Scottish Sentencing Council

Mental Health and Sentencing

Literature Review

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Executive Summary

The complex task of sentencing becomes even more challenging when the offender suffers from a mental disorder. When such individuals appear for sentencing the court must consider a wider range of circumstances affecting the offender's level of culpability. In addition, the priority of sentencing objectives may change, and certain disposals become more appropriate. A sentencing court has a duty to consider evidence of mental disorder placed before it, and must weigh the relevance and weight of this evidence. This report reviews the sociolegal literature addressing the sentencing of mentally disordered offenders.

Incidence of mental disorder in the offender population

Mental disorders are very common among offender populations and are much more prevalent than in the general population. Research suggests that rates of suicide, suicide attempts and self-harming behaviour are higher among prisoners than the general population. Rates are typically higher amongst female prisoners and remand prisoners.

Examples of common mental disorders, disabilities and impairments amongst offender populations include:

- Mental illnesses: schizophrenia, depression, bipolar disorder, delusional disorder, anxiety disorders and post-traumatic stress disorder (PTSD);
- Substance use disorders;
- Developmental disorders: intellectual disability or learning disability, autism and autistic spectrum disorder, attentional deficit hyperactivity disorder (ADHD), conduct disorders, personality disorders;
- Dementias;
- Acquired brain injury.

While there are few representative studies of the prevalence of mental disorder in the population of offenders awaiting sentence, research on prisoners and probation supervisees suggests that offenders are affected by a wide range of mental disorders, and some may be affected by more than one disorder (known as ‘comorbidity’).

Role of mental disorder at sentencing

The psychiatric literature makes clear that certain mental disorders are risk factors for offending, while others are not. Mental disorder is, however, just one factor amongst many that contributes to offending, and the interaction between mental disorder and other factors such as social deprivation, unemployment, homelessness and substance misuse is complex. It is therefore difficult to establish a direct causal connection between mental disorder and offending.

It is vital to stress the complexity of the relationship between mental disorders and offending. The evidence presented in this report indicates that a mental disorder does not necessarily mean that a person is dangerous, nor does it mean that a person's mental disorder caused them to offend. Only a small minority of individuals with mental disorder violently offend, even in groups with an elevated risk of offending.

The report identifies three areas where mental disorders may be especially relevant to proportionality and fairness. First, there may be equality considerations arising from a mental disorder. Second, a mental disorder may mean that a punishment will have a harsher impact or weigh more heavily on a person with a mental disorder. This may be something that a court is required to consider in terms of ensuring fairness and proportionality. It may also be something courts consider in terms of equality. Third, for sentencing purposes, culpability (i.e., the blameworthiness of the perpetrator or offender) is a key consideration.

For some mentally disordered offenders, certain disposals may be impractical (e.g., certain requirements of a community orders) for those with certain mental disorders. Even where a person's mental disorder means imprisonment is a suitable disposal type, the disorder may still affect the impact of the sentence. In some circumstances, the impact of a prison sentence could be so severe, or the conditions of detention so unsuitable, as to breach the person's right not to be subjected to inhuman treatment under Article 3 of the ECHR. At the lower end of the scale, the impact of the sentence may be taken into account in determining proportionate punishment and mitigation of sentence.

Ashworth and Player argue for a general sentencing principle of equal treatment, through which the sentencing court should avoid sanctions which may have an unequal impact on different offenders or groups of offenders. Mentally disordered offenders may find the experience of imprisonment significantly more aversive. One consequence is that there may be grounds for reducing the length of a custodial sentence where there is evidence that imprisonment will have an adverse effect on the offender's mental health.

Consequently, sentencing courts should consider mental disorders in determining the suitability of disposals and, for custodial disposals, the appropriate length of the sentence. However, the effect of this consideration will be highly contingent on the circumstances of the particular offence and offender. The sociolegal literature surveyed in this report makes clear that there are problems with requiring a direct causal connection between mental disorder and offending in order to establish reduced culpability at sentencing. This is because causal connections are difficult to establish on the basis of psychiatric evidence.

The Sentencing Council for England and Wales advises that at sentencing, courts must have regard both to any additional impact of a custodial sentence on the offender

because of an impairment or disorder, and to any personal mitigation to which their impairment or disorder is relevant. It advises that impact may ground a rehabilitative approach where an offender is on the cusp of a custodial sentence, and may warrant a shorter custodial sentence or suspended sentence if a custodial sentence is unavoidable. The guideline makes clear that a formal diagnosis of a mental disorder is not always necessary for the court to consider it a live issue in sentencing. In part, this reflects a pragmatic approach. Not all mental disorders will be diagnosed and, in some communities, under-diagnosis may be more prevalent creating greater potential for sentencing disparities.

Although the Scottish Sentencing Council has yet to develop a guideline on the subject, the Sentencing Council for England and Wales has issued a generic guideline for sentencing offenders with mental disorders, developmental disorders, or neurological impairments. In light of the similarities in court structures and options, the experience in England and Wales may provide a starting point or model for the Scottish Council to consider. Other promising models include the *Verdins* principles established by the Court of Appeal in Victoria, Australia.

Reports

The research reviewed raised questions about the timeliness and utility of psychiatric and pre-sentence reports relating to mental disorders. Psychiatric experts may be conflicted in their roles of advising the court and also treating the patient. Social workers and probation officers may lack the necessary expertise and training in mental health. Time and financial constraints also play a role, and these may have become more pressing as a result of the pandemic.

Reports are only available to defence lawyers on the day, thereby limiting opportunities to draw the courts attention to mitigating mental disorders. Liaison and Diversion services (now established across England) can ameliorate some of the difficulties of timeliness of psychiatric reports, where psychiatric reports are not mandated, in providing courts access to expert evidence. However, these services need sufficient expertise to identify and assess less obvious mental disorders beyond active psychosis, such as neurodevelopmental disorders.

The literature suggests that the current provision of information and advice with respect to mental disorder is insufficient. As a result, an as yet unknown proportion of offenders experiencing mental disorders are sentenced without the court having an adequate picture of the mental health dimension. In addition to more, and more systematic information, courts in Scotland may well benefit from greater guidance with respect to sentencing mentally disordered offenders.

Introduction

The complex task of sentencing becomes even more challenging if the offender suffers from a mental disorder. When such individuals appear for sentencing the court must consider a wider range of circumstances affecting the offender's level of culpability. In addition, the priority of sentencing objectives may change, and certain disposals become more appropriate. A sentencing court has a duty to consider evidence of mental disorder placed before it, and must weigh the relevance and value of this evidence. One leading mental health scholar and practitioner notes several reasons why mental disorders should affect the sentencing decision:[1]

- The offender is less culpable as a consequence of the mental disorder. Mental disorder is an important source of personal mitigation, one that is recognised in sentencing guidelines;
- Mentally disordered offenders often have greater difficulty adjusting to imprisonment, and a custodial sentence may therefore be more severe for these individuals;
- Imprisonment and possibly other sanctions may exacerbate existing mental disorders, thereby contributing to adverse health outcomes and possibly a greater chance of re-offending;
- A mitigated sentence may increase the likelihood and effectiveness of treatment;
- The sentencing objectives of general and specific deterrence, and denunciation may be less relevant when sentencing offenders suffering from mental disorders;
- Rehabilitation may become more important when sentencing mentally disordered offenders;
- Sentencing options which include treatment are generally more appropriate than sanctions which are purely or primarily punitive.

A number of jurisdictions now operate specialised ‘mental health courts’ which focus on addressing the causes of offending when a mental disorder has caused or contributed to the offending behaviour. Mental health courts are based on a ‘therapeutic jurisprudence’ approach to offending which “supports the application of the knowledge, specialised skills, and techniques of many professions to achieve a therapeutic experience”.[2] By treating the causes of offending, mental health courts also contribute to reducing re-offending through treatment. In jurisdictions like Scotland and England and Wales without such specialised mental health courts, sentencers must rely on the advice and guidance from a range of professionals at the sentencing hearing.

[1] These derive from the so-called ‘Verdins’ principles discussed later in this report. Schneider, R., 2020. 'Sentencing Mentally Disordered Offenders' in Cole, D. and Roberts, J.V. (eds.) *Sentencing in Canada. Essays in Law, Policy and Practice.* Toronto: Irwin Law.
[2] Schneider, R., 2020. (n1) at p. 280.

