Sentencing Council

Sentencing Council meeting:	**28 September 2018**
Paper number:	**SC(18)SEP05 – Mental Health**
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1 ISSUE

1.1 At the last meeting the Council considered the results of a review of CACD caselaw to consider what guidance has so far been given on these issues, so to inform the basis of the guideline. Following consideration of this review, the Council agreed that the guideline should be amended to incorporate the following key points and principles:

- The guideline should be discursive/narrative, and follow the approach taken in the youth O/P guideline;
- The guideline should say that careful analysis of evidence is required, it is the Judge's responsibility to decide, the guideline should give Judges confidence to make decisions;
- To delve into the assessment of culpability more deeply, using the factors highlighted in the CACD review, it is not simply about 'higher' or 'lesser' culpability;
- That a causal connection between the condition/offence needs to be established, and that conditions should only be relevant where a significant issue is raised, not for general application in every case;
- To give 4 or 5 features of conditions/disorders that may be relevant in the deliberations;
- Incorporate principles from *Vowles*[1] and *Edwards*[2], and consider *Clarke* and *Cooper*[3];
- The guideline must stress the importance of the protection of the public/consider the regime on release when deciding sentence

[1] R v Vowles [2015] EWCA Crim 45
[2] R v Edwards [2018] EWCA Crim 595
[3] R v Clarke and Cooper [2017] EWCA 393

1.2 Over the summer the draft guideline was substantially revised to incorporate these points, as discussed in detail below. The guideline was then sent to Rosa, Rebecca and Tim for comment, and it has greatly benefited from their comments and observations.

2 RECOMMENDATION

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

- To confirm if they are content with the revised section on assessing culpability
- To confirm if they are content with the wording in paragraph 12, regarding alternatives to custody in exceptional cases
- To confirm whether the list of disorders/conditions at Annex A of the guideline is to be exhaustive or not
- Whether the guideline should refer to practical difficulties with the assessing/resourcing of mental health treatment requirements, or not.

3 CONSIDERATION

Section 1: General approach

3.1 The draft guideline is attached at **Annex A,** it has been restructured to make it clearer and more straightforward for users, and also now has a contents page at the start. There is a new 'general approach' section, at section one on page 4, similar to the one in the youth O/P, and incorporates reference to the fact that conditions/disorders should only be relevant where a significant issue has been raised, in paragraph 1.

3.2 Paragraph 3 includes a fuller reference to s.157 of the Criminal Justice Act (CJA) 2003, this having appeared only as a footnote in previous drafts. Having referenced this, the paragraph then states that obtaining reports may be unnecessary if existing sources of information can be used, and lists potential sources of information. There is also a new reference to s.39 of the Mental Health Act (MHA) 1983, which provides for a court to request information from health services if a hospital order is being considered. This paragraph has been drafted to try to address the Council's earlier concerns that the guideline shouldn't lead to large increases in the amount of reports requested.

Question 1: Are the Council content with the drafting of section 1 of the draft guideline? Does paragraph 3 adequately deal with earlier concerns expressed regarding reports?

Section 2: Assessing culpability

3.3 Paragraph 6 on page 5 contains new references to the fact that there should be a causal connection between the condition and the offence, and that it is for sentencers to

decide how much responsibility the offender retains for an offence. Paragraph 7 contains new wording stating that careful analysis of all the evidence is required, which the sentencer is best placed to make. It goes on to say that expert evidence, where offered and relevant should be taken into account, but that sentencers must make their own decisions and not be bound by psychiatric opinion, this reflects what the court said in *Vowles (para 51).*

3.4 Paragraph 8 provides new guidance to help courts reach an assessment of the level of culpability retained by an offender. The factors that were highlighted in the review of CACD cases discussed last month have been used as a basis to ask the sentencer a series of questions in order to assess culpability. As the Council may recall from the review of CACD cases, the applicability of these factors is far from straightforward, in some cases a factor can indicate greater culpability, in others, the same factor can indicate lesser culpability, as cases are so fact specific. Therefore, it is suggested that this new approach may be the best way to provide guidance on what is arguably one of the most difficult parts of the guideline to draft.

