Sentencing Council

Sentencing Council meeting:	**27 July 2018**
Paper number:	**SC(18)JUL04 – Mental Health**
Lead Council member:	**Rosa Dean**
Lead official:	**Mandy Banks** **0207 071 5785**

1 ISSUE

1.1 At the last meeting the Council considered an early draft of the guideline, and made a number of suggestions for rewording and amendments. The Council also discussed a number of objectives for the guideline, as set out below:

- to provide information and increase awareness, and assist sentencers to understand how mental health and other conditions affect culpability;
- to provide technical guidance about what is available in terms of disposals and to deal with distinctions and particular issues that can cause difficulty, e.g. distinction between learning difficulty and disability;
- to be useable in practical terms and not be too lengthy;
- to avoid increasing the number of reports/adjournments required; and
- possibly to affect resource allocation indirectly and the issues of sentencer confidence in community orders, related to practical problems of availability and issues within the probation system

1.2 In order to take the work further, Council recommended that officials visited a magistrates' court to speak to sentencers and mental health practitioners, to better understand the issues in that context, and to consider the report by the Prison Reform Trust. A visit to Camberwell Green magistrates court was made, and discussions held with District Judge Susan Green and a Consultant Forensic Psychiatrist who works at the court. A redraft of the guideline was prepared, and sent to Rosa, Rebecca and Tim for comment, ahead of the Council papers going out. Following this, all three members agreed that before going any further in trying to redraft the guideline, a review should be carried out of caselaw to establish what guidance has so far been given by the CACD, which would then form the basis of consideration of what topics the guideline should cover. Within the time available before the July Council meeting, a preliminary review of CACD cases was then conducted.

2 RECOMMENDATION

2.1 At this meeting the Council are asked:

- To note the review of CACD cases, attached at **Annex A**
- To consider what guidance the review has revealed, and to indicate if further work should be carried out, and if so, on what particular areas
- To consider and answer the key questions posed regarding the scope and focus of the guideline (paras 3.13-3.18)

3 CONSIDERATION

3.1 The draft guideline is attached at **Annex B,** but is attached for reference only-**it is not intended that it forms the basis of discussion at this meeting.** The changes that the Council asked for at the last meeting have been made, and it also incorporates some changes suggested by Rebecca and Rosa. However, as outlined in paragraph 1.2, it is suggested that the Council need to consider the review of caselaw before attempting to redraft the guideline any further.

Review of CACD cases

3.2 A summary of the cases studied as part of the review is attached at **Annex A** (with key words/sentences bolded for emphasis). The search for relevant cases focused primarily on cases that considered issues pertaining to assessments of levels of culpability, one of the main areas of difficulty in providing guidance within the guideline. Cases 1-14 broadly discuss factors which were considered to make the offenders have greater culpability, and cases 16-24 factors which made the offenders have lesser culpability for their offences.

3.3 The factors that were highlighted that may increase culpability were:

- Offenders having insight into their illness
- Elements of premeditation or pre-planning for the offences
- Attempting to minimise their wrongdoing or to conceal their actions
- Drinking/taking drugs
- Not taking prescribed medication
- Committing violent offences long before the onset of any illness

3.4 The factors that were highlighted that may lesser culpability were:

- Offenders lacking insight into their illness
- Lack of compliance in taking medication being due to the mental illness

- Being unaware of the effects of drinking given their condition/the illness itself leading to drinking
- Due to an offender's disordered state it couldn't be said there was real premeditation/pre-planning
- That some conditions are latent for many years before clearly manifesting themselves, so may have been a factor in early offending pre- diagnosis

3.5 The contents of paragraphs 3.3 and 3.4 highlight that the review of CACD has revealed that for every factor that indicates greater culpability, there are arguments for the same factor to indicate lesser culpability, the issue of drinking, for example. Case no 24 in **Annex A**, *R v Przybylski*, is a good example of this, the sentencing Judge had assessed there was culpability, as the offender had been drinking alcohol. On appeal, it was found that culpability in fact was much reduced: it was the mental illness that drove him to drink; and he wouldn't have appreciated the disinhibiting effect of alcohol. In the discussion of the case of Knapper within case no 25, *R v Edwards,* the sentencing Judge had found that the offender knew his condition affected his behaviour, but had chosen to stop taking his medication because it affected his weight, and concluded he remained criminally responsible to a moderate degree. On appeal, it was found that his responsibility was low, as he had no reason to know that he would become violent if he failed to take prescribed drugs.

3.6 This leads to the conclusion that cases are very fact specific, and that providing guidance on this within the guideline cannot be prescriptive, but can only provide factors for courts to consider to what degree they affect levels of culpability in a case. It was noted during the review that the CACD will often remark that their decisions on a particular case were heavily fact specific, and would be unlikely to be of wider application. Or, in a case where a prison term was replaced with a community order, the court commented that '*it would not be right to say that a custodial sentence could never be justified in such a case'.* Similar comments were seen in other cases.

3.7 In the review of cases it has also been noted that often expert psychiatrists disagree about diagnosis and the extent to which any condition affected an offender's responsibility for their actions in a case.

Question 1: What are the Council's views on what the review has revealed?