This research review addresses the sentencing of mentally disordered offenders. It is likely that many defendants appearing for sentencing have a mental disorder, and sentencing such individuals represents one of the most challenging areas of sentencing. A court must determine whether, and to what extent, the offender's mental disorder should be considered at sentencing. In some cases, mental disorder will have played a key role in the offence; in others it will be peripheral. Independent of the causal role of mental disorder with respect to the offence, it may affect the court's selection of sentence. For all offenders, courts rely on advice and information contained in professional reports. In the case of mentally disordered offenders these reports assume an even greater importance. The purpose of the review is to bring together the relevant literature in order to contribute to development of the Scottish Sentencing Council's mental health sentencing guideline.

Scope of review and methods of review

This report summarises existing academic, legal, and empirical research relevant to the sentencing of offenders with mental disorders. The literature search encompassed the literature on sentencing in a number of socio-legal domains over the period 2001-2021. The principal focus is upon Scotland and England and Wales, although we provide some limited comparisons with other common law jurisdictions. England and Wales is an important comparator jurisdiction for two reasons. First, the legal regime is broadly similar, albeit there are important differences with respects to some elements of mental health law. Second, in 2020, the Sentencing Council for England and Wales issued a stand-alone guideline on *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments*.[3] This is the first and only sentencing guideline on the issue in any jurisdiction; elsewhere guidance is provided only by the courts of appeal.

In this report, 'mental disorder' is used to refer to conditions that fall within the broad definition of mental disorder under section 328 of the Mental Health (Care and Treatment) Scotland Act 2003 (MH(CT)(S)A 2003):

"any—
(a) mental illness;
(b) personality disorder; or
(c) learning disability, however caused or manifested."

According to the legislative definition, "a person is not mentally disordered by reason only of any of the following—

(a) sexual orientation;
(b) sexual deviancy;
(c) transsexualism;

[3] Sentencing Council for England and Wales, 2020. *Guideline on Sentencing offenders with mental disorders, developmental disorders, or neurological impairments.*

(d) transvestism;
(e) dependence on, or use of, alcohol or drugs;
(f) behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person;
(g) acting as no prudent person would act."[4]

Specific mental disorders are referred to in this report by name where relevant. Examples of common mental disorders amongst offender populations include:

- Mental illnesses: schizophrenia, depression, bipolar disorder, delusional disorder, anxiety disorders and post-traumatic stress disorder (PTSD);
- Substance use disorders;[5]
- Developmental disorders: intellectual disability or learning disability, autism and autistic spectrum disorder, attentional deficit hyperactivity disorder (ADHD), conduct disorders, personality disorders;
- Dementias;
- Acquired brain injury.[6]

'Mental disorder' as defined by the legislation is a legal concept rather than a psychiatric or medical concept. It should be noted that the terminology used by sources cited in this report varies, and includes references to specific mental disorders as well as more general terms such as "impairment", "mental health condition", "mental health problem" or "severe mental illness". These terms should be interpreted as falling within the legal definition of mental disorder unless otherwise stated.

Contents of the volume

Chapter 1 summarises the recent literature documenting the prevalence of different mental disorders in the offender population. We draw upon research which compares the incidence of mental disorder among people proceeding through the courts as defendants and offenders to trends in the general population.

Chapter 2 explores the relevant statutory provisions and sentencing guidelines in Scotland and England and Wales. The latter jurisdiction is of particular interest because the Sentencing Council for England and Wales has issued a guideline to guide courts when sentencing offenders with mental disorders.

Chapter 3 summarises the legal defences available to defendants in both jurisdictions and identifies and compares the disposals used when sentencing offenders with mental disorders in Scotland and England and Wales.

[4] Section 328(2) of the MH(CT)(S)A 2003.
[5] These will only meet the legal definition of mental disorder where they amount to more than dependence on or use of alcohol or drugs, or where present in combination with another mental disorder.
[6] Sentencing Council for England and Wales, 2020. (n3).

Chapter 4 discusses the role of professional reports when sentencing offenders with mental disorders.*

* The authors are grateful to Professor Andrew Ashworth for his helpful comments on an earlier draft.

Chapter 1: The prevalence of mental disorders and the relationship to offending

This chapter examines the prevalence of mental disorders. It also explores links between mental disorders and certain types of offending. The objective is to provide an indication of how commonly courts will be required to pass a sentence upon someone with a mental disorder, and whether any particular disorders are risk factors for certain offences. This endeavour can inform where guidance may be most useful. The task is complicated by the fact that that there have been no large-scale studies of rates of mental disorder amongst offenders awaiting sentence in Scotland or in England and Wales. The best evidence is based on large-scale studies of *prisoner* populations. However, this data is not up to date and there is no guarantee that prisoners are representative of those sentenced by the courts. Some limited evidence is available regarding the prevalence of mental disorder amongst arrestees, defendants awaiting trial, and offenders on probation. As with the prisoner studies, this evidence should be interpreted with caution as it is not fully representative of the wider population who are sentenced.

In the general population, approximately one in six people have a mental health problem and "early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely."[7] Within the criminal justice system, "mental health problems are very common" and the evidence indicates that rates are much higher than in the general population.[8] According to HM Chief Inspector of Prisons for Scotland,

> "The most common types of severe and enduring mental health problems in Scottish prisons are schizophrenia and bi-polar affective disorder. There is also a significant number of prisoners with a personality disorder. The majority of prisoners with mental health problems also have substance misuse issues." [9]

Defendants before the courts may be affected by a wide range of mental disorders, disabilities and neurological conditions, and some may be affected by more than one disorder (known as 'comorbidity'). Not all mental disorders encountered by the courts

[7] Scottish Government, 2022. *Short Life Working Group for Mental Health in Primary Care: Report*, p. 14. Edinburgh: The Scottish Government. The impact of the Covid pandemic may have been particularly pronounced for those in prison due to the cancellation of visits, reduced access to mental health services and an increased sense isolation caused by greater time spent in cells. See Johnson, L., Gutridge, K., Parkes, J., Roy, A. and Plugge, E., 2021. Scoping review of mental health in prisons through the COVID-19 pandemic, *BMJ Open*, Volume 11, Issue 5; Hewson, T., Shepherd, A., Hard, J. and Shaw, J., 2020. Effects of the COVID-19 pandemic on the mental health of prisoners, *Lancet Psychiatry*, 7(7): 568–570.

[8] National Institute for Health and Care Excellence, 2017. *Mental Health of Adults in Contact with the Criminal Justice System*, para. 3.1.

[9] HM Chief Inspector of Prisons for Scotland, 2008. *Out of Sight - Severe and Enduring Mental Health Problems in Scotland's Prisons*, para. 3.81.3. Edinburgh: The Scottish Government.

will be severe, and not all may be relevant to sentencing. However, the Sentencing Council for England and Wales advises that "the fact that an offender has an impairment or disorder should always be considered by the court" and sentencing courts should take an individualised approach to assessing the impact of any disorder on sentencing.[10]

We now examine in more detail the rates of persons with mental disorders amongst offender populations with rates in the general population of England and Wales, before turning to examine the relationship between mental disorder and offending behaviour.

Statistics on incidence of mental disorder in offender populations

Mental health and the general population

According to the 2016 psychiatric morbidity survey for England and Wales, one adult in six (17%) had symptoms of depression or anxiety in the past week, assessed through clinical interview.[11] In the past year, just 0.7% experienced psychotic disorder;[12] 13.7% screened positive for personality disorder;[13] 0.8% were estimated to have an autism spectrum disorder; and 4.4% screened positive for PTSD; 6.7% reported having attempted suicide[14] and 7.3% reported having self-harmed at some point in their lives.[15] Similar findings have been reported in Scotland. In a survey of the Scottish population in 2019, 17% of all adults were estimated to have a possible psychiatric disorder;[16] 12% reported experiencing two or more symptoms of depression and 14% reported having two or more anxiety symptoms;[17] 7% of adults reported that they had attempted suicide[18] and 7% reported that they had self-harmed at some point in their lives.[19]

Research on Prisoners

The most comprehensive studies of the prevalence of mental health disorders amongst sentenced and remand prisoners are from England and Wales in the 1990s. Estimates of the prevalence of mental disorders in the prison population of England and Wales compared to the general population are provided in Table 1.