Question 2: Are the Council content with the revised guidance on assessing culpability?

Section 3: Determining the sentence

3.5 Section 3 starting on page 6 provides information to assist courts determine the appropriate sentence, and aims to present all the considerations in a balanced way. Paragraph 9 contains a reference to the importance of the protection of the public, a point that the Council agreed, at the last meeting, should be highlighted by the guideline.

3.6 Paragraph 12 states that, if there was a serious risk of imprisonment having a gravely adverse effect on the offender's condition, courts could in exceptional cases look at alternatives to custody. This paragraph has the capacity to be controversial. On the one hand, if the offence calls for custody, with a hospital order not being appropriate, is it appropriate to suggest alternatives to custody? Or, should this ability to look at alternatives remain. For example, could a situation be envisaged whereby a drug dependant third strike burglar could finally be able to go into residential rehab? Or an offender with PTSD who needs community based cognitive behavioural therapy not hospital? For these types of cases, providing this wording would allow for alternatives to custody to be considered in appropriate cases, the emphasis being on treating the cause behind offending and trying to prevent further reoffending.

3.7 Paragraph 13 provides a counterbalance to the preceding paragraph, stating that although consideration of the impact of imprisonment is a legitimate one, any consideration should be balanced against the gravity of the offending, and consideration of the harm done

to victims. This reflects what the CACD said in *Clarke* and *Cooper* (para 25), suitably adapted as that case was looking at physical ill health and extreme old age considerations.

3.8 Paragraph 14 reflects another point that the Council agreed in July that the guideline should cover, the different release regimes for sentences. Rather than leave courts to find the relevant information on release regimes which is contained within the quite detailed sections later within Annex C, a summary of the relevant information is contained within this paragraph. Unfortunately it is quite difficult to reduce the relevant information any further, as it is not something that can be summarised in one or two lines.

Question 3: What is the Council's view on the wording within paragraph 12? Is the Council content to retain it- with paragraph 13 providing a counterbalance to it?

Question 4: Are the Council content with the drafting of section 3 as a whole?

Section 4: Sentencing disposals

3.9 This section starting on page 8 aims to provide courts at a quick glance with information on what disposals are available, by court. Further detailed information is provided within Annex C but, as that is necessarily detailed, this section just provides what is hoped is a useful summary. The guidance – for the Crown Court only – regarding the appropriate consideration of section 45A and section 37/41 orders is taken from the recently published definitive Manslaughter guideline.

Question 5: Does the Council think the information within section 4 will be a useful summary of disposals for sentencers or not?

Annex A- details on conditions/disorders

3.10 Annex A, starting from page 9 onwards, provides brief detail of each of the main features of conditions/disorders that may be relevant in this context, as per the discussion at the last meeting. New in the list of conditions is dependence syndrome, which was agreed should be included. This information has been checked by a mental health professional (Charles de Lacey at the Old Bailey). Currently the draft does not specify whether the list of conditions at Annex A is exhaustive or not. If the guideline does not specify that the list is exhaustive, then courts may be asked to consider other conditions, the range of which could be quite varied and wide, for example the World Health Organisation has recently classified gaming addiction and compulsive sexual behaviour as mental illnesses.

Question 6: Are the Council content with the revised information within Annex A of the guideline? Does the Council wish to make the list of conditions/disorders that can be considered exhaustive or not?

Annex B - reports

3.11 This annex, starting at page 13 onwards, provides more detailed information on requests for reports. If a report is to be considered (and the section starts with a reminder that they should only be necessary in a limited amount of cases) then there are examples of types of information that courts may wish to request within the reports. This list was suggested by Charles de Lacey, to try to prevent incomplete reports holding up cases.

3.12 There is also a reference to s.38 MHA orders (interim hospital orders). This reference has been caveated to remind courts to think carefully about proportionality when considering s.38 orders, given the pressure on secure beds (reflecting what the court said in *Vowles (*paras 23, 50ii)). There also follows further information on powers to order reports in the Magistrates' Courts and on s.157 CJA Act 2003.