3.8 The general principles set out in paragraph 34 in *R. v Edwards* (and as set out in case no 25 in **Annex A**) it is suggested should be referred to within the draft guideline. In addition, some of the principles relating to when a s.37/s.41 order may be appropriate to be included within the guidelines, as set out in paragraph 50(iii) in *R. v Vowles (no 26 in Annex A). Vowles*

also notes that a Judge should not feel circumscribed by psychiatric opinion, and the fact that two psychiatrists supported a s.37/41 order was never, alone, a reason to make one (paras 51-53).

Question 2: Does the Council agree that the principles discussed above from Vowles and Edwards should be referred to within the guideline?

3.9 The Council may recall that the draft guideline discussed last month gave guidance which suggested that mental disability could justify a reduction in sentence. Tim has commented that the draft gave no reference to caselaw to support this suggested approach. There is established case law (*R. v Bernard,* no 29 in the list at **Annex A)** that sets out the limited circumstances in which, and the limited extent to which, physical disability may justify a reduction in a prison sentence on the grounds that it makes the experience of imprisonment much harder for a particular offender than it is for most other offenders. May's Council paper had noted that the guideline may need to reflect the growing movement to deliver parity of esteem between physical and mental health, and relevant international obligations, such as the UN *Convention on the rights of persons with disabilities*[1] (2006), which was ratified by the UK in 2009.

3.10 The review of CACD cases so far has highlighted four cases in which the offenders' sentence was altered, one had a custodial sentence reduced, one an immediate custodial term replaced with a suspended sentence and two had their custodial sentences replaced by hospital orders, due to their mental disability, *R.v Khelifi, R. v Beaver, R. v Khan and R. v Smith,* nos 3, 28, 12 and 13 at **Annex A.**

3.11 The Council may also note that a factor relating to mental disorder/learning disability is already embedded into most guidelines, appearing as either a factor in lesser culpability, or as a mitigating factor. Accordingly, there is already precedence within guidelines for mental disorder/learning disability potentially reducing or otherwise altering sentences.

Question 3: ***Does the Council feel that the caselaw identified so far provides sufficient basis for the guideline to give guidance on a) the appropriate circumstances in which culpability is reduced and thus can reduce sentence, and/or offender mitigation which can reduce or alter sentence in appropriate cases?***

Question 4: If the Council does think there is sufficient basis, how should any guidance be given?

[1] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

3.12 The review of cases attached at **Annex A** does not claim to be a thorough and complete analysis of all possible relevant CACD cases, but only what it was possible to do in the time between the suggestion being made and the July Council meeting. It has nevertheless highlighted the difficulties and limitations in trying to find guidance from other sources that could be utilised to inform the guideline. It may be that caselaw will only be able to assist so far and the Council may have to set the agenda in providing guidance on these difficult issues. Over the summer the review of caselaw will continue. It would be helpful if the Council could indicate if there are other sources of guidance or particular areas of caselaw that it would be instructive to focus on, to further inform the development of the guideline.

Question 5: Are there any other particular areas of caselaw or other sources of guidance that the Council think should be considered over the summer?

3.13 The Council are also asked to consider at this stage some key questions to inform the work of the guideline over the summer. In previous Council discussions concern has been expressed about the guideline potentially widening the scope beyond what is appropriate, in considering an ever-increasing list of conditions that courts would be invited to consider might reduce an offender's culpability, and potentially affect/reduce sentence. As noted within para 4.1, CPD data does not include data about whether offenders have a mental disorder/learning disability, so it is difficult to know exactly in how many cases currently mental health has been an issue which may have made a difference to sentencing. It would be helpful to have an idea of the current numbers, in order to consider what effect the draft guideline might have in terms of numbers of cases affected, and how sentences might be affected. One possible way of getting an indicative idea of the proportions involved would be to conduct an analysis of case transcripts that the office holds for a number of different offences, to see how many have a mental health context, and if/how that has affected sentencing. This could be done over the summer, however it would only give indicative information, not precise numbers involved.

3.14 However, the Council are asked to consider, if the guideline would be thought to widen the scope and consider a wider list of conditions that previously courts would not have considered relevant in sentencing – is that wrong in principle? If the approach to be taken in a new guideline were to apply to a greater number of offenders than before such guidance existed, potentially affecting the sentence they receive, does that just reflect the numbers of these offenders coming before the courts and a wider awareness of the way in which the factors influence offending? The guideline would be providing assistance in areas courts are increasingly grappling with, which may either have the effect of a) reflecting how the courts are trying to take such factors into account (in which case it won't radically change sentencing practice or b) changing sentencing practice through increased awareness of relevant issues, which would be an appropriate outcome.

3.15 This guideline is, similarly to the Children and Young Persons guideline, focused on the *offender* - unlike the main body of guidelines which are focused on the *offence* - and which focus primarily on factors which make the offence more serious. The approach to this guideline has to be different, and perhaps reflects a growing focus towards a more offender centric perspective in sentencing, whether this is because of age, mental health or abuse the offender has suffered. The benefit of properly addressing the conditions which lie behind the offending would be to reduce further offending and protect the public, two of the purposes of sentencing.

Question 6: Does the Council wish to try to limit the scope of the guideline? If so, are there areas or conditions that the Council does not want to include, so to try and restrict the numbers of offenders that the guideline might apply to? Or does the Council wish to develop the guideline based on best evidence, accepting the risk that it may apply to a large number of offenders?

