Sentencing Council

Sentencing Council meeting:	**18 May 2018**
Paper number:	**SC(18)MAY05 – Mental Health**
Lead Council member:	
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1 ISSUE

1.1 The Council previously agreed to include *Mental Health - Overarching Principles* as a guideline on the work plan. Background work on this project commenced some months ago, and this is the first meeting at which the Council are asked to consider the proposed guideline. At this meeting the focus will be principally upon deciding the scope of the guideline.

1.2 There are four Council meetings currently scheduled to consider the guideline, with sign off of the draft guideline to take place at the September meeting and a consultation to run from December 2018. However, at this very early stage in the project these are indicative dates only, and may be subject to change, depending on the scope of the project.

2 RECOMMENDATION

2.1 At this meeting the Council are asked:

- To note the background information on this subject matter
- To note the current work in this area within the wider Criminal Justice system, which could have implications for the draft guideline
- To decide on the broad scope and structure of the guideline, principally whether to include learning disability and learning difficulty, autism and acquired brain injury, alongside mental health considerations

3 CONSIDERATION

Background information

Proportion of offenders with mental health issues and/or learning disabilities

3.1 Available evidence suggests that people in the criminal justice system are far more likely to suffer from mental health problems than the general population, for example, when a survey screened prisoners on arrival at prison, 23% reported that they had had some prior contact with mental health services[1]. The National Institute for Health and Care Excellence

[1] https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf.

(NICE) states that an estimated 39% of people detained in police custody and an estimated 29% of those serving community sentences have a mental health issue[2]. 7% of the prison population is thought to have a learning disability[3], compared with 2% of the population. The exact number of people with autism in prisons is unknown, but the proportion is thought to be more than double that within in the general population, and this is likely to be an underestimate because many offenders are undiagnosed. Estimates also suggest that between 7-40% of offenders within the criminal justice system may have a learning difficulty such as ADHD.

3.2 NICE states that around 60% of prisoners have personality disorders, compared to 5% of the general population, 11% of those serving community sentences have psychotic disorders compared to 1% of the general population, and 76% of female and 40% of male remand prisoners have a common mental health disorder[4]**.** The Prison Reform Trust state that self-inflicted deaths are 8.6 times more likely in prison that in the general population.

3.3 In addition, among adults with mental health problems serving community sentences, an estimated 72% also screened positive for either an alcohol or drug problem. Estimates of drug dependence within the prison population is 45%, in comparison to 5.2% within the general population (Public Health England 2016.)

3.4 Some organisations in this area believe that the reduction in the number of secure hospital beds in recent years and reductions in funding for mental health services generally has led to more people with mental health problems ending up within the criminal justice system than previously. Organisations have also expressed concern at what they see as the over use of custody for these offenders, believing that community orders and other options are underused. Organisations also refer to the 'criminalising of disability', referring to the high proportion of offenders with these conditions who have been victims of crime/abuse themselves, or whose conditions have led to the offending.

3.5 The prevalence of offenders with mental health issues coming before the courts has led to calls for a guideline for sentencing these offenders, most notably a recommendation in a report published in November by JUSTICE, entitled '*Mental health and fair trial*'[5]*.* There is little guidance for courts to use when sentencing offenders with mental health disorders/learning difficulties, which can be a difficult exercise. A lack of guidance could lead to inconsistencies in the way these offenders are sentenced, and there is an increasing public

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[2] https://www.nice.org.uk/guidance/ng66/evidence/full-guideline-pdf-4419120205.

[3] http://www.prisonreformtrust.org.uk/Portals/0/Documents/FairAccesstoJustice.pdf.

[4] NICE Guideline 66, p.17

[5] https://2bquk8cdew6192tsu41lay8t-wpengine.netdna-ssl.com/wp-content/uploads/2017/11/JUSTICE-Mental-Health-and-Fair-Trial-Report-2.pdf.

and media focus on mental health/learning difficulties generally (issues such as the abuse at the Winterbourne care home, and reports into the premature deaths of people with learning disabilities, and so on.)

Mental disorder

3.6 Guidelines have used the term 'mental disorder' as this is the term used in the Mental Health Act 1983 (M.H.A), which defines it as 'any disorder or disability of the mind' (s1(2). S1(3) 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. Mental illness can include conditions such as schizophrenia, for example, and conditions can fluctuate, with people experiencing periods of 'wellness'.

Learning disability

3.7 The M.H.A defines 'learning disability' as a '*state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'* (s1(4). A learning disability is a lifelong condition and can vary from a mild disability in which an individual may only need support with certain activities, e.g form filling, to someone with a severe or profound learning disability who may need full time care and support with every aspect of their life.