[10] Sentencing Council for England and Wales, 2020. (n3) at [2]-[3].
[11] McManus, S., Bebbington, P., Jenkins, R., Brugha, T. (eds.), 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, p. 10. Leeds: NHS Digital.
[12] McManus, S. et al., 2016. (n11) at p. 132.
[13] McManus, S. et al., 2016. (n11) at p. 175.
[14] McManus, S. et al., 2016. (n11) at p. 302.
[15] McManus, S. et al., 2016. (n11) at p. 303.
[16] Scottish Government, 2020. *The Scottish Health Survey 2019 edition. Volume 1: main report. A National Statistics Publication for Scotland*, p. 54. Edinburgh: The Scottish Government.
[17] Scottish Government, 2020. (n16) at p. 55.
[18] Scottish Government, 2020. (n16) at p. 56.
[19] Scottish Government, 2020. (n16) at p. 57.

Table 1
Prevalence Estimates: Prisoners and the Population, England and Wales[20]

	Prisoners	General population
Psychotic disorders	18%	1%
Learning disability	7%	2%
Traumatic brain injury	50%	<1%
Personality disorder	55%	12%
Anxiety	36%	7%
Mood disorders	25%	5%
PTSD	16%	2%

The international evidence suggests that rates of suicide, suicide attempts and self-harming behaviour are higher amongst prisoners than the general population. Rates are typically higher amongst female prisoners and remand prisoners. According to one study, in 24 high-income countries, rates of suicide for male prisoners were typically three times higher than in the general population. Rates amongst female prisoners were typically nine times higher.[21] According to another meta-analysis of international studies, while less than 1% of adults in the general population engage in self-harm each year, the estimated annual prevalence of self-harm is 5–6% amongst male prisoners and 20–24% amongst female prisoners.[22] According to a systematic review of the international evidence conducted in 2012, one in seven prisoners had major depression or psychosis.[23] The prevalence of ADHD amongst adult prisoners is estimated at 26% - significantly higher than the rate of 2.5% found in the general population.[24]

[20] Data is drawn from Tyler, N., Miles, H. L., Karadag, B., and Rogers, G., 2019. An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences, *Social Psychiatry and Psychiatric Epidemiology*, 54, 9, 1143-1152 and National Institute for Health and Care Excellence, 2019. *Mental health of adults in contact with the criminal justice system: NICE guideline [NG66]*.
[21] Fazel, S., Ramesh, T. and Hawton, K., 2017. Suicide in prisons: an international study of prevalence and contributory factors. The *Lancet Psychiatry*, 4(12): 946-952, p. 951.
[22] Favril, L., Yu, R., Hawton, K. and Fazel, S., 2020. Risk Factors for Self-Harm in Prison: a Systematic Review and Meta-Analysis, *The Lancet. Psychiatry*, 7(8): 682-691, p. 682.
[23] Fazel, S. and Seewald, K., 2012. Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *Br J Psychiatry*, 200(5): 364–73.
[24] Young, S. and Cocallis, K., 2021. ADHD and offending, *Journal of Neural Transmission*, 128: 1009–1019, p. 1009.

Rates of comorbidity between mental health disorders and substance misuse amongst prisoners are high.[25] Comorbidity increases the likelihood of repeat offending.[26] There are high levels of drug and alcohol misuse amongst people on probation compared to the general population.[27]

Mental disorders are believed to be prevalent within Scottish prisons: "It has been estimated that over 90% of prisoners have at least one of the following psychiatric disorders: psychosis; anxiety or depression; personality disorder; alcohol misuse; drug dependence."[28]

In Scottish prisons, severe and enduring mental health disorders are less common: it is estimated that people with severe mental disorders make up at least 4.5% of the prison population.[29] This figure is significantly higher than the expected prevalence in the general population.[30]

To conclude, the prevalence of mental disorders within prisons is significantly higher than in the general population and most of these mental disorders will have existed at the time the person was sentenced.

Defendants and arrestees

The evidence relating to prisoners sheds some light on the nature of the mental disorders that have come before the courts. Yet custodial sentences represent only 15% of sentences imposed for all convictions in Scotland.[31] We therefore know much less about the prevalence of mental disorders amongst those offenders who receive disposals other than custody.

Few recent studies are available on the prevalence of mental ill-health and disabilities amongst arrestees or defendants. However, the evidence points to a higher prevalence of mental health conditions and disabilities amongst these populations (compared to the general population). A study of 1,284 detainees in police custody conducted in London in 2014 found that 39% of the sample had a mental health

[25] Butler, T., Indig, D., Allnut, S., and Marmoon, H., 2011. Co-occurring mental illness and substance use disorder among Australian prisoners, *Drug and Alcohol Review*, 30: 188-94.
[26] Chang, Z., Lichtenstein, P., Larsson, H., Fazel, S., 2015. Substance use disorders, psychiatric disorders, and mortality after release from prison: a nationwide longitudinal cohort study, *The Lancet Psychiatry*, 2(5): 422-30.
[27] Brooker, C., Sirdifield, C, Blizard, R., Denney, D. and Pluck, G., 2012. Probation and mental illness, *Journal of Forensic Psychiatry & Psychology*, 23(4): 522-537.
[28] National Institute for Health and Care Excellence, 2017. (n8) at para. 3.1.
[29] HM Chief Inspector of Prisons for Scotland, 2008. (n9) at para. 3.45. This figure excludes Polmont (a facility for young offenders).
[30] HM Chief Inspector of Prisons for Scotland, 2008. (n9) at para. 3.81.3.
[31] Scottish Government, 2021. *Criminal Proceedings in Scotland, 2019-20*. Edinburgh: The Scottish Government.

condition.[32] This compares to about 20% of the general population. Eight percent of the sample had psychotic disorders and between five and eight percent had major depression.[33] In a separate study, 3% of detainees in West Yorkshire police stations and 7% in police stations in London screened positive for intellectual disability.[34] A study published in 1999 screened 229 defendants attending Manchester magistrates' court from the community and 1,689 attending from overnight custody. It found relatively low rates of mental disorder amongst those attending court from the community, at 1.3%. Rates were significantly higher amongst defendants held overnight in custody, at 6.6%.[35] The most common diagnoses amongst those with serious mental disorder in the overnight custody sample were depressive disorder (56%) and schizophrenia or other psychoses (34%).[36]

Probation supervisees

No large-scale studies have been conducted into the prevalence of mental ill-health amongst probationers in the UK. One study of 173 randomly sampled supervisees in Lincolnshire found a high prevalence of mental disorder.[37] The study estimated that 17.3% of the sample was experiencing a major depressive episode, 2.3% were experiencing either a manic or hypomanic episode, 11% had a current psychotic disorder, and 4.6% were experiencing post-traumatic stress disorder.[38] The most common disorder was probable personality disorder, affecting 47% of the sample.[39] These rates are slightly lower than those recorded in the prison population but significantly higher than the general population of England and Wales (see Table 1). The prevalence of past or lifetime mental illness amongst offenders under supervision in Lincolnshire was also high. The study estimated that 41.6% of the sample had experienced a major depressive episode in the past, and 24.3% had recurrent depression. Approximately 11% had previously experienced a manic or hypomanic episode in the past, and 18.5% had a lifetime psychotic disorder.[40]

[32] McKinnon, I., Thomas, S., Noga, H. and Senior, J., 2016. Police custody health care: a review of health morbidity, models of care and innovations within police custody in the UK, with international comparisons, *Risk Management and Healthcare Policy*, 9: 213-226, pp. 217-218.
[33] McKinnon, I. et al., 2016. (n32) at p. 218.
[34] McKinnon, I. et al., 2016. (n32) at p. 217.
[35] Shaw, J., Creed, F., Price, J., Huxley, P., and Tomenson, B., 1999. Prevalence and detection of serious psychiatric disorder in defendants attending court, *The Lancet*, 353, 1053–1056, Table 2.
[36] Shaw, J. et al., 1999, p. 1055. Percentages have been calculated based on the data in the article: 99 individuals screened positive for mental disorder, of whom 34 had schizophrenia or other psychoses and 55 had depressive disorder.
[37] Brooker, C., Sirdifield, C, Blizard, R., Denney, D. and Pluck, G., 2012. Probation and mental illness, *Journal of Forensic Psychiatry & Psychology*, 23:4, 522-537.
[38] Brooker et al., 2012. (n37) at p. 529.
[39] Brooker et al., 2012. (n37) at p .529.
[40] Brooker et al., 2012. (n37) at p. 529.