Question 7: Is the Council content with the wording within Annex B? in particular, is the Council content with the reference to s.38?

Annex C – sentencing disposals

3.13 Annex C, from page 16 onwards, provides full detail on each of the applicable disposals available, starting with Mental Health Treatment Requirements (MHTR). As the Council are aware, there is currently a Community Sentence Treatment Requirement Protocol (CSTRP) being tested in five areas across England, following concern about the low use of treatment requirements. There is currently a data collection phase of the evaluation underway, due to finish in October, with a review then due by Ministers ahead of any further roll out. In advance of any definite changes to treatment requirements, and given that there are often practical difficulties regarding resources for assessments and for treatment, the Council may like to consider whether the guideline should refer to these practical difficulties.

3.14 There is now fuller guidance on the release regimes for each of the orders within this section, as discussed earlier. There is also now additional information with regards to s.43 MHA, in reference to the Crown Court being limited to magistrates' courts sentencing powers if a hospital order is not imposed.

Question 8: What are the Council's views of Annex C? In particular, does the Council wish to refer to practical difficulties in relation to MHTRs?

Age applicability of the guideline

3.15 The Council may recall that in one of the earlier meetings the question of whether the guideline should apply to all offenders, or only those over 18 was discussed. During this discussion Rob Butler suggested that young offenders may have different, specific needs

compared to adult offenders, and that it may be difficult to accommodate these within a general guideline. He suggested contacting an expert in this area, Professor Dame Sue Bailey, to ask. Professor Bailey has agreed to consider the question and provide her thoughts. It is suggested that the Council comes back to this question once we have her response.

3.16 Consideration has also been given to an appropriate title for this guideline, to reflect the fact that it is broader than just mental health, although it would be impractical to include in the title all the conditions/disorders listed within Annex A. There are three suggestions for a new title, either '*Overarching Principles: Mental Health and other vulnerabilities'* or *'Sentencing Offenders with mental health conditions or other vulnerabilities', or Sentencing Offenders with mental health or other related, or similar, conditions.'*

Question 9: Which title does the Council prefer? Or does the Council wish to suggest a different title?

Question 10: Is there anything missing from the draft guideline that the Council thinks should be added, or anything that should be removed from the draft?

4 IMPACT/RISK

4.1 In terms of the impact of the guideline, the CPD data, which we would usually draw upon to help 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 on the volumes and sentences involved and to try and assess what the impact of the guideline might be. A lack of data could make the draft resource assessment problematic, in terms of accurately assessing the impact of the draft guideline.

4.2 Officials are also maintaining close links with officials in the MOJ and other Government departments to keep up to speed with developments on the various related initiatives in this area, the L&D scheme, CSTRP, review of the MHA, and so on. On the review of the MHA, it is understood that a final report is expected around November/December this year.

Question 11: is the Council content that the impact/risks have been sufficiently considered at this stage?

Sentencing Council

Annex A

Overarching Principles:

Mental Health

Contents

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."

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

Section one: General approach

1. The guidance given in this guideline will assist sentencers when sentencing offenders who have any of the conditions or disorders outlined in **Annex A**. The mere fact that an offender has such a condition or disorder does not necessarily mean that it will have an impact on sentencing. Where it does, it is likely that it will have been raised as a significant issue by the defence advocate.

2. There are a wide range of mental health conditions and developmental disorders, and the level of any impairment will vary between individuals. Accordingly, in assessing whether the condition or disorder has any impact on sentencing, the approach to sentencing should be individualistic and focused on the particular issues relevant in the case concerned. In particular:
    - care should be taken to avoid making assumptions, as unlike some physical conditions, many mental health conditions or learning disabilities are not easily visible
    - no inference should necessarily be drawn if an offender had not previously been formally diagnosed, or had not previously declared a condition (possibly due to a fear of stigmatisation or because they are unaware they have a condition)
    - it is not uncommon for people to have a number of different conditions, 'co-morbidity', and for drug and/or alcohol dependence to be a factor, 'dual diagnosis'[1]
    - 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

3. In any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law, unless, in the circumstances of the case, the court is of the opinion that it is unnecessary (s.157 Criminal Justice Act 2003)[2]. It may be unnecessary if existing sources of information can be used, such as from probation, defence representatives, prison, police or court mental health teams, or family members. In addition, s.39 of the Mental Health Act (MHA)1983 provides that a court may request information about a patient from local health services if considering making a hospital or interim hospital order. Further information about requests for reports can be found at **Annex B** of this document.