3.16 Related to the discussion about scope, is the issue of whether drug addiction should be included within the scope of the guideline. Rosa has suggested that it should be considered for inclusion. S1(3) of the Mental Health Act states that drug or alcohol dependence is not a mental disorder of itself, but may co-exist with a condition that is a mental disorder. Accordingly, the Council could decide to include drug addiction within scope, but perhaps not give equal weight to it, compared to other conditions.

Question 7: Does the Council wish to include drug addiction within the scope of the guideline? If so, should equal weight be attached to it- compared to other conditions?

3.17 Rebecca has also raised a question as to whether the earlier decision by the Council to exclude fitness to plead from the guideline should be revisited. She notes that there are other guidelines that are wider than sentencing, for example the Children and Young Persons guideline which deals with allocation. There are additional difficulties in the magistrates' courts as there is no fitness to plead procedure which can cause complications, so the draft guideline could address the options available in the magistrates' courts.

Question 8: Does the Council wish to revise its decision on not including fitness to plead within the guideline?

3.18 The Council are also asked how far, if at all, as part of the guideline, should consideration be given to the resources available for dealing with mental health and other conditions both within prison and the community? With other guidelines, particular sentences are included on the basis of what is appropriate for that offence, notwithstanding pressures on the prison population, for example. With this guideline, if MHTR are thought to be appropriate, should they be included as a potential disposal, even though currently take up is very low and there are issues with availability? Is it possible that if the guideline includes a particular

disposal, that resources may follow? The Council did indicate last month that one of the objectives was to potentially indirectly affect resource allocation and issues of sentence confidence in community orders (para 1.1).

Question 9: Does the Council think it should consider resources available within and outside prisons as part of the guideline?

Update on the L&D scheme and the Community Sentence Treatment Requirement Protocol (CSTRP)

3.19 Given the links between the work on the guideline and relevant work elsewhere within the Criminal Justice system, the Council may like to note updated information regarding the liaison and diversion (L&D) schemes that exist in police stations and the courts, following a discussion with officials at NHS England, who have responsibility for the schemes. The scheme places clinical staff at police stations and courts to provide assessments and referrals to treatment and support. Health information can then be shared so that charging and sentencing decisions can be tailored to meet needs. There is currently coverage within 83% of all police stations and magistrates' courts, with the aim to have 100% by 2019/2020. There is limited coverage within Crown Courts, currently the scheme is operational within 13 court centres, with Preston and Sheffield to commence operation within this financial year, and rollout to a further 16 centres between 2019-21.

3.20 There have been concerns raised that information from these assessments does not reach the court. One of the explanations given for this is that people do not consent for the information to be shared with the court (even though it may be in their best interest to do so), as they are happy to for their information to be used within a medical context, but not necessarily within the courts.

3.21 The CSTRP has been developed following concerns about the low use of treatment requirements. The CSTRP will build on the L&D assessment, amounting to a proper treatment plan, tailored for each individual offender as they pass through the criminal justice system and complete their sentence. It will also set out a new maximum waiting time for court-ordered treatment so that offenders will be able to hold agencies to account for the treatment they receive and these waiting times will be in line with those for the general population. The CSTRP is being tested in five areas across England, and there is currently a data collection phase of the evaluation underway, which is due to finish in the Autumn. There will then be a review by Ministers ahead of any further roll out.

4 IMPACT/RISK

4.1 In terms of the impact of the guideline, the CPD data, which is the court data usually used to develop guidelines, does not include information about whether the offender had a mental health disorder or learning difficulty. The A&R team is continuing to explore what other data is available in this area, including looking at the CCSS, to see if it contains any data to help assess the numbers involved/what the impact of the guideline might be. Officials are maintaining close links with officials in the MOJ and other Government departments to keep up to speed with developments on the various initiatives, the L&D scheme, CSTRP, review of the Mental Health Act, and so on.

Question 10: is the Council content that the impact/risks have been sufficiently considered at this stage?

Annex A

Review of relevant CACD cases

1. R. v Fox [2011] EWCA Crim 3299

The imposition of a hybrid sentence comprising imprisonment for public protection and hospital and limitation directions under s.45A for offences of kidnapping and causing grievous bodily harm with intent was neither wrong in principle nor manifestly excessive where, although the offender had been suffering from an undiagnosed serious mental illness (paranoid schizophrenia), **criminal culpability was not wholly absent,** and the degree of harm caused together with the significant risk to the public of future serious harm was also taken into account.

2. R. v Welsh [2011] EWCA Crim 73

A Judge had been right to sentence an offender suffering from schizophrenia, who had committed manslaughter on the grounds of diminished responsibility, to life imprisonment rather than make a hospital order under s.37 together with a restriction order under s.41 as, on the evidence, public confidence in the resolution of the case would not be met by a hospital order. The Judge concluded that W had a **bad record of violence before the onset of his illness,** and his **culpability for the unprovoked attack** with the need to protect public safety necessitated a life sentence.