Young offenders

More than a third of children in custody in England and Wales have a diagnosed mental health condition.[41] According to the Youth Justice Board, 71% of sentenced children in England and Wales in 2018-2019 had mental health needs and 71% had communication issues.[42]

Female offenders

Offending by women is often related to their life circumstances, including addiction, poverty and social deprivation, mental health problems, and experiencing physical, mental or sexual abuse.[43] Indeed, in 2007 the Corston Report called for a "woman-centred approach"[44] and there have been other reports and policy strategies aiming to address female offenders.[45] Moreover, and perhaps related to issues of domestic abuse, women in prisons may be more likely to suffer from head injuries as well as PTSD. Evidence suggests a high prevalence of head injuries among women in prisons, and this *may* be a risk factor for some offending behaviours.[46] Consequently, female offenders with certain mental disorders and histories may have complex needs that are different from those of typical male offenders.[47]

The distinct needs of female offenders was recognised by the Independent Forensic Mental Health Review which found differences in the needs of women with mental disorders and the availability of service provision. For example, Scotland has no high security facility for women with mental disorders and those with such needs are transferred to Nottinghamshire. The review found this inadequate for high needs women who are on remand or have outstanding charges and noted human rights concerns.[48]

Therefore, sentencing female offenders may pose different considerations in light of distinct needs, offending behaviours, and service availability of women with mental disorders. However, until there is a large-scale study specifically examining how female offenders with mental disorders are sentenced, gaps in the evidence base will persist.

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[41] Taylor, C., 2016. *Review of the Youth Justice System in England and Wales*, p. 2. London: Ministry of Justice.
[42] Youth Justice Board and Ministry of Justice, 2020. *Assessing the needs of sentenced children in the Youth Justice System 2018/19: England and Wales*. London: Ministry of Justice.
[43] Mallock, M. and McIvor, G., 2011. Women and community sentences, *Criminology & Criminal Justice*, 11(4): 325-344.
[44] Corston, J., 2007. *The Corston Report: The Need for a Distinct, Radically Different, Visibly-Led, Strategic, Proportionate, Holistic, Woman-Centred, Integrated Approach*. London: Home Office.
[45] For example, the Angiolini Commission on Women Offenders.
[46] McMillan, T., Aslam, H., Crowe, E., Seddon, E. and Barry, S., 2021. Associations between significant head injury and persisting disability and violent crime in women in prison in Scotland, UK: a cross-sectional study, *The Lancet Psychiatry*, 8(6): 512-520.
[47] NHS Scotland Forensic Network, 2019. *Women's Service and Pathways across the Forensic Mental Health Estate*, p. 2.
[48] Scottish Government, 2021. *Independent Forensic Mental Health Review: What we think should happen. Final Report*. Edinburgh: The Scottish Government.

The relationship between mental disorder and offending

Rates of mental disorder are high amongst prisoners and others in the criminal justice system when compared to the general population. It is not clear, however, whether this is because people with a mental disorder are more likely to commit or be convicted of crimes, or whether criminal justice processes provoke or exacerbate mental disorder. This section examines the evidence for a relationship between mental disorder and offending, with a specific focus on violent offending.

The relationship between mental disorder and violence

It is difficult to establish a causal connection between mental disorder and offending due to the presence of confounding factors, particularly substance abuse and comorbid mental disorders. Mental disorder is one factor amongst many that contributes to offending, and the interaction between mental disorder and other factors such as social deprivation, unemployment, homelessness and substance misuse is complex. While mental disorder is feared and stigmatised, the evidence indicates that "most people with mental disabilities are not violent, and most violence is not committed by people with mental disabilities."[49]

A recent meta-analysis estimated that 5% of people diagnosed with mental illness (excluding those with personality disorders, schizophrenia and substance misuse) committed a violent crime over a 5–10 year period.[50] For those diagnosed with personality disorders and schizophrenia spectrum disorders, the rate increased to 6–10%.[51] In men and women diagnosed with bipolar disorder, the rates are 8% and 2% respectively. For those diagnosed with substance misuse disorders, the rate was more than 10%.[52] By comparison, general population rates were estimated to be between 0.6% and 0.9% over a 10 year period.[53] Nevertheless, the majority of those who commit violent crimes do not have a mental disorder. Thus, putting these figures into perspective, 11% of people convicted of homicide in the UK (excluding Northern Ireland) between 2008 and 2018 were mental health patients.[54]

The relationship between mental disorder and offending is explored in further detail below with respect to distinct mental disorders. While some mental disorders are

[49] Peay, J., 2017. 'Mental Health, Mental Disabilities, and Crime' in *The Oxford Handbook of Criminology*, Liebling, A., Maruna, S., and McAra, L. (eds.), p. 646. Oxford: Oxford University Press.
[50] Whiting, D., Lichtenstein, P., and Fazel, S., 2021. Violence and mental disorders: A structured review of associations by individual diagnoses, risk factors, and risk assessment, *The Lancet Psychiatry*, 8(2), 150-161, p. 150.
[51] Whiting, D. et al., 2021. (n50) at p. 150.
[52] Whiting, D. et al., 2021. (n50) at p. 150.
[53] Sariaslan, A., Arseneault, L., Larsson, H., Lichtenstein, P., Fazel, S., 2020 Risk of Subjection to Violence and Perpetration of Violence in Persons With Psychiatric Disorders in Sweden, *JAMA Psychiatry*. 77(4):359–367, at p.363. These figures are based on studies of the Swedish population. Rates of violent offending and psychiatric morbidity in Sweden are similar to rates in other high-income countries. See further Whiting, D. et al., 2021. (n50) at p.150.
[54] National Confidential Inquiry into Suicide and Safety in Mental Health, 2021. *Annual report 2021: England, Northern Ireland, Scotland and Wales*, p. 35. Manchester: University of Manchester.

associated with an elevated risk of violent offending, alcohol and drug abuse are stronger predictors of criminal conduct than most mental disorders. In addition, those diagnosed with mental disorders who misuse drugs or alcohol are at a higher risk of offending compared to those who do not.

Schizophrenia

A study conducted in Victoria, Australia comparing a community control group to a group diagnosed with schizophrenia found that individuals diagnosed with schizophrenia were 4.57 times more likely than controls to have been found guilty of a criminal offence.[55] This ratio reduced to 3.11 once age, gender and substance use disorders were controlled for. This suggests that schizophrenia is a risk factor for violent offending. Studies have found that comorbid substance misuse in people diagnosed with schizophrenia typically doubles their risk of violent offending.[56] In the study conducted in Victoria, it was found that schizophrenia patients overall were 4.57 times more likely to commit a violent crime and 2.5 more likely to commit a non-violent crime than community controls. By comparison, those who were diagnosed with schizophrenia who did not have a substance-use disorder were 2.5 times more likely than a community sample to be convicted of a violent crime.[57] Patients with a history of offending and comorbid schizophrenia and substance misuse were almost 14 times more likely to commit violent crime than community controls.

The study cautions that increased rates of offending amongst individuals diagnosed with schizophrenia does not demonstrate that mental disorder causes offending. Rather, where an association has been found, mental disorders, such as schizophrenia, should be considered as risk factors that, if present, increase the risk of offending. Other risk factors, including psychopathy, a history of violence, and male gender, are more closely associated with violence than schizophrenia.[58]

Bipolar disorder

A longitudinal study of 3,743 individuals with bipolar disorder in Sweden concluded that there was an increased risk of violent crime amongst individuals diagnosed with bipolar disorder.[59] 8.4% of the sample with bipolar disorder committed a violent crime in the study period, compared to 3.5% of general population controls.[60] However, patients with bipolar disorder who did not have comorbid substance misuse were just 1.3 times more likely than controls to commit violent crime, compared to 6.4 times for

[55] Short, T., Thomas, S., Mullen, P. and Ogloff, J., 2013. Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls, *Acta Psychiatrica Scandinavica*, 128(4): 306–313, p. 309.
[56] Whiting, D. et al., 2021. (n50) at p. 151.
[57] Short, T. et al., 2013. (n55).
[58] Short, T. et al., 2013. (n55) at p. 312.
[59] Fazel, S., Lichtenstein, P., Grann, M., Goodwin, G. M., and Långström, N., 2010. Bipolar disorder and violent crime: new evidence from population-based longitudinal studies and systematic review, *Archives of General Psychiatry*, 67(9): 931-8, p. 931.
[60] Fazel, S. et al., 2010. (n59) at p. 936.

those with comorbid substance misuse.[61] The severity or type of bipolar disorder (i.e., manic or depressive episode) were not associated with a violent crime risk increase – rather, the authors concluded that the relationship between bipolar disorder and violent crime was largely mediated by comorbid substance misuse.[62]
Thus, it appears from the evidence that, for individuals without comorbid substance misuse, schizophrenia is a stronger predictor of violence than bipolar disorder. However, the increases in risk for both disorders are small when compared to the 6-7 fold increase in violence risk associated with substance misuse alone.[63]

ADHD

Individuals diagnosed with ADHD are more likely to have contact with police and are at an increased risk of conviction and imprisonment than peers without ADHD.[64] The relationship between ADHD and offending is not straightforward, however, due to high comorbidity with other disorders associated with offending amongst offenders diagnosed with ADHD. These disorders include oppositional defiant disorder, conduct disorder, antisocial personality disorder and substance use disorder.[65] Studies have found that "the association between ADHD symptoms and criminality are reduced or no longer present after adjusting for lifetime substance use disorders".[66] Thus, a diagnosis of ADHD alone is not a significant risk factor for offending.

