Sentencing Council

Sentencing Offenders with Mental Health Conditions or Disorders - for consultation only

Effective from: to be confirmed (draft for consultation only)

Applicability

Section one: General approach

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

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

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

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

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

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

6. There are particular issues courts may also wish to familiarise themselves with, with regards to cultural and ethnicity considerations and offenders within a mental health context. Further information can be found at Chapter Eight of the Equal Treatment Bench Book.

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

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

Section two: Assessing culpability

8. 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.

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

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

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

This is not an exhaustive list.

Section three: Determining the sentence

11. Courts should consider all the purposes of sentencing during the sentencing exercise: the punishment of offenders, reduction of crime, rehabilitation of offenders, protection of the public, and reparation. Although there is a statutory requirement under section 142 of the Criminal Justice Act 2003 to consider all the purposes of sentencing, that statutory requirement does not apply when making a hospital order, a hospital order with restrictions or a hospital and limitation direction. However, consideration of the purposes of sentencing may still be relevant in some cases. Just because an offender has a mental health condition, neurological impairment or disability, it does not mean they should not be punished, and in the case of serious offences protection of the public may be paramount. For offenders whose condition has

contributed to their offending the effective treatment of their condition should in turn reduce further offending and protect the public.

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

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

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

14. In deciding on a sentence, courts should also carefully consider the criteria for, and regime on release. It should not be assumed that one order is better than another, or that one order offers greater protection to the public than another. Careful analysis of all the facts is required in each case, including what is practically available, before deciding on the appropriate disposal. The graver the offence and the greater risk to the public on release of the offender, the greater emphasis the court must place upon the protection of the public and the release regime. Further details are given at **Annex C,** but in summary:

- A **section 37 hospital order** lasts initially for six months but can be renewed for a further six months and then for a year at a time. Discharge from a hospital order can be made by the responsible clinician (RC) or the hospital at any time. The RC can also make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The patient can apply to the tribunal (First Tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal in Wales) for discharge after six months and annually thereafter.
- A **restriction order under section 41** lasts indefinitely and does not need to be renewed. The Secretary of State for Justice (SoS) can lift the restriction order at any time if satisfied that it is no longer necessary to protect the public from serious harm. A patient who is still in hospital when the restriction order is lifted is treated as if admitted under a hospital order on the day the restriction order ended.
- A **limitation direction under section 45A** 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.

This information provided below is correct as of 09/04/2019

Section four: Sentencing disposals

The following is a non-exhaustive list of available mental health disposals/orders and relevant guidance (further details on each are at **Annex C). This information provided is correct as of 09/04/2019.**

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:

- the evidence of medical practitioners suggests that the offender is currently suffering from a mental disorder,
- treatment is available, and
- 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

1. Before a hospital order is made under section 37 MHA (with or without a restriction order under section 41), consider whether the mental disorder can appropriately be dealt with by custody with a hospital and limitation direction under section 45A MHA. In deciding whether a section 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.
2. If a penal element is appropriate and the mental disorder can appropriately be dealt with by a direction under section 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 section 41 restriction order

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

Annex A – main classes of mental disorders and presenting features

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

These classification systems come with a warning of 'the risks and limitations of [their] use in forensic settings' (e.g. DSM-5[1], page 25). This is partly because they classify presentations. They do not take a disease oriented approach, which requires some specification of the cause of the condition, its natural course if untreated and likely outcomes if treated and partly because there is an 'imperfect fit' between medical and legal concepts of disorder. DSM has been criticised for being in thrall to private healthcare systems and drug companies.[2]

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

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

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

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

Psychotic illnesses

These affect cognitions, emotional capacities and actions.

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

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

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

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

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

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

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

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

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

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

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

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

Non-psychotic illnesses

These include 'simple' depression (seriously low mood and perhaps suicide related behaviours, but without delusions) and anxiety disorders. The latter include a range of conditions; the more common include phobic disorders (sufferers recognise that their fear is not well founded in fact, but experience fear anyway which may interfere with their everyday life), obsessive compulsive disorders (again, the fear recognised for what it is, but still thoughts and fears intrude and maybe rituals must be performed), panic attacks and post-traumatic stress disorders [PTSD].

PTSD can only be diagnosed if it follows a seriously traumatic event which happened directly to the person, which the person witnessed it as it happened to others and/or had to deal with the aftermath (emergency service workers may be as vulnerable as the general population), or which the person learned about soon afterwards but it affected someone very close to him/her. Generally the scale of the event is taken to be life threatening or life changing and/or that the person affected unquestionably thought it so. Guidance is that the condition must emerge within six months of this – it may not be immediately apparent. It is important to have evidence that the condition did follow the event. Most people will get some of the symptoms or signs in such circumstances; guidance is that these may be collectively regarded as a disorder if they persist to a degree that they are disruptive to the individual's usual lifestyle for over a month. There are people who have experienced multiple traumas and the presenting features may therefore represent a worsening/exacerbation of PTSD which started after a previous event rather than a completely new presentation.

