Sentencing Council

Sentencing Council meeting:	**22 June 2018**
Paper number:	**SC(18)JUN04 – Mental Health**
Lead Council member:	**Rosa Dean**
Lead official:	**Mandy Banks**
	0207 071 5785

1 ISSUE

1.1 Following the last Council meeting at which the Council agreed the scope of the guideline, a first draft of a mental health guideline has been developed, this is attached at **Annex A**. This early draft aims to facilitate a discussion on what the objective of the guideline is. At the last meeting it was suggested that officials should meet with Charles de Lacey, Clinical Nurse Specialist at the Old Bailey, this has happened and the guideline has been developed with his input. The draft guideline has also benefited from substantial input from Rosa, the Council lead for this guideline, and from an assessment of the available international literature in this area conducted by the A&R team.

1.2 At the last meeting the question of the age applicability of the guideline was discussed, whether it should be for adults and children/young people, or whether there were particular issues relating to adolescent offenders and mental health that meant this would not be feasible. It was suggested that officials contact Professor Dame Sue Bailey, a Consultant adolescent forensic Psychiatrist, to discuss this issue with her. Initial contact has been made but no substantive discussions have yet taken place, so it is recommended that the question of the age applicability of the guideline is discussed at a future meeting. Further Council meetings have been made available to discuss the draft guideline, than the initial four meetings scheduled.

2 RECOMMENDATION

2.1 At this meeting the Council are asked:

- To consider what the objective of the guideline is
- To note that the question of the age applicability of the guideline and issues relating to gender will be discussed at a future meeting
- To ask for feedback from the Council on this early first draft of the guideline, as posed in the various questions contained within the paper

3 CONSIDERATION

Scope of the guideline

3.1 At the last meeting the Council agreed that the guideline would cover three broad areas: factual information to assist courts, (for example, available disposals); guidance on how to assess culpability; and guidance on how different disposals may affect offenders with certain conditions. The Council also agreed that the guideline would cover: mental disorders, learning disability/difficulty, Autism Spectrum Disorders (ASD), acquired brain injury (ABI) and dementia. It was agreed that the guideline would not apply to defendants who were unfit to plead, and would only relate to matters post conviction.

3.2 At this early stage of development it would be helpful if the Council considered and agreed what the objectives of the guideline are. It would be instructive if the Council were to articulate what it is that the guideline is to achieve, for example, does the Council wish to promote any particular approach (for example, particular types of sentence, or hospital orders, or greater understanding of mental health conditions and offending) within this area of sentencing? Or should the guideline aim to discourage any particular approach currently seen within this area of sentencing? Or is the guideline simply to provide all the relevant information in one place, with some very general guidance?

Question 1: What does the Council wish to achieve in producing a new guideline on mental health?

3.3 The scope of the guideline is set out in paragraph 1, on page 2 of **Annex A.** It provides a brief list of what conditions/disorders are covered by the guideline, but no definitions, instead providing a link to the World Health Organisation's International Classification of Diseases, which Charles de Lacey recommended as the appropriate expert authority. It is suggested that it would be impractical to do anything else, there are a wide number of possible mental disorders, conditions, and so on, to attempt to provide definitions of them would be difficult and very lengthy. In any case, difficulties of definition are common, the draft guideline emphasises: '*what is important is what the available evidence says about the nature, extent and effect of the impairment experienced by the offender at the relevant time'. (page 3 of Annex A)*

Question 2: Are the Council content with the wording of the scope of the guideline section? Are the Council content that the guideline does not provide definitions of conditions?

Sentencing principles

3.4 Paragraph 2 of Annex A sets out the suggested principles for the guideline, that the approach to sentencing should be individualistic, as levels of impairment will vary, that care should be taken to avoid making assumptions, as some conditions are not obvious, or offenders may have not previously been diagnosed, possibly due to fears around the stigmatisation around mental health conditions.

3.5 Paragraph 3 deals with the importance of pre-sentence and medical reports, and has been developed in conjunction with Charles de Lacey. When the guideline was discussed with him, he suggested that getting reports sufficiently specific (and on time) is invaluable to the appropriate sentencing of these offenders. For this reason the paragraph gives examples of information that could be requested by courts, to try and avoid courts receiving reports that are incomplete on key issues, which can then delay the progression of cases (something he says is not uncommon).

3.6 He also suggested including a reference to interim hospital orders (s.38 Mental Health Act (MHA), in order to facilitate the completion of effective reports, which can be seen on page 4. However, Rosa has expressed concern about this reference, pointing out that in *R v Vowles*[1] (paras 22,23, 50(ii)) courts were told to think long and hard before making these orders due to severe pressures on hospital beds. Charles has since clarified this wording to say '*when requested by Clinicians',* which perhaps might act as a curb on making these orders, as Clinicians in making such a request would be best placed to know about bed availability and so on. However this reference could be a potential risk.

Question 3: Is the Council content with the proposed emphasis on courts obtaining effective reports and the wording of paragraphs 2 and 3?

Question 4: Does the Council wish to include the reference to s.38 orders on page 4?