Traumatic brain injury

There is evidence that traumatic brain injury (TBI) impairs cognitive function, memory, social communication, and the regulation of emotions and behaviour.[67] These impairments can affect judgment and self-control, thereby increasing risk of offending.[68] International evidence has linked TBI to violent and criminal behaviour, including increased risk of impulsive aggression.[69] A Finnish study involving more than 12,000 subjects found that a traumatic brain injury in childhood or adolescence was associated with a four-fold increased risk of developing later mental disorder and offending in men (aged 31).[70] A meta-analyses of population studies that controlled for confounding factors (including substance misuse) concluded that TBI is an

[61] Fazel, S. et al., 2010. (n59) at p. 936.
[62] Fazel, S. et al., 2010. (n59).
[63] Fazel, S. et al., 2010. (n59) at p. 936.
[64] Young, S. and Cocallis, K., 2021. (n24) at p. 1010.
[65] Young, S. and Cocallis, K., 2021. (n24) at p. 1010.
[66] Young, S. and Cocallis, K., 2021. (n24) at p. 1011.
[67] Kent, H. and Williams, H., 2021. *Traumatic Brain Injury*. HM Inspectorate of Probation: Academic Insights 2021/09, p. 5. Manchester: Her Majesty's Inspectorate of Probation.
[68] McMillan, T. et al., 2021. (n46).
[69] Williams, W. H., Chitsabesan, P., Fazel, S., McMillan, T., Hughes, N., Parsonage, M., and Tonks, J., 2018. Traumatic brain injury: a potential cause of violent crime?, *The Lancet Psychiatry* 5(10): 836-844; Williams, W. H., Mewse, A. J., Tonks, J., Mills, S., Burgess, C. N. W., and Cordan, G., 2010. Traumatic brain injury in a prison population: Prevalence and risk for re-offending, *Brain Injury*, 24(10): 1184–1188, pp. 1184-1185.
[70] Timonen, M., Miettunen, J., Hakko, H., Zitting, P., Veijola, J., von Wendt, L. and Räsänen, P., 2002. The association of preceding traumatic brain injury with mental disorders, alcoholism and criminality: The Northern Finland 1966 birth cohort study, *Psychiatry Research*, 113(3): 217–226.

independent risk factor for crime.[71] One population study based on Swedish subjects found that people with TBI were 3.3 times more likely than controls to commit a violent offence. After controlling for age, gender, socio-demographic confounders and substance misuse, the TBI group were 2.3 times more likely to commit a violent offence than controls. [72] In a UK study of 200 adult male prisoners, 60% reported having experienced a TBI. Those who reported having a TBI entered custody at a younger age and reported higher levels of reoffending than those who had not experienced a TBI.[73]

A study of women prisoners in Scotland found high rates of traumatic brain injury: 78% of a sample of 109 prisoners had a significant head injury, and 40% of these women had a disability associated with their injury.[74] The study found a strong association between severe head injury and violent offending (but not other crimes), and there was high multimorbidity in women with a history of severe head injury, particularly of substance abuse and PTSD.[75]

Autism and learning disabilities

Some literature has suggested that deficits associated with autism spectrum disorder (ASD) may contribute to offending. This literature posits that challenging behaviours, increased social naiveté and vulnerability to manipulation, disruption to routines, over-rigid adherence to rules, a lack of understanding of social skills may lead people with ASD to become aggressive.[76] Conversely, it has been argued that a tendency to adhere to rules in people with ASD may mean they are at low risk of offending.[77]

Recent studies demonstrate that there is little evidence that individuals with a diagnosis of autism who do not have comorbid ADHD or conduct disorder are at increased risk of violent offending.[78] A meta-analysis found that people diagnosed with autism spectrum disorder committed the same number of, or fewer, offences than controls who were not diagnosed with autism spectrum disorder.[79] This suggests that

[71] Williams, W. H. et al., 2018. (n69).
[72] Fazel, S., Grann, M., Langstrom, N., and Lichtenstein, P., 2011. Risk of violent crime in individuals with epilepsy and traumatic brain injury: A 35-year Swedish population study, *PLOS Medicine*, 8, 12. On page 1 of the study, committing violent crime is defined as having "convictions for homicide, assault, robbery, arson, any sexual offense, or illegal threats or intimidation".
[73] Williams, H. W. et al., 2010. (n69).
[74] McMillan, T. et al., 2021. (n46).
[75] McMillan, T. et al., 2021. (n46) at p. 518.
[76] King, C. and Murphy, G. H., 2014. A systematic review of people with autism spectrum disorder and the criminal justice system, *Journal of Autism and Developmental Disorders*, 44(11): 2717-33, pp. 2717-2718.
[77] King, C. and Murphy, G. H., 2014. (n76) at pp. 2717-2718.
[78] Heeramun, R., Magnusson, C., Hellner Gumpert, C., Granath, S., Lundberg, M., Dalman, C. and Rai, D., 2017. Autism and Convictions for Violent Crimes: Population-Based Cohort Study in Sweden, *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(6): 491–497, p. 494.
[79] King, C. and Murphy, G. H., 2014. (n76). See also Browning, A., and Caulfield, L., 2011. The prevalence and treatment of people with Asperger's Syndrome in the criminal justice system, *Criminology & Criminal Justice*, 11(2): 165-180.

individuals with autism spectrum disorder are not at a higher risk of offending than the general population. Individuals diagnosed with both autism *and* ADHD or conduct disorder were at an increased risk of violent offending.[80] There is evidence that individuals with autism receive less favourable outcomes in the criminal justice system than individuals without autism, including longer sentences.[81] This may be due to communication behaviours associated with autism.[82]

Personality disorder

A meta-analysis has shown that personality disorders are associated with a three times higher risk of violence compared to the general population. This is similar to the risk of violence in people with schizophrenia, bipolar disorder and acquired brain injury. Offenders diagnosed with any personality disorder had two to three times higher odds of repeat offending than offenders without personality disorder. The association is most pronounced between violence and antisocial personality disorder. In one review, 14% of individuals diagnosed with antisocial personality disorder were violent, representing a 12.8 times higher odds of violent offending amongst individuals with antisocial personality disorder compared to the general population. However, the study reported a similar odds of violence amongst drug and alcohol abusers.[83]

As antisocial personality disorder incorporates past offending behaviour into its diagnostic criteria, the association between antisocial behaviour and violence may be merely 'trivial' or descriptive.[84] As is the case with other mental disorders, causality between personality disorder and violence is difficult to establish due to the multiplicity of confounding factors affecting personality disordered offenders. These include comorbid substance abuse disorders, mental illnesses and post-traumatic stress disorder (PTSD).[85]

Post-traumatic stress disorder

There is a lack of representative population studies of the relationship between violence and PTSD. Those studies that do exist are based on small convenience

[80] Heeramun, R. et al., 2017. (n78) at p. 494.
[81] Foster, T.R. and Young, R.L., 2021. Brief Report: Sentencing Outcomes for Offenders on the Autism
Spectrum. *Journal of Autism and Developmental Disorders*. Online first. https://doi.org/10.1007/s10803-021-05212-4.
[82] Foster, T.R. and Young, R.L., 2021. (n81).

[83] Yu, R., Geddes, J. R., and Fazel, S., 2012. Personality disorders, violence, and antisocial behavior: a systematic review and meta-regression analysis, *Journal of personality disorders*, 26(5): 775-792, p. 784.
[84] Howard, R., 2006. How is Personality Disorder Linked to Dangerousness? A Putative Role for Early-onset Alcohol Abuse, *Medical Hypotheses*, 67, 702–708; Howard, R., 2015. Personality Disorders and Violence: What is the Link? *Borderline Personality Disorder and Emotion Dysregulation*, 2(12).
[85] Duggan, C. and Howard, R., 2009. 'The 'Functional Link' Between Personality Disorder and Violence: A Critical Appraisal' in McMurran, M. and Howard, R. (eds.) *Personality, Personality Disorder and Violence: An Evidence-Based Approach*. Chichester: John Wiley and Sons.

samples and self-report measures.[86] There is therefore insufficient quality evidence on the relationship between PTSD and offending.