As well as mental and physiological symptoms and signs (like racing heartbeat, tight chest, uncomfortable sensations in the gut), and of anxiety, and often some depressive features, typical features are:

1. extremely distressing intrusions of memories or experiences of the event which disrupt waking life (flashback memories) and/or sleep (nightmares), dissociative reactions (if the surroundings are perceived as unreal this is called 'derealisation'. If the person him-or herself feels detached, outside him/herself and/or more as an observer of self than a real person this is called 'depersonalisation'), when the individual is not very aware of his/her real surroundings but living again in the trauma; sometimes specific real experiences may trigger this (for example if an assailant had been wearing a particular perfume/aftershave chance contact with a perfectly harmless person who happens to use the same may trigger a flashback and reaction more appropriate to the traumatic experience than the reality;
2. persistent, active avoidance of any reminders of the trauma – including unwillingness to talk about it, inability to read documents relating to it;
3. persistent negative feelings about self and others; many have no concept of a future;
4. alterations in arousal – so, irritability, reckless behaviour, being over-watchful, problems with concentrating, exaggerated 'startle responses' to actually non-threatening events, various difficulties with sleep.

Developmental disorders

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

Autism and autistic spectrum disorder (the latter sometimes known as Asperger's syndrome) are pervasive developmental disorders in which intelligence may or may not be impaired, but emotional and relationship capacities, often with aspects of speech development, are. Generally, parents are always aware that their child is 'different', but this will certainly be clear by the age of three years. In recognition that these conditions encompass many shades of disorder and disability, there is a growing tendency to use the term 'autistic spectrum disorder' with indications of the specific behaviours affected and the severity; the American DSM-5 no longer uses the term autism at all. It is still used in the UK, generally to indicate the most pervasive and extreme incapacity to understand or empathise with others, to show any emotional reciprocity and to develop or maintain relationships. Generally the individual seeks 'sameness' and so is inflexible in routines or repeated, simple actions and may become very aggressive if interrupted.

'Autism'/autistic behaviours were once seen as one of the core sets of features of schizophrenia, and may still be referred to in this context. The underlying neurological/brain difficulties may well be similar in some respects, but these are distinct conditions. Most people with autism/autistic spectrum disorders do not become psychotic.

Attentional deficit hyperactivity disorder [ADHD] is similarly apparent from a very early age, although may not be completely recognised until the individual starts school. It is not uncommonly associated with other developmental disorders, but also occurs alone, when it is characterised by profound difficulties in

concentrating in ordinary social situations or on tasks (many can focus on computer based activities) and very high levels of physical activity. Children are seen as 'disruptive' and can easily be made worse under conventional behavioural control efforts. As with all developmental disorders, it may persist into adult life.

Substance misuse disorders

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

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

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

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

Cluster A – the paranoid, eccentric, schizoid

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

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

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

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

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

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

The dementias

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

Evidence for dementia will come in several forms – the clinical examination, which should include asking the affected person about his/her experiences and for a history of the development of the condition; for obvious reasons it is more than usually important to get a history from relatives and friends too. People with dementia

may retain the capacity to give a long and fascinating account of their problems which has little basis in reality (referred to as confabulation).

Simple tests of memory and other cognitive functions may be enough for basic diagnosis and to help the court, but it is generally best to map cognitive functions with detailed psychological testing, and there may be some very specific deficits which are relevant in court – for example difficulties in recognising people or experience of perceptual distortions. Brain imaging techniques may have particular value in verifying the nature and extent of the brain damage underpinning the problems.

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

The most common dementias are a function of unhealthy aging. There has been an increase in offending among older people, so these are conditions increasingly likely to be seen in the courts. A few of the dementias usually those with early onset – have a clear genetic cause; there is evidence that there is a genetic contribution to most.

Alzheimer's disease/dementia is among the commonest given a name. The pattern of destruction of brain tissue is more-or-less specific to this dementia, and there is a genetic component to it. Where the genetic component is strong, onset may be at a younger age (50, occasionally younger) but more typically onset is around 65-70. The characteristics are more-or-less as described above. Variations in presentation often indicate which parts of the brain are most affected at any particular time, but this is a generalised condition.

