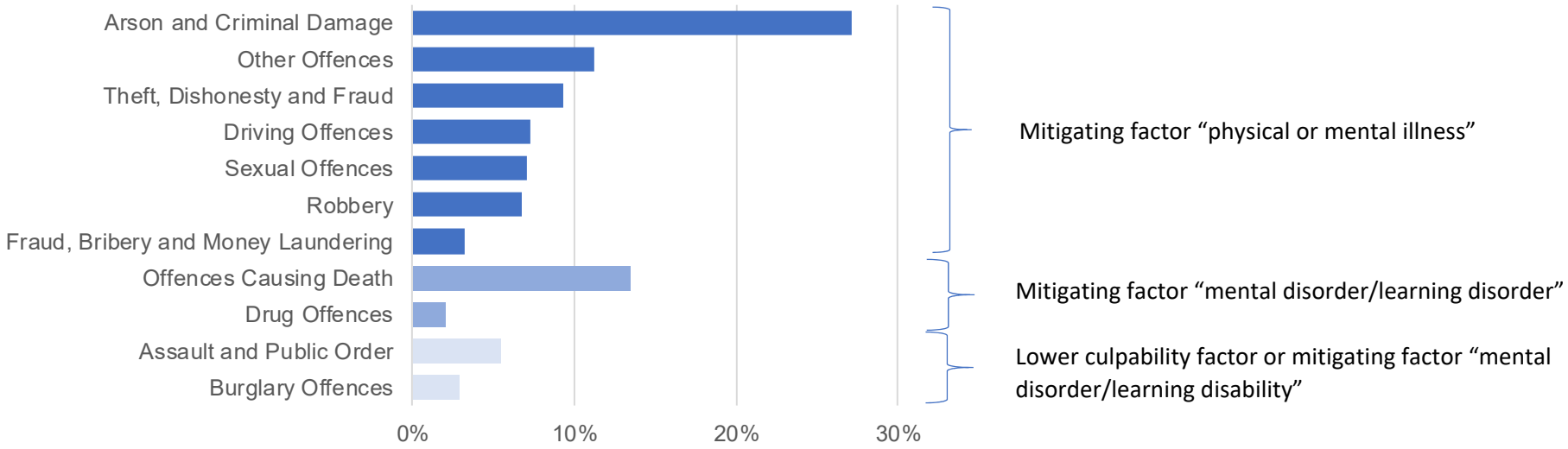
In respect of a person who is aged 16 or over and who is	summary conviction with custody or charged before (but not convicted by) that court with such an offence, if the court is satisfied that the person did the act or made the omission charged	imprisonment (other than murder)
if the court is satisfied	on the written or oral evidence of two doctors, at least one of whom must be approved under section 12, that the offender is 16 or over, and is suffering from mental disorder of a nature or degree which warrants the offender's reception into guardianship under the Act	
and the court is of the opinion	having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with the offender, that a guardianship order is the most suitable method of dealing with the case	
and it is also satisfied	that the local authority or proposed private guardian is willing to receive the offender into guardianship	

Guardianship enables patients to receive care outside hospital where it cannot be provided without the use of compulsory powers. The Act allows for people ('patients') to be placed under the guardianship of a guardian. The guardian may be a local authority, or an individual ('a private guardian'), such as a relative of the patient, who is approved by a local authority. Guardians have three specific powers: residence, attendance and access.

- The *residence power* allows guardians to require patients to live at a specified place.
- The *attendance power* lets guardians require the patient to attend specified places at specified times for medical treatment, occupation, education or training. This might include a day centre, or a hospital, surgery or clinic.
- The *access power* means guardians may require access to the patient to be given at the place where the patient is living, to any doctor, approved mental health professional, or other specified person. This power could be used, for example, to ensure that patients do not neglect themselves.