One area where PTSD may be relevant is with regard to female offenders. Violence against women and girls is a recognised issue in Scotland. Such violence, including domestic abuse, can be a risk factor for PTSD.[87] Thus, victimisation can lead to the development of PTSD. Indeed, as we will discuss in Chapter 3, the defence of diminished responsibility has been used in cases where women have killed their abusive partner and suffer from PTSD.[88]

Conclusion

While there are no recent or large-scale studies of mental disorder amongst defendants in sentencing courts, there is clear evidence that the prevalence of mental disorders is higher amongst offender populations than amongst the general population. It is also clear that certain mental disorders, particularly personality disorders, traumatic brain injuries and schizophrenia, are associated with an elevated risk of offending. As a result, rates of mental disorder are likely to be higher amongst defendants dealt with by Scottish sentencing courts than in the general population.

It is vital to stress the complexity of the relationship between mental disorders and offending. The evidence presented here is based on populations and caution should be exercised when making judgments about an individual's risk of offending. The presence of a mental disorder does not necessarily mean that a person is dangerous, nor does it mean that a person's mental disorder caused them to offend. As the studies surveyed here demonstrate, only a small minority of individuals with mental disorder violently offend, even in groups with an elevated risk of offending.

It should also be noted that high levels of comorbidity of mental disorders, particularly with substance misuse disorders, can make it difficult to determine the relationship between mental disorder and offending in individual cases. Mental disorders should therefore be considered as risk factors for offending, and sentencing should take into account individual histories in the assessment of risk and culpability.

The next chapter of this report considers the relevance of mental disorder to sentencing.

[86] See for example: Barrett, E.L., Mills, K.L., and Teesson, M., 2011. Hurt people who hurt people: Violence amongst individuals with comorbid substance use disorder and post-traumatic stress disorder, *Addictive Behaviors*, 36: 721–728; Karatzias, T., Power, K., Woolston, C., Apurva, P., Begley, A., Mirza, K., Conway, L., Quinn, C., Jowett, S., Howard, R., and Purdie, A., 2018. Multiple traumatic experiences, post-traumatic stress disorder and offending behaviour in female prisoners, *Criminal Behaviour and Mental Health*, 28(1): 72-84.

[87] Dutton, M. A., Green, B. L., Kaltman, S. I., Roesch, D. M., Zeffiro, T. A. and Krause, E. D., 2006. Intimate partner violence, PTSD, and adverse health outcomes, *Journal of Interpersonal Violence*, 21(7): 955-68.

[88] See: McPherson, R., 2019. Battered Woman Syndrome, Diminished Responsibility and Women Who Kill: Insights from Scottish Case Law, *Journal of Criminal Law*, 83(5): 381-393.

Chapter 2: How do mental disorders interact with sentencing principles?

We now examine the bearing a mental disorder may have on the sentencing process. At the outset, it should be reiterated that the term "mental disorder" is used to refer to a wide range of neurodiversity among those sentenced for offences.[89] As mental disorders are diverse, different disorders can impact the sentencing processes in a variety of ways. Here, the focus will be on sentencing those who have been convicted of an offence.[90] In some cases it will be necessary for the court to make a mental health disposal. The criteria for making these orders and their effects are discussed in more detail in Chapter 3.

This chapter focuses on two distinct groups of offenders. The first group are those who fulfil the criteria for a mental health disposal. It should be noted that where a person meets the criteria for a mental health disposal, courts are not obliged to make such a disposal. Rather, judges sentencing these offenders have a wider range of disposals from which to choose. The second group are those who have a mental disorder but who do not fulfil the criteria for a mental health disposal. The second set of cases may be expected to be more common than the first, given that severe mental disorders are rarer in offending populations than mild to moderate mental ill-health or disability (see Chapter 1). Some, but not all, of those in the second set may be eligible for a community payback order with a mental health treatment requirement attached.[91] In these instances, a person will be convicted and sentenced in the normal manner, but the judge may take the presence of a mental disorder into account when determining sentence or mitigation of penalties.

At sentencing, the judge will determine what effect, if any, the mental disorder should have on a sentence. In making this decision it is imperative for the judge to relate the effects of the mental disorder to the principles that underpin sentencing. We explore how these sentencing principles may interact with mental disorders below. In doing so, we will also examine the guidance in other jurisdictions.

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[89] Note that for the purposes of the Criminal Procedure (Scotland) Act 1995 (by virtue of section 305), "mental disorder" has the same meaning given in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

[90] Note that a person with a mental disorder may be found to lack criminal responsibility entirely, either through denial of the actus reus and/or mens rea of the offence, or due to a finding that the individual lacks criminal responsibility by virtue of mental disorder under section 51A of the Criminal Procedure (Scotland) Act 1995. These issues will be discussed in Chapter 3. See further: Chalmers, J., 2009. Section 11 7 of the Criminal Justice and Licensing (Scotland) Bill: A Dangerous Loophole? Scottish Criminal Law, 2009, 1240-1242. This chapter will not deal with those found unfit for trial or those found to lack criminal responsibility by virtue of a mental disorder under section 51A of the Criminal Procedure (Scotland) Act 1995. Those convicted of culpable homicide after a successful plea of diminished responsibility are included in the analysis.

[91] This is because the mental health criteria for making such an order are less stringent than for making a mental health disposal, such as a compulsion order. See further Chapter 3.

General principles relevant to sentencing those with mental disorders

In Scotland, fairness and proportionality are an essential component of sentencing.[92] The same is true for other jurisdictions. For example, in England and Wales the importance of proportionality at sentencing is reflected in both Chapter 3 of the Sentencing Act 2020[93] and guidelines issued by the Sentencing Council for England and Wales. Where a person has a mental disorder, it may have a bearing when considering what is a fair and proportionate sentence. A detailed discussion of proportionality and fairness is beyond our present scope. However, we can highlight three areas where mental disorders may be especially relevant to proportionality and fairness. We can also highlight how mental disorders may interact with consequentialist objectives of sentencing.

First, there may be equality considerations arising from a mental disorder. Second, a mental disorder may mean that a punishment will have a harsher impact or weigh more heavily on a person with a mental disorder. This may be something that a court is required to consider in terms of ensuring fairness and proportionality. It may also be something courts consider in terms of equality. Third, for sentencing purposes, culpability (i.e., the blameworthiness of the perpetrator or offender) is a key consideration. Finally, sentencing in Scotland has a number of consequentialist objectives: including rehabilitation and desistance. These principles will be considered in turn.

Equality

Rights are always an important consideration in the Scottish criminal justice system. There is a vast body of law relevant to rights that cannot be fully detailed here: for example, the Human Rights Act 1998, the Scotland Act 1998, and the Equality Act 2010.[94] All public authorities (including courts and tribunals) in Scotland must act in a way that respects the European Convention on Human Rights (ECHR).[95]

It is necessary to ensure those with mental disorders are treated fairly and not discriminated against. Indeed, “mentally disordered offenders, although they sometimes may have committed serious criminal offences, may often be very vulnerable, and additional vigilance in protecting their rights is necessary.”[96] Rights

[92] Scottish Sentencing Council, 2018. *Sentencing Guideline: Principles and Purposes of Sentencing*. The same is true of England and Wales is reflected in both the Sentencing Act 2020 Chapter 3 (replacing the Criminal Justice Act 2003 s.143(1)) and guidelines issued by the Sentencing Council for England and Wales.
[93] Replacing the Criminal Justice Act 2003 s.143(1).
[94] Notably disability is a protected characteristic and mental disorders may fall within this. See Equality Act 2010, section 6(1) and Schedule 1. See also the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.
[95] Patrick, H. and Stavert, J., 2016. *Mental Health, Incapacity and the Law in Scotland*, second edition, chapter 1. Haywards Heath: Bloomsbury Professional. This duty was found to have been violated by a sentencing court in *Price v United Kingdom* (2002) 34 E.H.R.R. 53.
[96] Patrick, H. and Stavert, J., 2016. (n95) at chapter 45.2.

will be discussed where appropriate going forward. However, here we note two key points.