One of the more difficult dementias to recognise in relation to offending is fronto-temporal dementia (referring to the lobes of the brain most affected). Compared with other dementias, memory is spared for longer, but behavioural problems may be prominent. It is also less common than Alzheimer's or dementia of old age, and more often missed. It should be considered if a well socialised person becomes aggressive or antisocial for the first time in later adulthood (onset generally 45-65).

Dementias may also, however, follow from brain damage from external causes, for example a serious head injury, in relation to other disorders affecting the whole body, like diabetes, or from having taken noxious substances – especially excessive alcohol, but a range of other drugs too.

Acquired brain injury

An injury caused to the brain since birth, the cause of which can vary from a fall, road accident, tumour or stroke. The effects may vary widely, but the more severe the brain injury, the more likely long term effects are likely to be. Some of the effects can be impaired reasoning, disinhibition, memory loss, irritability and changes in personality.

Learning difficulty

A learning difficulty, such as dyslexia, is different to a learning disability as it is unrelated to intelligence.

Multi-morbidity and comorbidity (dual diagnosis)

These terms are often used interchangeably to mean that the individual has more than one disorder although, strictly, comorbidity means that the conditions arose simultaneously. This is a very common situation among people who have a disorder of mental health. It is generally very hard to disentangle which disorder came first or whether they arose simultaneously. Psychiatrists and other clinicians still sometimes use the term 'dual diagnosis'. It is always worth checking what they mean. The term 'dual diagnosis' was invented to describe people who had a psychosis and a substance misuse disorder, but sometimes people use it for other pairs of disorders (e.g. psychosis and personality disorder) and, in practice, it is quite usual for people who come to court and have more than one disorder to have several – so a psychotic illness *and* more than one substance misuse disorder *and* a personality disorder *and* sometimes also a learning disability.

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

Annex B – reports

This information provided below is correct as of 09/04/2019. It does not form part of the guideline.

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

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

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

http://www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015

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

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

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

Power to order reports – magistrates courts

The only power to order medical reports in magistrates' courts arises after conviction or after a finding under section 37(3) of the MHA, see section 11 Powers of Criminal Courts (Sentencing) Act 2000[3]. However, before conviction the court can request a report and a duly qualified medical practitioner who provides such a report can be paid out of central funds, under section 19 Prosecution of Offences Act 1985[4] and regulation 25(1) Costs in Criminal Cases (General) Regulations 1986.[5]

Additional requirements in case of mentally disordered offender (section 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 MHA (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 MHA by the Secretary of State [or by another person by virtue of section 12ZA or 12ZB of that Act] as having special experience in the diagnosis or treatment of mental disorder.

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

Annex C – Sentencing disposals

This information provided below is correct as of 09/04/2019. It does not form part of the guideline.

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

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

- Even when the custody threshold is crossed, a community order with a MHTR may be a proper alternative to a short or moderate custodial sentence.
- A MHTR is not suitable for an offender who is unlikely to comply with the treatment or who has a chaotic lifestyle.

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

Hospital order (section 37 Mental Health Act 1983)		
May be made by:	A magistrates' court or the 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 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 section 37** (without a restriction order) authorises the detention of the patient in hospital for medical treatment.

- Discharge from the order can be made by the responsible clinician (RC) or the hospital at any time. The order initially lasts for six months but can be renewed by the hospital for a further six months and then for a year at a time if the conditions for making the order are still satisfied. There is no limit to the number of times that the order can be renewed.
- The patient can apply to the tribunal[6] 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 protection of other people (the order can be renewed during a period of absence if hospital treatment remains necessary).
- The RC can make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The CTO lasts for an initial six months and can be extended for a further six months and annually thereafter.

Restriction Order (section 41 Mental Health Act 1983)

A restriction order (section 41) may be imposed by the Crown Court where a hospital order has been made and:

If	At least one of the doctors whose evidence is taken into account by the Court before deciding to give the hospital order has given evidence orally
And, having regard to	• the nature of the offence • the antecedents of the offender, and • the risk of the offender committing further offences if set at large
The Court thinks	It necessary for the protection of the public from serious harm for the person to be subject to the special restrictions which flow from a restriction order

A restriction order lasts until it is lifted by the Secretary of State (SoS) 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 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:	The 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 (SoS) 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 (section 43(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 section 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	
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.

[1] Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition

[2] Mayes R & Horwitz AV (2005) DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences,* Vol. 41(3), 249–267. The system has now moved on to DSM-5 (and there will shortly be an ICD-11, currently ICD-10 is being used), with some differences, but the concerns raised by Mayes and Horwitz are still broadly valid.

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

[4] https://www.legislation.gov.uk/ukpga/1985/23/section/19

[5] https://www.legislation.gov.uk/uksi/1986/1335/regulation/25/made

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