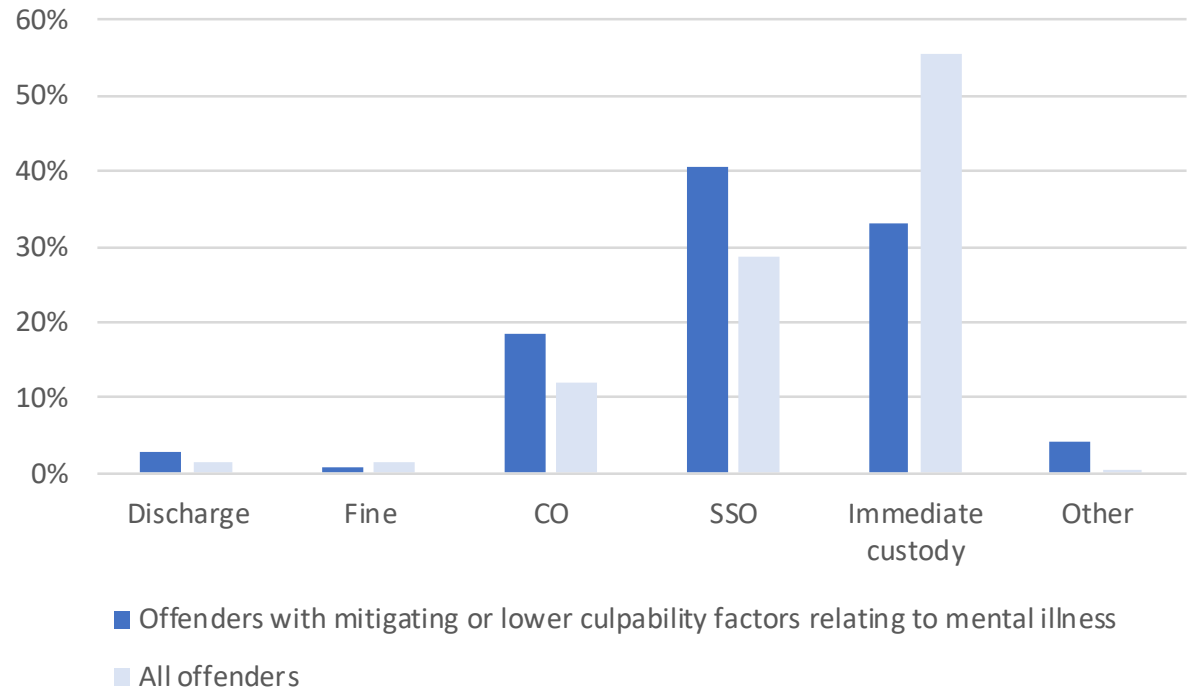
Crown Court Sentencing Survey data, 2014[1,2]

Proportion of offenders with factors relating to mental illness taken into account in sentencing, by offence type

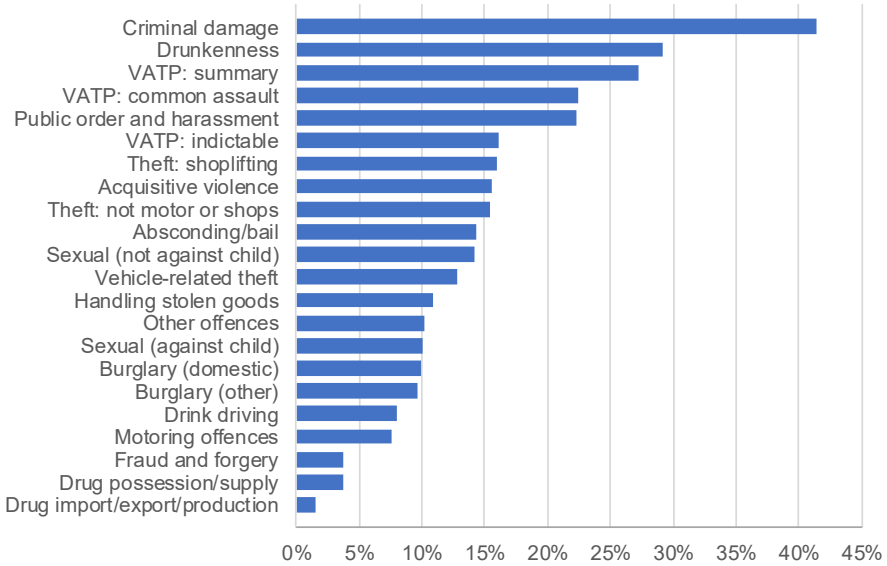


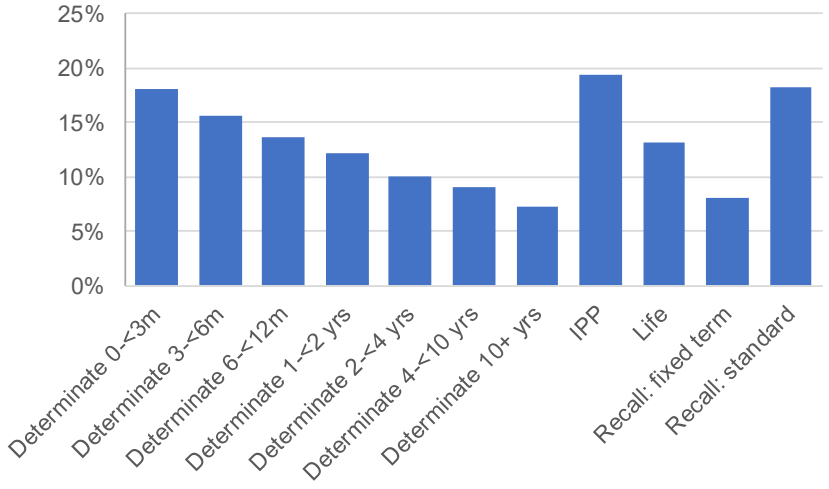
[1] Source: Crown Court Sentencing Survey.
[2] Excludes youths.