Learning difficulty

3.8 A 'learning difficulty' can cover such conditions as dyslexia, or ADHD, and is different to a learning disability as it does not affect intellect. Dyslexia is thought to affect around 10% of the general population, and around 1.5% of the population have ADHD. Studies have shown[6] that people with ADHD were more likely to commit crime than adults without the condition (although of course the causes of crime are complex). Symptoms of ADHD can include impulsiveness, extreme impatience, inability to deal with stress, and so on, which can lead to difficulties with relationships, social interaction, employment and self-medication with drugs.

Autism

3.9 Around 700,000 people in the UK have a form of autism, which is a lifelong developmental disability that affects how people perceive the world and interact with others. Autism is a spectrum condition, all autistic people share certain difficulties, but being autistic will affect them in different ways. Some autistic people have learning disabilities, mental health problems or other issues. Like autism, Asperger syndrome is a lifelong developmental

[6] http://www.bbc.co.uk/news/health-20414822.

disability. Some people with the syndrome may also have mental health problems, or specific learning *difficulties*, but do not have the learning disabilities that that many autistic people have, as they tend to be of average or above average intelligence. As noted above in para 3.1, it is thought that people with autism are over represented within prisons. This could be due to aspects of the condition contributing to offending, such as social naivety (being befriended by criminals/becoming unwitting accomplices), difficulty particularly with change or unexpected events, misunderstanding of social cues, rigid adherence to rules or not understanding the implications of their behaviour.

Acquired brain injury

3.10 Acquired or traumatic brain injury (ABI) is an injury caused to the brain since birth, caused by falls, road accidents, tumour or strokes, for example. Survivors of severe brain injuries are likely to have complex long-term problems. These can include impaired reasoning, affecting their ability to understand rules. They can also have impaired insight into their own behaviours and that of others, they may have a loss of control over their behaviour and may behave inappropriately without being aware that there is anything wrong with their actions. This can include making inappropriate sexual advances. Other problems can be irritability, aggression, impulsivity, and egocentricity. A recent report[7] published in The Lancet Psychiatry claimed that up to 60% of the prison population have suffered some kind of head injury, ranging from mild to severe, compared to 0.56% of the general population (Headway, 2016).

3.11 As Dr Grounds noted in his presentation to Council last month, an important point to make in relation to offenders with mental disorder is that diagnoses may not be single. Co-morbidity, a person having a combination of different mental disorders is common.

3.12 It is recommended that the draft guideline includes learning disability, learning difficulty, autism spectrum disorder (ASD) and ABI alongside guidance for offenders with mental disorders. There is already a factor in most guidelines, either at step one or two that refers to mental disorder and learning disability. So, as sentencers are used to considering how these two issues affect offenders, it would be inconsistent not to include guidance on learning disability within this guideline. Also, given the high proportion of prisoners thought to have ABI, ASD or a learning difficulty, and the impact of this condition on cognitive processes, it is argued that these should also be within scope.

Question 1: Does the Council agree to include learning disability, learning difficulty, ASD and ABI within the scope of the guideline?

[7] https://www.telegraph.co.uk/science/2018/02/26/60-per-cent-prisoners-have-head-injuries-experts-warn-brain/.

Current related work in this area- review of the Mental Health Act (MHA)

3.13 Last year the Government announced an independent review of the MHA, to look at how the legislation is used and how practices can improve, following concerns with rising rates of detention, particularly amongst BAME groups, and concerns that some processes relating to the act are out of step with a modern health system. An interim report was published on the 1 May 2018. This report[8] states that they are considering a range of options for reforming the MHA, from large-scale changes to more specific amendments, combined with system and practice changes. They state that '*we are mindful of the current short term issues that limit ambitious legislative proposals, but that will not prevent us looking further into the future'.*

3.14 Going forward they state they will consider further the potential to reduce inappropriate use of custody for people with mental illness, how to make it easier for courts to use section 35 (remand to hospital for report on a defendant's medical condition) when appropriate, and sentencing options for courts and the circumstances in which they are used. The report specifically refers to recent case law and sentencing 'guides' relating to s.45A, (the 'hybrid order' which directs an offender to hospital for treatment alongside a term of imprisonment) which may increase the use of the order, further commenting that there is a lack of consensus as to in what circumstances s.45A is appropriate to use. The interim report also mentions considering the interface between the MHA and the Mental Capacity Act, that changes are required to Community Treatment Orders, and that the whole area of the overlap between the criminal justice system and mental health is in need of an overhaul. A final report with recommendations for change is expected to be published in Autumn 2018.

Community sentence treatment requirements protocol

3.15 The MOJ, in partnership with a number of other Government departments is currently working to develop a protocol for community sentence treatment requirements. The protocol aims to set out what action is required by health and justice staff to ensure pathways into timely and appropriate treatment are in place, and that greater use is made of treatment requirements as part of community sentences. The protocol includes a new minimum of standard of service, a new maximum waiting time for court ordered treatment which is in line with waiting times for the general population, and a new single point of contact within local services. It aims to give a consistent approach, providing better and quicker access to mental health and substance misuse treatment.

[8] https://www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report.