First, the existence of separate disposals for individuals who have a mental disorder, under which the person can be treated without their consent, is arguably discriminatory. As people without these disabilities cannot be given medical or psychiatric treatment without their consent, detention and compulsory treatment powers under mental health legislation give rise to unequal treatment of people with disabilities. This is permitted under the ECHR, which allows detention on the grounds of unsoundness of mind under Article 5.1(e)[97] and allows treatment without consent where this is deemed a therapeutic necessity.[98] This means that the ECHR is out of step with Article 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD), which states that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life". While the UN CRPD is not directly enforceable in UK courts, the UK is a signatory and has therefore agreed to protect and promote the rights contained in the UNCRPD.

Second, it is important to note that mental disorders are not evenly distributed among the population, and that certain groups are disproportionately likely to be subject to mental health legislation. In Scotland, people from a disadvantaged or ethnic minority background are more likely to be detained under mental health legislation than the general population.[99]

The Sentencing Council for England and Wales guideline advises that:

> "It is important that courts are aware of relevant cultural, ethnicity and gender considerations of offenders within a mental health context. BAME communities may be more likely to experience stigma attached to being labelled as having a mental health concern, may be more likely to have experienced difficulty in accessing mental health services and in acknowledging a disorder and seeking help, may be more likely to enter the mental health services via the courts or the police rather than primary care and are more likely to be treated under a section of the [Mental Health Act]."[100]

Similar issues may arise in Scotland[101] and if factors such as the above are not considered, then there could be a greater risk of inequality at sentencing related to mental disorders. Indeed, as will be seen below, while generalisations in terms of

[97] *Winterwerp v Netherlands* [1979] ECHR 4.
[98] *Herczegfalvy v Austria* (1992) 15 EHRR 437.
[99] Mental Welfare Commission for Scotland, 2021. *Mental Health Act Monitoring Report 2020-21: Statistical Monitoring*. Edinburgh: Mental Welfare Commission for Scotland.
[100] Sentencing Council for England and Wales, 2020. (n3) at [5].
[101] Mental Welfare Commission for Scotland, 2021*. Racial Inequality and Mental Health in Scotland*. Edinburgh: Mental Welfare Commission for Scotland.

sentence ranges for the diverse cases concerning mental health would be difficult, a possible strength of guidelines could be in supporting fairness and equality.

The relationship between mental ill-health and the impact of punishment

Attention should be given at sentencing to the nature of the mental disorder and how this may affect the available disposals and their impacts. There will be cases where some disposals may be impractical (e.g., certain requirements of a community orders) for those with certain mental disorders. Even where a person's mental disorder means imprisonment is a suitable disposal type, the disorder may still affect the impact of the sentence. In some circumstances, the impact of a prison sentence could be so severe, or the conditions of detention so unsuitable, as to breach the person's right not to be subjected to inhuman treatment under Article 3 of the ECHR. At the lower end of the scale, the impact of the sentence may be taken into account in determining proportionate punishment and mitigation of sentence.

Ashworth and Player argue for a general sentencing principle of "equal treatment", through which "a sentencing system should strive to avoid its punishments having an unequal impact on different offenders or groups of offenders".[102] They recognise that "many mentally disordered offenders may find the experience of imprisonment significantly more painful than others." [103] They further argue that there are grounds for reducing the length of a custodial sentence where there is evidence that imprisonment has a deleterious impact on the person's condition.

There is ample evidence that prison can "exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide".[104] A prison sentence may therefore subject an offender with a mental disorder to a greater degree of hardship. A study of the relationship between imported vulnerabilities and the prison environment in England and Wales[105] found that levels of mental distress were at their highest amongst all groups in the first week of custody, but that psychiatric symptoms amongst male and convicted prisoners declined significantly over time. There was, however, no decline amongst female or remand prisoners.[106] Symptoms decreased over time amongst prisoners with major depressive disorder but not amongst prisoners with other mental disorders.[107] Symptoms persisted or were exacerbated amongst a small group of prisoners with mental disorders.[108] This study suggests that female

[102] Ashworth, A. and Player, E., 1998. 'Sentencing, Equal Treatment and Impact of Sanctions' in Ashworth, A. and Wasik, M. (eds.) *Fundamentals of Sentencing Theory: Essays in Honour of Andrew Von Hirsch*. Oxford: Clarendon Press, p. 255.
[103] Ashworth, A. and Player, E., 1998. (n102) at p. 255.
[104] Bradley, K. J. C., 2009. *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. London: Department of Health.
[105] Hassan, L., Birmingham, L., Harty, M. A., Jones, P., Jarrett, M., Jones, P., King, C., Lathlean, J., Lowthian, C., Mills, A., Senior, J., Thornicroft, G., Webb, R. and Shaw, J., 2011. Prospective cohort study of mental health during imprisonment, *The British Journal of Psychiatry*, 198(1): 37–42.
[106] Hassan, L. et al., 2011. (n105) at pp. 40-41.
[107] Hassan, L. et al., 2011. (n105) at pp. 40-41.
[108] Hassan, L. et al., 2011. (n105) at pp. 40-41.

prisoners, remand prisoners and those with pre-existing mental disorders are particularly vulnerable to mental distress in prison and are slower to recover, and that spending further time in prison can exacerbate symptoms for some prisoners.[109]

Consequently, sentencing courts should consider mental disorders in determining the suitability of disposals and, for custodial disposals, the appropriate length of the sentence. However, the effect of this consideration will be highly contingent on the circumstances of the particular offence and offender. The Sentencing Council for England and Wales advises that sentencing courts "must have regard both to any additional impact of a custodial sentence on the offender because of an impairment or disorder, and to any personal mitigation to which their impairment or disorder is relevant"; it advises that impact may ground a rehabilitative approach where an offender is on the cusp of a custodial sentence, and may warrant a shorter custodial sentence or suspended sentence where a custodial sentence is "unavoidable".[110]

In some situations, a mental disorder may mean that what would be an acceptable sentence for many could amount to inhuman or degrading treatment under Article 3. In such an eventuality, consideration of alternative sentences will be required, as is the case with other serious illnesses.[111] Such alternatives may include a compulsion order, where available, or a community payback order (see Chapter 3).

In *Qazi*,[112] the Court of Appeal held that, provided that the Justice and Health Secretaries' arrangements for prisoners with mental or physical health needs work in practice, "a sentencing court does not need to enquire into the facilities in prison for the treatment of a medical condition."[113] In extreme cases, however, "imprisonment itself might expose the individual to a real risk of an art.3 breach".[114] Such a finding would require "proper medical evidence before a court that any sentence of imprisonment ipso facto would cause a breach of art.3."[115]

O'Loughlin argues that, while the Court of Appeal sought to confine the scope of the sentencing court's duty in *Hall*[116] to extreme cases, this is "at odds with *Qazi* and with the ECtHR's longstanding insistence that rights protection must be practical and effective."[117] It is also at odds with the Court's statement in *Qazi* that a sentencing

[109] The limitations of this study should be noted - it did not examine participants' mental health before conviction and imprisonment, and the follow-up period with prisoners was limited to two months.
[110] Sentencing Council for England and Wales, 2020. (n3) at [22].
[111] *Mouisel v France* (2004) 38 EHRR 34 (735) suggests the need for special measures for serious physical illness. See also *Price v UK* (2002) 34 EHRR 53 (1285). In some cases, measures may be required for those with certain (severe) mental disorders.
[112] *R. v. Qazi (Saraj) and Hussain (Majid)* [2010] EWCA Crim 2579; [2011] 2 Cr. App. R. (S.) 8.
[113] *Qazi*, at para. 35.
[114] *Qazi*, at para. 35.
[115] *Qazi*, at para. 35.
[116] *R. v. Hall (Daniel Patrick)* [2013] 2 Cr. App. R. (S.) 68
[117] O'Loughlin, A., 2021. Sentencing mentally disordered offenders in England and Wales: towards a rights-based approach, *Criminal Law Review*, 2, 98-112 at p. 100, citing *Stafford v United Kingdom*

court cannot "simply rely on legal provisions as to the duties of the Secretary of State for Justice; it is the actuality of the performance of those duties…that is an essential consideration".[118]

She argues that:

> "Courts should read *Qazi* as setting out two grounds for examining whether a prison sentence poses a real risk of breaching art.3: first, where there is evidence that the practical operation of existing arrangements is insufficient to protect the offender's rights; secondly, where there is medical evidence that imprisonment would breach art.3 regardless of any possible arrangements."[119]

Excessive delays in transfers of prisoners to hospital and deteriorating conditions in prisons could therefore form part of the evidence that judges should examine in the first type of case. In the second type of case, courts should have regard to what the prison or hospital would actually be able to provide, rather than to what could hypothetically be provided in an ideal world.