3. R. v Khelifi [2006] EWCA 770

Although medical evidence supported a hospital order, it was held that the Judge had correctly exercised his discretion instead to impose a prison sentence; there is no presumption that a hospital order will be made in these circumstances. The psychotic illness K suffered from had not been so severe at the time of the offences as **to disable him from his culpability for participation in a serious crime** (fraud). The five-year sentence was reduced to three and a half years, partly as the Appeal court had the benefit of evidence to show that a prison term **would be more onerous on K than it would on a person without his condition.**

4. R. v Jenkin [2012] EWCA Crim 2557

Having pleaded guilty to GBH with intent, the appellant was sentenced to life imprisonment with a six-year minimum term, combined with a hospital direction and limitation direction under s.45A. He appealed unsuccessfully against sentence, arguing for a restricted hospital order or alternatively an IPP sentence. A life sentence should be reserved for those cases where the culpability of the offender is particularly high or the offence itself particularly grave, both were met in this case. The s45A hybrid order was appropriate as the criteria were met and the disorder was treatable, but when treatment was no longer necessary the risk to the public required that he be released from hospital to prison and for the Parole Board to make the release decision. It was found that J had **significant responsibility for the offence, before it he was drinking to excess, failing to take prescribed medication, he did not believe he was driven to commit the offence or was under threat, and sought to minimise/excuse his actions. He also had committed violent offences long before becoming delusional.**

5. **R. v Graciano [2015] EWCA Crim 980**

A sentence of life imprisonment with a minimum term of 7.5 years, was appropriate for an offender who had pleaded guilty to manslaughter. Although psychiatrists recommended a hospital order with restrictions, and his mental illness was a significant contributory factor in causing him to act as he did, the offender retained some **significant elements of rationality,** such that the abnormality of mental functioning did not overwhelm him and he retained a **significant degree of culpability** for the killing. The Judge stated that he had taken account of the requirement for public confidence in his sentencing decision, and the appreciation of the different release regimes which applied to indeterminate sentences.

6. **R. v Quirk [2014] EWCA Crim 1052**

A Judge had been entitled to impose a sentence of life imprisonment, coupled with hospital and limitation directions under s.45A, on an offender aged 63 who had pleaded guilty to damaging property being reckless as to whether life was endangered, despite medical evidence indicating that his criminal actions were attributable to his autistic spectrum disorder. It was held that the Judge had been right to assess Q's **culpability as high**, despite his condition, there had been a clear element of **planning in his conduct**, and when apprehended Q had sought **to minimise or conceal his wrong doing**. Although such awareness was possibly not entirely to be equated with responsibility, those matters could not simply be disassociated from the assessment of culpability.

7. **R. v Watson [2007] EWCA Crim 864**

A sentence of five-and-a-half years' imprisonment imposed on a defendant following a conviction for causing death by dangerous driving was not manifestly excessive in the light of the aggravating features. Further, a medical report diagnosing attention deficit hyperactivity disorder **had not provided sufficient reason to reduce the culpability of the offender**. W had exacerbated the situation by **failing to stop and attempting to hide his responsibility** for the accident.

8. **R. v Whitnall [2006] EWCA Crim 2292**

A defendant **could not seek to reduce culpability** for an offence of causing death by dangerous driving where he admitted the offence and had **insight into the mental illness** (mania/psychosis) that he suffered from at the time of the commission of the offence.

9. **R. v Cooper [2010] EWCA Crim 2335**

An unsuccessful appeal against a s.45A order. C had been found guilty of manslaughter by reason of diminished responsibility and attempted murder. It was held that **C's responsibility for the crimes was diminished by his mental disorder (psychosis), but not wholly extinguished. A significant degree of responsibility remained**. It was noted that the **psychosis may have been stimulated by his misuse of illegal drugs, (amphetamines).**

10. **R. v Nafei [2004] EWCA Crim 3228**

Appeal against 12-year prison sentence for importation of drugs, in circumstances where the medical evidence supported a hospital order, was refused: the Judge had properly exercised his discretion, particularly since there was no causal connection between the mental illness (schizophrenia) and the offending; the 12-year term was not excessive.

11. R. v Costin [2018] EWCA Crim 1381

The offender had pleaded guilty to seven counts of doing an act tending and intended to pervert the course of justice, and had been sentenced to a community order for 3 years. The offender had autism, a personality disorder, PTSD, ADHD and pathological avoidance demand syndrome. At the time of sentencing the Judge was concerned about the risk of self-harm or suicide if C was given a custodial term, and decided the better option was to treat and divert her away from offending.

It was then referred by the Solicitor General under the unduly lenient scheme. The appeal court acknowledged the extent of the offender's difficulties but stated that the level of seriousness of these offences was such that it was not possible to impose upon her a community penalty, stating that the sentencing judge had placed too much emphasis on the offender's problems and difficulties and insufficient emphasis on the impact of her offences on the victims and for the criminal justice system as a whole. The sentence was increased to 4 years custody.

12. R. v Khan [2017] EWCA Crim 174

A sentence of five years' imprisonment imposed on K for offences involving fraud would be replaced by a s.37 hospital order given medical evidence as to his mental state (K had bipolar affective disorder) and the serious risk that he would attempt to commit suicide in prison. The Court had **rejected an argument for reduced culpability**, as there was no evidence that of the time of the offence K was affected by the disorder. However, the CACD stated that '***we make it plain that this decision is heavily fact specific and is most unlikely to be of wider application. In the ordinary case the existence of culpability will call for a custodial sentence, but in the circumstance of this case this is not a practical option'.***

13. R. v Smith [2015] EWCA Crim 1685

An offender's imprisonment for public protection (for unlawful wounding was replaced with a hospital order under s.37. The offender had suffered mental illness (psychosis) that had **partially contributed to the commission** of the offence and, on the evidence, the court was satisfied that the medical route was better for protecting the public and achieving his return to the community. It was held that S's mental illness had played a significant part in the offence, along with drugs, alcohol and anger, **there was culpability, but not full culpability.** Punishment was required, but in his case it had been imposed and served, as he had spent 3 years in prison, during which time he was suffering very badly due to his mental illness.