[1] There is more information on co-morbidity and dual diagnosis in Annex A
[2] There is more information on s.157 of the Criminal Justice Act in Annex B.

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

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

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

Section two: assessing culpability

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

7. In some cases the condition may mean that culpability is significantly reduced, in others, the condition may have no relevance to culpability. Assessments of culpability will vary between cases due to the differences in the nature and severity of conditions; it is not possible to be prescriptive in this regard. Careful analysis of the evidence is required to make this assessment, which the sentencer, who will be in possession of all the relevant information, is best placed to make. Expert evidence, where offered and relevant, should be taken into account, but sentencers must make their own decisions and should not feel bound to follow psychiatric opinion.

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

- Did the offender's condition mean they were unable to exercise appropriate judgement?

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

This is not an exhaustive list.

Section three: determining the sentence

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. Just because an offender has a mental health condition, it does not mean they should not be punished, and in the case of serious offences protection of the public may be paramount. For offenders whose condition has contributed to their offending the effective treatment of their condition should in turn reduce further offending and protect the public.

10. 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.

11. An offender's condition at the point of sentence could have a bearing on the type of sentence that is imposed. Some points to consider are:
    - The existence of a condition at the date of sentencing, or its foreseeable recurrence, could mean that a given sentence could weigh more heavily on the offender than it would on an offender without that particular condition

- Imprisonment can exacerbate poor mental health and in some cases increase the risk of self- harm
- 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 requirements of community orders may be impractical, consideration should be given to tailoring the requirements of orders, as necessary in individual cases. An offender should not receive a more severe sentence, such as custody, because they would be unable to do unpaid work as part of a community order, for example

12. If there is a serious risk of imprisonment having a gravely adverse effect on the offender's condition, courts will need to consider this risk very carefully, in exceptional cases looking at alternatives to custody, and potentially sentencing outside the range indicated by the offence guideline. Where the offence is very serious and retained 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.

13. However, although consideration of the impact of imprisonment on an offender is a legitimate one, any consideration should be balanced against the gravity of the offending, including the harm done to the victim(s), and the public interest in appropriate sentences being set.

14. In deciding on a sentence, courts should also carefully consider the criteria for, and regime on release. The graver the offence and the greater risk to the public on release of the offender, the greater emphasis the court must place upon the protection of the public and the release regime. Further details are given at **Annex C,** but in summary:

- A **s37 hospital order** lasts initially for six months but can be renewed for a further six months and then for a year at a time. Discharge from a hospital order can be made by the responsible clinician (RC) or the hospital at any time. The RC can also make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The patient can apply to the tribunal[3] for discharge after six months and annually thereafter.
- A **restriction order under s41** lasts indefinitely and does not need to be renewed. The Secretary of State for Justice (SoS) can lift the restriction order at any time if satisfied that it is no longer necessary to protect the public from serious harm. A patient who is still in hospital when the restriction order is lifted is treated as if admitted under a hospital order on the day the restriction order ended. The Tribunal has no general discretion to discharge restricted patients but must conditionally discharge patients who are subject to

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

a restriction order if it is not satisfied that the criteria for continued detention for treatment under a hospital order are met.

- A **limitation direction under s45A** ends automatically on the patient's 'release date'. The effect of this is that the limitation direction will end at the halfway point of a determinate sentence. If the patient is serving a life sentence, or an indeterminate sentence, the release date is the date (if any) on which the person's release is ordered by the parole board. Although the limitation direction ends on the release date, the hospital direction does not. So a patient who is still detained in hospital on the basis of the hospital direction on their release date, remains liable to be detained in hospital from then on as an unrestricted hospital order patient. While the limitation direction remains in effect, if the patient no longer requires treatment in hospital for a mental disorder, the SoS may direct that the patient be removed to prison (or equivalent) to serve the remainder of their sentence, or else release them on licence.