3.16 This follows concerns about the low use of treatment requirements. A study of adult offenders starting community orders in 2009/10 showed that 35% reported having a formal diagnosis of a mental health condition, however, in 2016 only 0.5% of commenced requirements as part of a community order or suspended sentence were Mental Health Treatment Requirements (MHTRs). Numbers were also similarly low for Alcohol Treatment Requirements (4%) and Drug Rehabilitation Requirements (5%). As noted above in para 3.4, there is concern amongst stakeholders in this area that community orders are underused. A contributing issue could of course be a lack of availability/provision for these treatment requirements within different areas around the country.

3.17 The protocol is being tested in a number of areas, the data from which will be evaluated ahead of any possible further rollout. An interim report for the data collected so far is expected to be published in July, with the final report in October.

Liaison and diversion services

3.18 Liaison and diversion services place 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 around 83% coverage of these services throughout the UK.

Proposed approach to be taken with the guideline

Proposed structure of the guideline

3.19 As the guideline is to provide overarching principles, and is not offence specific, it is proposed that it will be structured in a narrative format, in the same way as the recent *Overarching Principles: Domestic Abuse* and *Overarching Principles: Children and Young People* definitive guidelines.

Question 2: Does the Council agree that a narrative format is the most suitable structure for this guideline?

Proposed scope of the guideline

3.20 It is proposed that the guideline will apply to children and young people as well as adults. There are only very brief references to considering mental health or learning disabilities when sentencing in the *Overarching Principles: Children and Young People* definitive guideline. Therefore it is proposed that the guideline would apply to under 18s, but that courts would be instructed to also refer to the *Overarching Principles: Children and Young People* guideline if sentencing someone under 18.

Question 3: Does the Council agree that the guideline should apply to under 18s as well as adults?

3.21 At this early stage of thinking, it is proposed that the guideline will cover three broad areas, as set out below.

1) Factual information

3.22 This will cover factual information that will be of use to the court, such as available mental health disposals, and links to other relevant information, such as the appropriate Criminal Procedure Rules/Criminal Practice Directions. It may be helpful to courts to include a flowchart as to which mental health disposals are available in which courts, and for what age of offender, for example.

2) Guidance on assessing culpability

3.23 It is proposed that this section will give guidance to assist courts to decide what extent, if any, an offender's condition reduces their culpability. The Council will recall that a factor relating to mental disorder (and the impact of abusing drugs or alcohol or failing to follow medical advice) has been discussed recently within the manslaughter and seriousness guidelines. Work will build on the consideration already given to these issues, and the comments made by Dr. Grounds last month regarding assessing the level of impairment caused by a condition. This section will arguably be the most difficult part of the guideline to develop. In previous guidelines factors have variably been dealt with at step one, at culpability, or at step two, as mitigation. Accordingly it may be necessary to consider how the guidance might need to reflect the different ways these factors are considered throughout guidelines. All of these issues may require a completely fresh approach, perhaps something like a new 'step back' consideration. It is also proposed to look at other related issues, such as 'remorse', a standard mitigating factor, which may require additional guidance for consideration for these types of offenders.

3) Guidance on how different disposals may affect offenders with certain conditions

3.24 It is proposed that the draft guideline should give guidance on the additional considerations when considering different disposals, for example an offender who has autism may find custody a greater struggle compared to other offenders, or an offender who has learning disabilities may not be able to participate effectively on certain courses as part of a Community Order. The guideline may also 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* (2006), which was ratified by the UK in 2009. However, there may be conflicts between the Convention's emphasis on

equality before the law and non-discrimination, and the purposes of sentencing, the protection of the public, and the punishment of offenders, and so on.

Question 4: Does the Council agree with the three proposed broad areas for development within the draft guideline?

Question 5: Are there any other areas or issues not mentioned that the Council think should be included within the draft guideline?

4 IMPACT/RISK

4.1 We expect development of a draft guideline to be welcomed by many external bodies. As noted in the paper, organisations such as JUSTICE in their recent report recommended that the Council produce a guideline on mental health and vulnerability. Organisations such as the National Autistic Society strongly feel that any guideline should include guidance on sentencing offenders with ASD, and the Council will be aware of the media attention given to cases such as Lauri Love and Gary McKinnon, who both had ASD**.** There could be criticism of the guideline therefore if it did not include guidance for sentencing offenders with ASD.

4.2 In terms of the impact of the guideline, the CPD data, which is the courts 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 will 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. It is also planned to do a Rapid Evidence Assessment of the available literature in this area to support development of the guideline. We will undertake the usual assessment of the resources required for the provision of prison places and probation services as a result of the guideline. In addition, we are developing contacts in the relevant bodies (NHS England, Department of Health and the Ministry of Justice) to explore the information available from these agencies to help us consider any implications any of the guideline on them.

Question 5: is the Council content that the impact/risks have been sufficiently considered at this stage?