14. R. v S [2012] EWCA Crim 92

An order under s.45A was the most appropriate sentence for an 18-year-old offender with Asperger syndrome who had been convicted of the rape of a teenage boy. The sentence of 10 years' detention would be served in hospital where the offender could receive medical treatment that would be difficult to provide under prison conditions. The Judge held that a s.37 hospital order would **neither properly reflect culpability** nor adequately protect the public, given that it was S's second serious specified offence.

15. R. v Atkinson [2014] EWCA Crim 2010

An indeterminate sentence of imprisonment for public protection with a minimum term of seven years was appropriate for an offence of wounding with intent involving a sudden attack on a 64-year-old man, where eight severe stab wounds had been inflicted. It had been open to the judge to conclude that the offender posed a risk of serious harm upon release. **Experts disagreed over the diagnosis, and whether the offence had been as a result of his illness, or had a criminal motive.**

16. R. v Jefferson [2016] EWCA Crim 2023

A sentence of life imprisonment with a minimum term of 10 years was appropriate following a conviction for attempted murder where the offender was suffering from a mental disorder requiring hospital treatment. The judge had not erred in finding that the mental disorder could be appropriately dealt with by imposing a sentence of imprisonment with a hospital and limitation direction under s.45A. However, the mental disorder (psychosis) was a significant factor which **lowered the offender's culpability.** Two psychiatrists stated that the **commission of the offence was directly linked to the illness**, and one stated that he believed the offence would not have taken place if J had not been ill.

17. R. v Ledgard [2010] EWCA 1605

A suspended 12-month term of imprisonment imposed on a bipolar disorder sufferer in respect of various driving offences was replaced by a community order. L had submitted that when he was in the manic phase of his disorder he had little if any control over what he was doing, so that **significantly reduced his culpability** and meant that the sentence would not work as a disincentive to further offending. It was held that in L's case a custodial sentence was not justified, **although the court stated it would not be right to say that a custodial sentence could never be justified in such a case.**

18. AG's ref no 22 of 2011 (R. v Lloyd [2011] EWCA Crim 1473)

A three-year community order imposed upon an offender suffering from mental ill-health who had attacked a man in a bar with a hammer was unduly lenient. Although the offender's mental health (depression, paranoia) **significantly reduced his culpability**, it did not eliminate it and his actions deserved retributive punishment. A sentence of five years' imprisonment was appropriate.

19. R. v McFly [2013] EWCA Crim 729

In setting a minimum term on a mandatory life sentence for murder, a Judge had erred in leaving the offender's anti-social personality disorder entirely out of account. The personality disorder was capable of being and was a relevant mitigating factor within Schedule 21 of the 2003 CJA Act. M submitted that the Judge had **overstated his culpability**, that it had been wrong to leave the disorder entirely out of account, and he should have had regard to it as a relevant mitigating factor, even if it had not **substantially diminished his responsibility**. The 24 year term was replaced with a minimum term of 21 years.

20. R. v Semanshia [2015[EWCA Crim 2479

A sentence of imprisonment rather than a hospital order had been appropriate for an offender notwithstanding psychiatric reports made after sentencing that indicated that he had paranoid schizophrenia. Even if evidence were to establish that the offender had been mentally unwell at offence and sentence, it would not follow that a hospital order should inevitably have been made. S had pleaded guilty to false imprisonment and GBH with intent. **Experts disagreed as to the extent to which culpability was reduced by his mental illness.**

21. R. v Shaw [2015] EWCA Crim 1489

A total sentence of 14 months' imprisonment for assault occasioning ABH, affray, and having an article with a blade or point was reduced to 10 months because the Judge had attributed insufficient weight to the offender's psychiatric condition before and at the time of the offending. S had a longstanding diagnosis of paranoid schizophrenia (of a mild severity) and generalised anxiety disorder. It was held that S's mental health problems, particularly his **lack of insight** at the time of the offences **served to lower his culpability** for what were otherwise violent offences which would merit a substantial custodial sentence.

22. R. v Staines [2006] EWCA Crim 15

There was no reason to quash a discretionary life sentence with a hospital and limitation direction under s.45A, and to substitute for it a hospital order under s.37 and s.41 of the Act where the offender, who had pleaded guilty to manslaughter by reason of diminished responsibility and had been diagnosed with a pathological borderline personality disorder, had later been diagnosed with a mental illness as well. A s.45A order did not, by its terms, preclude its application in cases where the offender suffered from both, and gave a better measure of control without impeding the offender's treatment.

23. R. v Teasdale [2012] EWCA Crim 2071

Two sentences of discretionary life imprisonment imposed following convictions in 1998 and 2000 for violent offences were replaced on appeal with hospital and restriction orders under s.37 and s.41 as those orders would have been the correct disposal at sentence had the offender's paranoid schizophrenia been identified at the time. The appeal court heard expert evidence that T had significant symptoms of psychosis from as early as the 1990s and that it **was highly likely that his subsequent criminal behaviour had been influenced by that illness.** There was good reason why the expert evidence was not available at the time, namely T's complete refusal to engage with any psychological assessment.