Section four: sentencing disposals

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

Magistrates' courts

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

Crown Court

- Community Order with a Mental Health Treatment Requirement (MHTR)
- Section 37 Hospital order
- Section 37 Guardianship order
- Section 41 Restriction order
- Section 45A Hospital and limitation direction

The following guidance applies in the Crown Court only:

Where:

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

(ii) treatment is available, and

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

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

Section 45A hospital and limitation direction

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

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

Section 37 hospital order and s41 restriction order

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

Annex A

The following information provides brief detail on common mental health disorders and developmental conditions, listing the main features that may be relevant in understanding how the condition may affect people with the condition.

Mental disorders – such as (but not limited to) depression, anxiety**,** schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), or personality disorders (particularly associated within the criminal context are anti- social, borderline, narcissistic and paranoid 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. The main features that may be relevant for each of the conditions are:

Depression/Anxiety

- difficulties in concentrating and making decisions
- poor memory
- irritability, anger, anxiety, agitation, restlessness, being distressed
- avoiding/leaving situations in order to relieve uncomfortable feelings
- on occasions depression may be accompanied by delusions and hallucinations

Schizophrenia

- hallucinations-experiencing something that isn't really there- most commonly hearing voices
- delusions-strongly holding beliefs that others do not share and have no basis in reality and which may exhibit paranoid thinking
- acting strangely or dangerously as a result of delusional beliefs or ideas
- muddled thinking and speech
- difficulty in relating to others
- apathy, disorganised thinking, difficulty in concentration and following instructions

Bi-polar disorder ('manic depression')

- extreme changes of mood, from severe lows (depression) to highs (mania)
- acting irrationally, unpredictable or unexpected behaviour
- overactive/excitable, excessive energy, become angry quickly or irritable
- unusual beliefs/delusions not based in reality
- spend excessive amounts of money/end up with debts

PTSD

- irritability/aggressive behaviour
- intense distress/panic in response to real or symbolic reminders of the trauma
- involuntary re-experiencing of the trauma with flashbacks, intrusive thoughts, nightmare, and images
- difficulty concentrating

Personality disorders

- reckless/impulsive behaviour
- not trusting others/feeling threatened
- irresponsible and anti-social behaviour
- disregards/violates the rights of others
- easily frustrated/angered
- unable to feel guilt
- emotionally unstable
- grandiose sense of self importance
- temporary psychotic states
- unfounded suspicion of others and bearing grudges

Psychosis- is a symptom of some mental health problems, and not a diagnosis in itself. Most common types of psychosis are hallucinations and delusions, some may also experience disorganised thinking and speech. The word is usually used to refer to an experience. Psychosis affects people in different ways, with some having only one experience, some having short episodes, and other people living with it most of the time. Psychosis, also called a psychotic experience or psychotic episode, is when people perceive or interpret reality in a very different way from others.

Learning disabilities – 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. The main features that may be relevant are:

- limited comprehension and communication skills
- being acquiescent and suggestible
- having difficulty understanding social norms.

Learning difficulties – 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. The main features that may be relevant for **ADHD/ADD** are:

- impulsiveness
- inattentiveness
- extreme impatience
- inability to relate to others in socially acceptable ways

- inability to express feelings and emotions in an appropriate way
- inability to deal with stress or to be able to think clearly.

People with **dyslexia** may have difficulties with reading, spelling, personal organisation and sequencing, getting dates, times or events in the wrong order.

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. The main features that may be relevant are:

- social naivety, potentially leading to being unknowingly being involved in crimes
- may develop highly specific interests in a subject or activity
- difficulty with change or unexpected events
- rigid adherence to rules
- being unaware of the consequences of their actions, due to an inability to link cause and effect
- lack of insight into behaviour
- lack of empathy or a limited ability to express emotion.