Distribution of sentences for offenders in the CCSS, for offenders with factors relating to mental illness taken into account in sentencing, and all offenders, 2014



Prevalence of severe mental health problems[3] among prisoners by offence and prisoner type, HMPPS data[4][5]





Notes:

- In order to obtain reasonably wide OASys coverage, assessments from past as well as current sentences are utilised. It is assumed that the prevalence of mental health problems is stable over time for these offenders. Various past OASys data exploration and research exercises have found that, in general, individuals' profiles on most OASys sections change slowly over time.
- Among short-term prisoners, OASys is more likely to be available for those who have previously experienced longer custodial sentences, been managed in the community by the NPS and/or had a full Pre Sentence Report. These offenders will in general be higher-risk and may have more criminogenic needs.
- Limited coverage: as of 30th June 2017, 73% of those in custody had an assessment that included a full criminogenic need profile and a Risk of Serious Harm rating.
- This data is primarily used to support operations and is not a clinically approved tool for medical diagnosis (although assessors are required to place substantial weight on information from medical sources). Data is subject to the limitations of any self-reporting tool.
- Data doesn't have information on specific mental health problems, i.e. the offender's specific psychological or psychiatric problem.

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[3] Those who have been scored 2 - significant problems - on a 0/1/2 rating scale for one/both of the OASys questions on psychological and psychiatric problems.

[4] Source: the "segmentation" dataset, which combines prison, probation, Offender Assessment System and Police National Computer data, for the adult (age 18+) HMPPS caseload on 30 June 2017

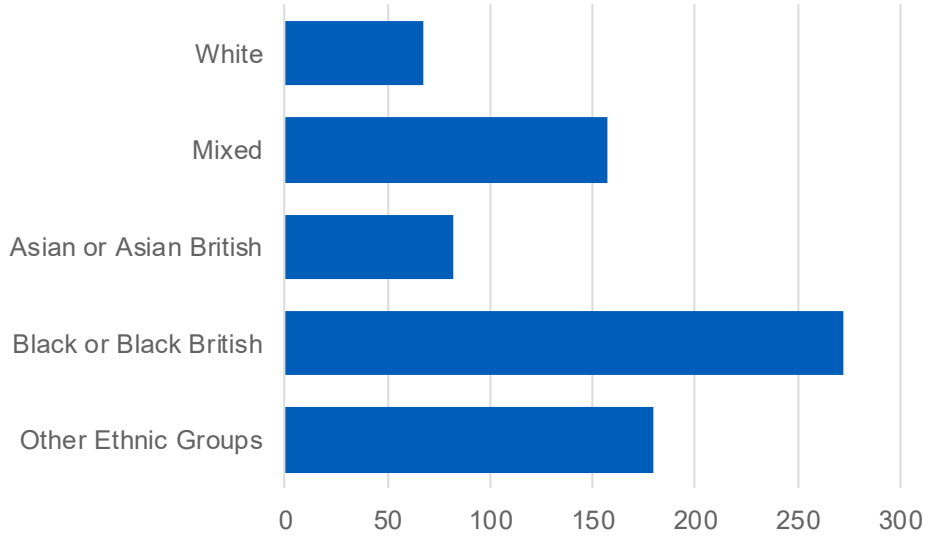
[5] VATP stands for "Violence Against The Person"

Statistics on detentions under the Mental Health Act and hospital orders, by ethnicity

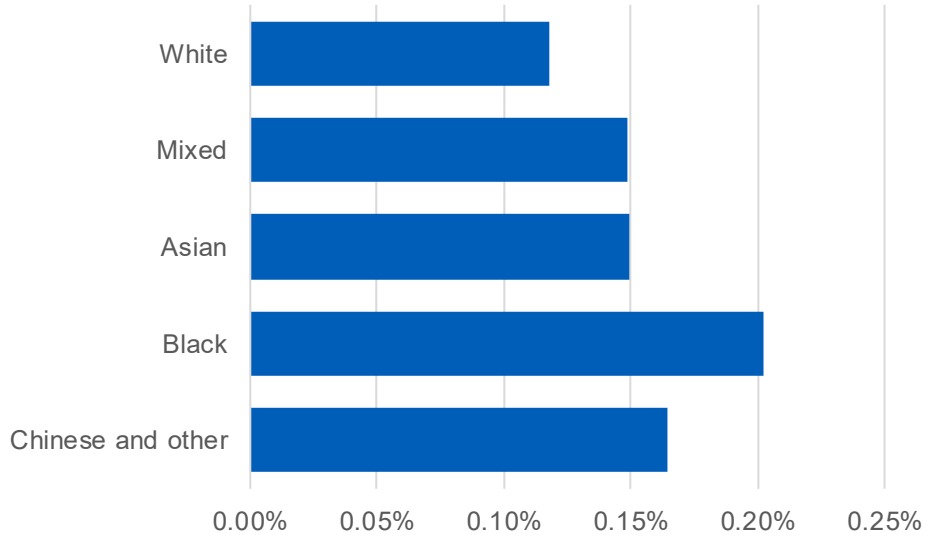
NHS Mental Health Act Statistics, 2016/17

Rates of detention under the Mental Health Act 1983 (including both civil detentions under Part II and detentions via the Criminal Justice System under Part III of The Act). Published figures are not broken down by the different parts of the Act.

Standardised hospital detention rate (includes both civil and criminal detentions) per 100,000 population, by ethnicity



Proportion of offenders sentenced receiving hospital orders, by ethnicity, 2017[6]



[6] Source: Court Proceedings Database, Ministry of Justice. Excludes youths.