24. R. v Przybylski [2016] EWCA Crim 506

A sentence of imprisonment together with a direction under s.45A would not adequately protect the public from an offender with serious mental health problems who was at high risk of relapsing into a psychotic state, and who had stabbed a woman after he had been drinking in an unprovoked attack. A s.37 hospital order together with a s.41 restriction order would better protect the public. The appeal court found that that P's **culpability was reduced**. It was **the mental illness which drove him to drink on the morning of his offence and because of his disordered state it could not properly be said that P had premeditated** his attack upon the victim. **P probably would not have realised the disinhibiting effect of alcohol.**

25. R. v Edwards [2018] EWCA Crim 595

The court summarised the general principles to be considered by those representing and those sentencing offenders with mental health problems that might justify a s.37 hospital order, s.41 order, a finding of dangerousness and/or as.45A order. The court reviewed the statutory framework and case law, and summarised the general principles set out below to be considered by those representing and sentencing offenders with mental health problems that might justify a hospital order, a finding of dangerousness and/or a s.45A order.

(a) consideration as to whether a hospital order was appropriate under s.37(2);

b) if yes, the judge should then consider all available sentencing options, including a s.45A order. This had to be considered before making a hospital order because a disposal under s.45A included a penal element and the court had to have "sound reasons" for departing from the usual course of imposing a sentence with a penal element;

(c) in deciding on the most suitable disposal, the judge had to bear in mind the importance of the penal element of a sentence;

(d) in deciding whether a penal element was necessary, the judge should assess the offender's culpability and the harm caused by the offence. The fact that an offender would not have committed the offence but for their mental illness **did not necessarily relieve them of all responsibility for their actions;**

(e) a failure to take prescribed medication was not necessarily a culpable omission. It might be attributable in whole or in part to the offender's mental illness;

(f) a judge deciding to impose a hospital order under s.37 or s.41 had to explain why a penal element was inappropriate;

(g) the regimes for release of an offender on licence from a s.45A order and for an offender subject to s.37/s.41 orders were different, but the latter did not necessarily offer a greater protection to the public, as might have been assumed in *Ahmed* and/or by the parties in the instant cases. Each case turned on its own facts;

(h) if an offender wanted to call fresh psychiatric evidence in their appeal against sentence to support a challenge to a hospital order, a finding of dangerousness or a s.45A order, they should lodge a s.23 application. If the evidence was the same as before the sentencing judge, he was unlikely to admit it;

(i) grounds of appeal should identify with care each of the grounds the offender wanted to advance. An applicant/appellant wishing to add grounds not considered by the single judge should make an application to vary.

The court also commented that a level of misunderstanding of the guidance offered in *Vowles* appeared to have arisen as to the order in which a judge should approach the making of a s.37 or s.45A order and the precedence allegedly given in *Vowles* to a s.45A order. While s.45A could have been better drafted, the position was clear: s.45A and *Vowles* does not provide a "default" setting of imprisonment, as some had assumed.

26. R v Vowles [2015] EWCA Crim 45

The court gave guidance on the approach to be taken in sentencing offenders suffering from mental disorder who had received indeterminate sentences of imprisonment specifying a minimum term so as to strike an appropriate balance between ensuring treatment in a

hospital and protecting the public. A judge should not feel circumscribed by psychiatric opinion, and the fact that two psychiatrists supported a s.37/41 order was never, alone, a reason to make one (paras 51-53).

A hospital and restriction order under s.37/41 is more likely to be appropriate in a case where the mental disorder is a severe mental illness (particularly a psychotic illness or an organic brain disorder) rather than a personality disorder. That is because it is more likely that such an illness may have a direct bearing on the offender's culpability and because the illness is likely to be more responsive to treatment in a hospital. In contradistinction it is more difficult to attribute a reduction in culpability to a personality disorder and at present individuals with severe personality disorders are less likely to benefit from hospitalisation (para 50 iii).

27. R v Birch [1990] 90 Cr. App. R.78

Case that notes that an offender detained under s37 order passes out of the penal system into the hospital regime. Where sentencer considers that notwithstanding the mental disorder there was an element of culpability which merits punishment a prison sentence can be justified.

28. R. v Beaver [2015[EWCA Crim 653

Although a sentence of three years' imprisonment imposed on an 82-year-old man for the manslaughter of his wife was neither wrong in principle nor manifestly excessive, mercy required that a 24-month term of imprisonment suspended for 24 months with a 12-month residential and mental health requirement be imposed instead. The offender had been the sole carer of his wife, who had dementia; he was in the early stages of dementia himself; and the strain of caring for his wife and serving part of his sentence had led to a decline in his physical and mental health.

29. R. v Bernard

B, aged 63, appealed against sentence of five years' imprisonment for being knowingly concerned in the fraudulent evasion of the prohibition on the importation of a Class B drug, 27.7 kilograms of cannabis. B argued that the six year starting point used by the judge was too high and that the judge had not given sufficient consideration to mitigating factors, particularly B's medical condition. B suffered from a narrowing of the oesophagus, causing difficulty in swallowing, diabetes and hyper-tension. The appeal was allowed, and the sentence reduced to three and a half years' imprisonment, that (1) considering the quantity of cannabis involved, the starting point was too high and (2) B's medical condition was taken into account as an act of mercy by the court.