Assessing culpability

3.7 Paragraph 4 provides guidance on how to assess whether or not culpability is reduced. It makes the point that just having one of the conditions listed in paragraph 1, doesn't necessarily mean it will have an effect on culpability, assessments will vary due to the nature and severity of symptoms. Conversely for some offenders, their condition may significantly impact their level of culpability. Parts of this paragraph and the list of ways in which impaired mental functioning may reduce an offender's culpability have been influenced by *R v Verdins*[2] a prominent Australian case.

[1] R v Vowles [2015] EWCA Crim 45
[2] R v Verdins [2007] VSCA 102

3.8 Paragraph 5 alludes to conditions such as autism, where a limited ability to express remorse or show empathy can be a feature of the condition. The wording in paragraphs 6 and 7 has been taken from the wording recently agreed by the Council for the manslaughter guideline.

Question 5: Is the Council content with the proposed wording and approach to assessing culpability? Is there any other information or guidance that the Council thinks should be included within this section?

Deciding on the appropriate sentence

3.9 Paragraph 8 sets out how sentencing should work for these offenders: courts should assess the level of culpability using both the relevant offence specific guideline and the guidance in paras 4 to 7 to arrive at a preliminary sentence, then consider whether an offender's condition at the time of sentence has any additional bearing on the sentence to be imposed. It states that courts may be justified in stepping outside of the guideline, for example to impose a community order, if this is not included within the sentence table for an offence. While in reality a holistic approach is often taken where the issues of culpability and the appropriate disposal are interlinked (particularly in cases where a hospital order is recommended), the guideline nevertheless sets out the appropriate structure for courts to follow.

3.10 Paragraph 9 discusses the sentencing of these offenders in relation to the purposes of sentencing, and suggests that both punishment and the rehabilitation of offenders is particularly important, having respectfully noted the discussion on these points in *R v Edwards.*[3]

3.11 Paras 10 and 11 set out guidance for courts on how an offender's condition may have a bearing on the type of sentence imposed. The wording and approach has again been influenced by some of the principles set out in *R v Verdins,* and also the discussion in *R v Stevenson*[4]*.* This section is not without controversy, deciding what impact an offender's condition might have on a potential sentence, particularly for serious offences, is a difficult balancing exercise. The reference to being in prison potentially exacerbating poor mental health and increasing the risk of self- harm has been included after noting the findings of the National Audit Office's 2017 report[5] into mental health in prisons which stated that the prison and Probation Ombudsman found that 70% of prisoners who had committed suicide between

[3] R v Edwards [2018] EWCA Crim 595
[4] R v Stevenson [2018] EWCA Crim 318
[5] https://www.nao.org.uk/report/mental-health-in-prisons/.

2012 and 2014 had mental health needs, and that the number of self-harm incidents has risen by 73% between 2012 and 2016.

3.12 There can be a number of different factors that might make it more difficult for offenders with mental health problems to cope in custody compared to prisoners without these problems. These can include the regimental prison environment making it more difficult for offenders to manage their mental illness, moving in and out of custody making the delivery of treatment difficult, poor information sharing between prison staff and healthcare, inadequate staff training and problems with the availability of treatments.

Question 6: Are the Council content with the wording and approach set out in paras 8,9 10 and 11?

3.13 Paragraph 12 relates to the sentencing of offenders with dementia. Offenders with this condition may pose additional difficulties for the courts at sentencing, they may have committed the offences some time ago, before they had the condition, they may not be suitable for hospital orders, but may have committed serious offences. Possibly the Council may feel that it is not helpful to try and articulate anything further for this offenders with this condition, other than the considerations already set out within paras 8 to 11.

Question 7: Does the Council wish to include some guidance on offenders with dementia? If so, are the Council content with the proposed wording at paragraph 12, or should it be amended?

3.14 Paragraph 13 suggests that courts consider whether a community order with a mental health treatment requirement (MHTR) might be appropriate. The Council are aware of the very low usage of MHTRs currently (in 2017 less than 0.5% of court orders started had a MHTR attached to the order), and there is concern amongst stakeholders that these are under used, and custody over used for this group of offenders. In addition, a recent study by MOJ[6] showed that for offenders with identified mental health issues, MHTRs attached to court orders were associated with significant reductions in reoffending where they were used, compared with similar cases where they were not. The reoffending rate was around 3.5 percentage points lower over a 1year follow-up period. There may be difficulties with the availability of these programmes for all courts, but the Council may feel that it is appropriate to include a clear reference to them in the guideline given the low rates of usage and the link to lower reoffending rates.

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/706597/do-offender-characteristics-affect-the-impact-of-short-custodial-sentences.pdf.

Question 8: Does the Council agree to including this paragraph on MHTRs?

3.15 Paragraph 14 has been included at the suggestion of Charles de Lacey, who felt it was important to have a reference to the forwarding of psychiatric reports to prison to ensure the health and welfare of prisoners. However, as this provision is set out in the Criminal Procedure Rules, which the guideline provides a link to within paragraph 3, the Council may feel that this is superfluous information.

Question 9: Does the Council wish to include paragraph 14? If so, is Council content with the proposed wording?