Acquired/ 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, with severe brain injuries causing complex long-term problems. The main features that may be relevant are:

- impaired reasoning, affecting the ability to understand rules
- impaired insight into own behaviour and that of others
- loss of control over behaviour and inappropriate behaviour
- rapid mood changes, aggression, impulsivity, irritability and egocentricity
- changes in personality
- memory loss
- reduced capacity to concentrate, reduced capacity to process information

Dementia – a syndrome associated with an ongoing decline of brain functioning, such as Alzheimer's disease or vascular dementia. The main features that may be relevant are:

- difficulty in controlling emotions, mood swings, aggression

- loss of empathy with others
- difficulty with social interaction
- problems with memory
- in some cases, experiencing hallucinations.
- problems with concentration and reduced ability to focus and pay attention
- reduced ability to reason and make judgements
- problems with speech and language

Dependence syndrome – a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance abuse and that typically includes a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences, and a higher priority given to using it than to other activities and obligations. The dependence syndrome may be present for a specific substance e.g alcohol, for a class of substances, e.g opioid drugs, or for a wider range of different psychoactive substances. The main features that may be relevant are:

- violent or anti-social behaviour
- reckless behaviour
- chaotic lifestyle
- strong desire or compulsion to consume the substance above all else
- psychotic states
- disinhibition

Co-morbidity

This is the term used to describe people who experience more than one condition, which is common amongst offenders, for example someone may have a mental health condition and a learning disability. Some people with mental health conditions or learning disabilities also may have communication difficulties.

Dual diagnosis

This is the term used to describe people with mental health and substance abuse problems. Many people with mental health conditions use drugs or alcohol to help them deal with their conditions.

Annex B

Requests for psychiatric reports should only be necessary in a **limited amount of cases,** as outlined in paragraph three. 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.

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.

When requested by clinicians wanting to undertake an inpatient assessment, courts may wish to consider making an interim hospital order (s.38 MHA). However, although such an order may enable a better assessment to be made than in a prison environment, courts should consider carefully the acute pressure on the availability of secure beds.

Power to order reports- magistrates courts

There are limited powers to order reports in the magistrates' courts. S.11 Powers of Criminal Courts (Sentencing) Act 2000[4] provides for the ordering a report, but it is only post- conviction or a finding under s.37 (3) Mental Health Act 1983 that the defendant did the act or made the omission charged. However, the court can request a report and a duly qualified medical practitioner who provides such a report can be paid out of central funds, using s.19 Prosecution

[4] https://www.legislation.gov.uk/ukpga/2000/6/section/11

of Offenders Act 1985[5] plus Regulation 25(1) Costs in Criminal Cases (General) Regulations 1986[6].

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.

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

Annex C

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

- Use of MHTRs attached to court orders for those offenders with identified mental health issues may result in reductions in reoffending, compared to the use of short term custodial sentences.
- Courts may also wish to consider a drug rehabilitation requirement and/or an alcohol treatment requirement in appropriate cases.
- A community order with a MHTR may be appropriate where the defendant's culpability is substantially reduced by their mental state at the time of the commission of the offence, and where the public interest is served by ensuring they continue to receive treatment.
- A MHTR is not usually suitable for an offender who is unlikely to comply with the treatment or who has a chaotic lifestyle.

Hospital order (section 37 Mental Health Act 1983)		
May be made by:	A magistrates' court or Crown Court	
In respect of a defendant who is:	*Where made by a magistrates' 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	*Where made by the Crown Court:* 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.

A hospital order made **under s37** (without a restriction order) lasts initially for six months but can be renewed for a further six months and then for a year at a time.

- Discharge from the order can be made by the responsible clinician (RC) or the hospital at any time.
- The patient can apply to the tribunal[7] for discharge after six months and annually thereafter.
- The RC can authorise a leave of absence for a limited period or indefinitely; such leave can be subject to conditions and the patient can be recalled at any time if the RC considers it necessary in the interests of the patient's health or safety or for the

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

protection of other people (the order can be renewed during a period of absence if hospital treatment remains necessary).

- The RC can make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The hospital order is in effect suspended while the CTO is in force so it does not need to be renewed. The CTO lasts for an initial six months and can be extended for a further six months and annually thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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