The following principles for considering the medical condition of offenders were set out by the judge:
(a) the Secretary of State could release a prisoner by means of the royal prerogative of mercy if his medical condition affected his life expectancy or the prison's
ability to provide satisfactory treatment. However, the threat of such occurrences at a future date did not provide a reason for interference with an appropriate sentence by the Court of Appeal;
(b) HIV positive offenders and others with a reduced life expectancy

could not expect a reduced sentence;
(c) a reduced sentence was not automatically available to those with a serious medical condition even when the illness was difficult to deal with in prison, and
(d) a court could impose a reduced sentence on an offender with a serious medical condition but it would be as an act of mercy rather than as a result of a principle of law,

Annex B

Sentencing Council

Overarching Principles: Mental Health[1]

[1] Working title- precise title to be decided in due course

Applicability of guidelines

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 xx and older, who are sentenced on or after xxxx, regardless of the date of the offence.

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."

Scope of the Guideline

1. This guideline identifies the principles relevant to the sentencing of offenders who have:

    - A mental disorder
    - A learning disability
    - A learning difficulty
    - Autism Spectrum Disorder
    - An acquired or traumatic brain injury
    - Dementia

    Further information on these can be found within **Annex C.**

2. The guideline seeks to assist courts in assessing culpability and personal mitigation and to assist with identifying an appropriate sentence. Courts should focus on what the available

evidence says about the **nature, extent and effect of the impairment** experienced by the offender at the relevant time. The presence of any of the conditions listed in paragraph one ***may*** be relevant to sentencing, but in some cases the condition will have **no relevance to sentence.**

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.

Sentencing principles

3. There are a wide range of mental health conditions and developmental disorders, and the level of impairment caused will vary between individuals, for this reason the approach to sentencing should be individualistic and focused on the particular issues relevant to each case. In particular:

- care should be taken to avoid making assumptions, as unlike some physical conditions, many mental health conditions or learning disabilities are not easily visible
- no inference should necessarily be drawn if an offender had not previously been formally diagnosed (albeit a formal diagnosis **will be required** for a condition to be considered at sentencing)
- 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 'dual diagnosis'.
- 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

4. If an offender has any of the conditions listed in paragraph 1, this may affect their level of responsibility for an offence, and it may also impact upon the suitability of sentencing options in the case. For this reason, when it appears to the court that a condition may be relevant to culpability or disposal, sentencers may seek further information. The relevance of any condition will depend on the nature, extent and effect of the condition on an individual and the circumstances of the particular offences(s). Before considering ordering a new report, courts should utilise all existing sources of information, such as from probation, defence representatives, court mental health teams or GP records. New reports should only be

necessary when a hospital order is being considered, or else in **exceptional** cases. Further information about request for reports[2] can be found at **Annex B** of this document.

5. In cases where custody is the only option for an offender as hospital disposals are not appropriate, then courts should forward psychiatric pre-sentence reports to the prison, to ensure that the prison has appropriate information about the offender's condition and can ensure their welfare.

6. Courts should always be alive to the impact of a condition for the defendant to understand and participate in proceedings. To avoid misunderstandings, which could lead to further offences, (or recall) 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, within the Equal Treatment Bench Book:

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

Assessing Culpability – offence mitigation

7. Courts should refer to offence specific guidelines to assess culpability, in conjunction with the following guidance. The presence of any of the conditions listed within paragraph 1 may impact on an offender's level of culpability, in some cases potentially very significantly, in others the condition will 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 nature and seriousness of the offence (taking into account the level of intent required for the offence), it is not possible to be prescriptive in this regard. However courts may find the following list helpful, of ways in which impaired mental functioning may reduce culpability:

Impaired mental functioning at the time of the offending may reduce the offender's culpability if it had the effect of:

- Impairing the offender's ability to exercise appropriate judgement
- Impairing the offender's ability to make calm and rational choices, or to think clearly
- Making the offender disinhibited
- Impairing the offender's ability to understand the consequences of their actions

[2] S.157 Criminal Justice Act 2003 may apply- see further details in Annex B

This is not an exhaustive list.

Acts or omissions by the offender

8. Any assessment of culpability must be made with reference to the medical diagnosis and all the relevant information available to the court. The degree to which the offender's acts or omissions contributed to the impact of their condition at the time of the offence may be a relevant consideration. For example, where an offender exacerbates their condition by voluntarily abusing drugs or alcohol or by voluntarily failing to seek or follow medical advice this may increase responsibility. In considering the extent to which the offender's behaviour was voluntary, the extent to which a condition has an impact on the offender's ability to have an insight into their condition, or exercise self-control or to engage with medical services will be relevant.

Undiagnosed/untreated conditions

9. The degree to which the condition was undiagnosed and/or untreated may be a relevant consideration. For example, where an offender has sought help but not received appropriate treatment this may reduce culpability.

Purposes of sentencing

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. The sentence should go some way to fulfilling all of those considerations, however particularly important is the punishment *and* the rehabilitation of an offender. Just because an offender has a mental health condition, it does not mean they should not be punished, particularly in serious offences where protection of the public is paramount. Equally, 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 to punishment. In a case where an offender's culpability was low, the sentence may be more weighted to rehabilitation.

Deciding on the appropriate sentence - offender mitigation

12. The court will need to consider as potentially significant mitigation that an offender's condition at the point of sentence could have a bearing on the type of sentence that is imposed, as set out below:

- 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.
- Being in prison can exacerbate poor mental health and in some cases increase the risk of self- harm, and for some prisoners their condition may mean a custodial sentence may have a greater punitive effect than it would for a prisoner without the condition.
- Some levels 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. If there was a serious risk of imprisonment having a gravely adverse effect on the offender's mental health, courts will need to consider this risk very carefully, in exceptional cases potentially looking at alternatives to custody, and potentially stepping outside of the guideline for sentence. Where the offence is very serious and culpability high, custody may be inevitable but the condition may still properly impact on sentence length. Courts should refer to any medical evidence or expert reports on this point to assist them.