3.16 Paragraph 15 deals with the importance of ensuring that offenders can understand proceedings, otherwise there is a risk that there could be further offending or recalls. This reference is kept quite brief as there is further information on this and other related issues regarding offenders with a mental disability within the Equal Treatment Bench Book, so a link to this is attached within the guideline.

Question 10: Is the Council content with the proposed wording of paragraph 15?

3.17 Paragraph 16 moves on to outlining the available sentencing disposals, and has been taken (save for the non-custodial option part) from the recently agreed diminished responsibility guideline.

Question 11: Is the Council content with the information within paragraph 16?

3.18 The information that follows paragraph 16 in a separate annex provides further detail and explanation about the various orders that are available to courts, as it is thought that this information might be helpful. The information, which is reasonably lengthy, is taken from Department of Health guidance[7] and does contain detail on rarely used Guardianship orders. As they are so rarely used the Council may feel that it is not appropriate to provide information on them, and it could be removed.

Question 12: Does the Council agree that providing further information on the various orders in a separate annex will be a useful part of the draft guideline? If so, should the information on Guardianship orders be included or not?

3.19 The Justice report, 'Mental Health and fair trial[8]' makes a recommendation, discussed at para 6.23 of their report, regarding Supervision orders, a disposal where a court finds a defendant has done the act but is not fit to plead. These would be out of the scope of the

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf

[8] https://justice.org.uk/our-work/areas-of-work/criminal-justice-system/mental-health-fair-trial/.

guideline as the Council agreed last month that the guideline will only include matters relating to sentencing post-conviction. The recommendation also seems to suggest that courts should have oversight of community orders imposed with a MHTR. Legislation does not appear to give any provision for this to happen (unlike for drug rehabilitation requirements where there can be regular reviews). Accordingly it is recommended that the guideline does not pursue this recommendation.

Question 13: Does the Council agree not to pursue this recommendation by Justice?

Question 14: Is there any guidance not currently included within this draft that the Council thinks should be?

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, review of the Mental Health Act, and so on.

Question 15: is the Council content that the impact/risks have been sufficiently considered at this stage?

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Annex A

Sentencing Council

Overarching Principles:

Mental Health

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

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.

More information on these conditions can be found within the World Health Organisation's International Classification of Diseases, which can be found here:

http://apps.who.int/classifications/icd10/browse/2016/en#/F00-F09.

However, 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. What is important is what the available evidence says

about the nature, extent and effect of the impairment experienced by the offender at the relevant time.

Sentencing principles

2. 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. Care should be taken to avoid making assumptions, as unlike physical disabilities, many mental health conditions are not easily visible, some people have not been formally diagnosed, and some offenders may not have previously declared a condition due to fear of stigmatisation. In addition, it is not uncommon for people to have a number of different conditions, and for drug and/or alcohol dependence to be a factor.

3. 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 is known or suspected that an offender has any of the conditions listed in paragraph 1, sentencers should seek further information to inform their sentencing decisions. This can include pre-sentence and medical reports. In 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.

Having a detailed report should assist in the prompt progression of cases, avoiding delays caused by incomplete reports or lack of pertinent information. Courts may want to consider

the effective use of interim hospital orders (s.38 Mental Health Act) when requested by Clinicians wanting to undertake an inpatient assessment prior to the Court to ensure that appropriate recommendations are made.

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.

Assessing Culpability

4. 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 offences, 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 appreciate the wrongfulness of the conduct
- Obscuring the intent to commit the offence
- Contributing causally to the commission of the offence

This is not an exhaustive list.

5. Courts should note that certain behaviours, such as a lack of empathy or limited ability to express remorse can be features of a particular condition, this can be relevant when considering aggravating and mitigating factors in offences.

6. Any assessment of culpability must be made with reference to the medical evidence 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 exercise self-control or to engage with medical services will be relevant.

7. 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 responsibility.

Deciding on the appropriate sentence

8. Referring to offence specific guidelines, courts should assess culpability taking into account the points outlined above to arrive at a preliminary sentence, then courts should consider whether an offender's condition at the time of sentence has any bearing on the type of sentence that could be imposed. This may mean that, in considering both the condition's impact on culpability and on types of sentence, it may be justified to reduce culpability to the lowest level, and it may justify stepping outside of the guideline entirely for sentence.

9. 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. Deciding on the appropriate sentence should go some way to fulfilling all of those considerations, however particularly important is the punishment *and* the rehabilitation of an offender. 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.

10. 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. 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 for example 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. Also, many community orders may be impractical.

11. 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. 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.

12. Courts will need to consider carefully the appropriate sentencing of offenders with dementia. The condition may be untreatable (in the sense that it is irreversible) and they may not be suitable for a hospital order. However they may have committed a very serious offence, and in some cases, the offence may have been committed some time before the onset of the condition.

13. 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.

14. 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.

15. 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/.

Sentencing disposals

16. 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.

Non-custodial option

If a non-custodial option is considered, and 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.

Further details on relevant orders and directions are below in **Annex A.**

Annex A

Hospital order (section 37)		
May be made by:	A magistrates' court or Crown Court	
	Where made by a magistrates' court:	*Where made by the Crown Court:*

In respect of a defendant who is:	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 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	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 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.