14. Courts should consider whether a community order with a mental health treatment requirement (MHTR) might be appropriate (where available).

- 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 may be appropriate where the defendant's culpability is substantially mitigated 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.
- It is not usually suitable for an offender who is unlikely to comply with the treatment or who has a chaotic lifestyle.

Sentencing disposals

15. Relevant mental health disposals/orders are listed below (further details on each are at **Annex A).**

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 Courts

- 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 order

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 responsibility assessed at step one.

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

Mental Health Treatment Requirement (section 207 CJA 2003)	
May be made by:	A magistrates' court or Crown Court
Where an offender suffers from a medical condition that is susceptible to treatment but does not warrant detention under a hospital order, a community order with a mental health treatment requirement under section 207 of the Criminal Justice Act 2003 may be appropriate. The offender should express a willingness to comply with the requirement.	

Hospital order (section 37)		
May be made by:	A magistrates' court or Crown Court	
In respect of a defendant who is:	*Where made by a magistrates' court:*	*Where made by the Crown Court:*
	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	Convicted before that court for 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, 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 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 hospital order is the most suitable method of dealing with the case	
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 period of 28 days starting with the day of the order.	

A hospital order is, essentially, 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.

Effect of unrestricted hospital orders on patients once detained [section 40(4)]

The hospital order lasts for six months initially, but can be renewed. The initial six month maximum period of detention runs from the day that the hospital order is made by the court, Patients admitted under a hospital order may not apply to the Tribunal until six months after the date of the making of the order (assuming the order is then renewed).

Restriction Order (section 41)	
A restriction order (section 41) may be imposed by the Crown Court if 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.

Hospital and limitation direction (section 45A)

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).

Hospital and limitation directions (section 45A)	
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.

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 be 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. 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 Secretary of State 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 Secretary of State 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 Secretary of State 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)	
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.

Guardianship order (section 37)		
May be made by	a magistrates' court or the Crown Court	
In respect of a person who is aged 16 or over and who is	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 summary conviction with custody or	convicted before that court for an offence punishable with imprisonment (other than murder)

	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	
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.

Annex B

Requests for psychiatric reports should only be necessary in a **limited amount of cases**. If asking for a report courts should make the request sufficiently 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
- 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.

When requested by Clinicians wanting to undertake an inpatient assessment, courts may wish to consider using interim hospital orders (s.38 MHA). Further information on requests for reports can be found within the Criminal Procedure Rules, which can be found here:

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

Power to order reports- Magistrates courts

There are limited additional powers to order reports in the Magistrates courts. S.11 Powers of Criminal Courts (Sentencing) Act 2000[3] provides for ordering a report, but it is only post conviction or finding of fact. Section 19 of the Prosecution of Offences Act 1985[4] plus Regulation 25(1) The Costs in Criminal Cases (General) Regulations 1986[5] allows for payment out of central funds to a duly qualified medical practitioner who provides a report.

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

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.

(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

- **A mental disorder –** such as (but not limited to) schizophrenia, bipolar disorder, depression, anxiety, post-traumatic stress disorder (PTSD), or personality disorders. These conditions can affect thought, feelings and behaviour. Conditions can be short or long term, some conditions can fluctuate, and a range of symptoms can be experienced.

- **A learning disability** – a life long condition which includes significant impairment of intelligence (an IQ of less than 70) and social functioning (a reduced ability to cope independently and adapt to the daily demands of a normal social environment). A learning disability can range from mild, moderate to severe. It may mean someone has limited language ability, comprehension and communication skills, be acquiescent and suggestible and have difficulty understanding social norms.

- **A learning difficulty –** such as dyslexia, Attention Deficit Hyperactivity Disorder (ADHD), or Attention Deficit Disorder (ADD). A learning difficulty is different to a learning disability as it is unrelated to intelligence. Symptoms can include impulsiveness, inability to relate to others in socially acceptable ways, inability to express feelings and emotions in an appropriate way or to be able to think clearly.

- **Autism Spectrum Disorder –** (including Asperger's syndrome) a lifelong developmental disability that affects how people communicate and relate to others, and make sense of the world. Aspects of the condition can be social naivety, difficulty with change or unexpected events, misunderstanding of social cues, adherence to rules and lack of insight into behaviour. It may be characterised by a lack of empathy or a limited ability to express emotion.

- **An acquired or traumatic brain injury –** an injury caused to the brain since birth, (from falls, or road accidents or illness, such as a tumour or stroke). Injuries can range from mild to severe, severe brain injury can cause complex long-term problems such as impaired reasoning, impaired insight into behaviour, loss of control over behaviour and inappropriate behaviour.

- **Dementia –** a syndrome associated with an ongoing decline of brain functioning, such as Alzheimer's disease or vascular dementia. Symptoms can be difficulty in

controlling emotions, loss of empathy with others, difficulty with social interaction, problems with memory and in some cases, experiencing hallucinations.

Further information about any of these conditions can be found here:

https://www.nhs.uk/conditions/.

Blank page