Culpability

Ashworth highlights that the Sentencing Council for England and Wales has long regarded mental illness or disability as a factor indicating significantly lower culpability.[120] Mitigation may be justified here on the basis that "such offenders may not have sound powers of reasoning or control, and may therefore not understand the significance of punishment or may not deserve it."[121] In Scotland the general "Principles and purposes of sentencing" guideline does not reference mental disorders, it does require that "the circumstances of the offender" be considered and notes "people should be treated equally, and without discrimination."[122] Additionally, even prior to the guideline, mental disorders could be raised as part of a plea in mitigation for the court's consideration when passing a sentence.

Precisely what effect a mental disorder has can vary. A mental disorder may be "selective in its impairment of rationality… whether mental illness affects blame depends not on the nature of the action but on the relevance of the illness to its performance."[123] For example, in some cases, a mental disorder may reduce culpability but still leave sufficient blameworthiness for a criminal offence to be proven. This may occur where a mental disorder has some effects on a person's cognition, but

(2002) 35 EHRR 1121. This principle was affirmed by the House of Lords in *Secretary of State for the Home Department v MB and AF* [2007] 3 W.L.R. 681 and recently reaffirmed by the Supreme Court in *Welsh Ministers v. PJ* [2018] UKSC66, at para. 18.

[118] *Qazi*, at para. 27.

[119] O'Loughlin, A., 2021. (n117) at p. 101.

[120] Ashworth, A., 2015. *Sentencing and Criminal Justice*. Sixth Edition. Cambridge University Press, p. 413.

[121] Ashworth, A., 2015. (n120) at p. 413.

[122] Scottish Sentencing Council, 2018. (n92).

[123] Gardner, J., 1996. 'Justifications and Reasons' in Simester, A. P. and Smith, A. T. H. (eds.), *Harm and Culpability*. Oxford: Oxford University Press.

these are not sufficient to raise a section 51A mental disorder defence.[124] Therefore, it is important to consider the particular offender and the effects of their mental disorder.

An illustration: autism spectrum disorder and personality disorder

As an illustration, we will take ASD and personality disorder (PD) as examples. According to Browning and Caulfield, "much of the current literature refutes the existence of a causal relationship between [ASD] and offending behaviour".[125] However, some authors also argue that "those with [ASD] who do break the law, do so in the context of [ASD]."[126] Thus, while the evidence suggests that there is no direct causal relationship between ASD and offending in general, ASD may contribute to offending in some individuals. Where individuals with ASD do offend, their offending tends to be associated with a deficient theory of mind or an intense preoccupation with a narrow interest. In general, the literature on culpability and ASD suggests that culpability is reduced where offending is causally related to ASD.[127] As argued further below, however, requiring evidence of a clear causal connection between the disorder and offending for culpability to be reduced may set the bar too high.

Antisocial and borderline personality disorders are associated with impulsive behaviour, and there is evidence that offenders with these disorders may find it particularly difficult to restrain themselves. Insofar "as violent behaviour (in those with or without PD) is responsive to incentives, it appears to be subject to choice and a degree of control".[128] Nevertheless, such individuals may experience great difficulty in exercising control over their behaviour, particularly given that violence is often a habitual or learned response to emotional distress.[129] As Peay argues, it is not easy to "draw a bright dividing line between those who do not and those who cannot control their behaviour".[130] For Peay, "factors such as a low tolerance for frustration and impulsivity, combined with substance misuse facilitated by impaired moral reasoning, can make for a murky picture" when it comes to judging culpability in those with personality disorder.[131] Nevertheless, some commentators argue that a personality disorder is grounds for sentence mitigation where there is sufficient evidence that the

[124] Such was the case in Joseph Llewellyn v HMA [2018] HCJAC 76, where "significant mental health difficulties" [at para. 7] were considered an important aspect of the offender's circumstances but a conviction was still possible. Similarly, a successful plea of diminished responsibility recognises that a person's ability to determine or control their conduct has been substantially impaired, yet they are sufficiently blameworthy for a conviction for culpable homicide to be registered.
[125] Browning, A., and Caulfield, L., 2011. The prevalence and treatment of people with Asperger's Syndrome in the criminal justice system, *Criminology & Criminal Justice*, 11(2), 165-180, p. 174.
[126] Browning, A., and Caulfield, L., 2011. (n125) at p. 174.
[127] Browning, A., and Caulfield, L., 2011. (n125) at p. 174.
[128] Pickard, H., 2015. Choice, Deliberation, Violence: Mental Capacity and Criminal Responsibility in Personality Disorder, *International Journal of Law and Psychiatry*, 40, 15-24, p. 20.
[129] Pickard, H., 2015. (n128) at p. 20.
[130] Peay, J., 2011. Personality Disorder and the Law: Some Awkward Questions, *Philosophy, Psychiatry, & Psychology*, 18(3): 231-244.
[131] Peay, J., 2011. (n130) at p. 234.

person's capacity to conform to the law is impaired, albeit criminal responsibility may not be entirely absent.[132]

In practice, assessing the effects of a disorder on culpability is challenging. While expert evidence may be used, its role is contentious. Hallett[133] argues that judges asking psychiatric experts to voice their opinion on the defendant's culpability is problematic, because culpability is a legal, rather than a medical concept, and questions of culpability therefore fall outside of the expertise of psychiatric witnesses. He argues that, while mental disorders may have a bearing on culpability, "in practice… it is almost impossible to distinguish between those who had the moral capacity to act differently but chose not to from those who lacked the moral capacity to act differently and could not have chosen otherwise."[134]

Peay highlights the difficulties with using traditional sentencing principles to assess culpability in offenders with mental disorder. She argues that traditional approaches, such as regarding evidence of premeditation and planning as indicating culpability, erroneously "imply that an offender's mental disorder is somehow divisible from his or her otherwise ordered behaviour".[135] Peay gives the example of *Brennan*, in which the psychiatric expert witness testified that the appellant's seemingly purposeful behaviour could be explained by his mental disorder: "the planning for the killing was a logical consequence of his illogical thought process. He has the illogical thought that he has to kill someone and then goes about planning it in a logical way."[136]

Therefore, the precise degree (if any) to which a sentence ought to be affected by a mental disorder can vary depending on the disorder itself and its relevance to the offence charged. Additionally, if the mental disorder is somehow linked to offending behaviour, the courts may also consider disposals that could treat the disorder particularly important.

Mental disorder and consequentialist sentencing aims

As noted above, the Scottish guideline sets out purposes of sentencing. The majority (three out of five) are preventive in nature and include: protection of the public; rehabilitation of offenders; and making amends. Additionally, the guideline notes that "the efficient use of public resources may be considered" - this is (essentially) another

[132] Glannon, W., 2008. Moral Responsibility and the Psychopath, *Neuroethics*, 1, 158–166; Glenn, A. L. and Raine, A., 2014. Neurocriminology: implications for the punishment, prediction and prevention of criminal behaviour, *Nature Reviews Neuroscience*, 15(1): 54–63.
[133] Hallett, N., 2020. To what extent should expert psychiatric witnesses comment on criminal culpability?, *Medicine, Science and the Law*, 60(1): 67–74.
[134] Hallett, N., 2020. (n133) at p. 69.
[135] Peay, J., 2016. Responsibility, Culpability and the Sentencing of Mentally Disordered Offenders: Objectives in Conflict, *Criminal Law Review*, 3, 152-164, at p. 161. See for examples of this approach, Peay, J. 2015. Sentencing Mentally Disordered Offenders: Conflicting Objectives, Perilous Decisions and Cognitive Insights. LSE Legal Studies Working Paper No. 1/2015.
[136] *R. v Brennan (Michael James)* [2014] EWCA Crim 2387.

consequentialist consideration. All of these factors can have implications for sentencing those mental disorders.

Mental disorders that are relevant to criminal conduct may require treatment to meet the above objectives: that is to protect the public from future offending; rehabilitate the offender (inter alia enabling them to live a more fulfilled life); and to allow offenders to make amends to victims and communities harmed. Additionally, to the extent that imprisonment is expensive and may offer a poor return on investment in consequentialist terms (especially where some mental health conditions are a risk factor for offending behaviour and better treated in the community), then the regard to the efficient use of public resources might suggest a non-custodial treatment option. Indeed, as the HM Chief Inspector of Prisons made clear in the foreword to their report:

> "The most common problems were schizophrenia and bi-polar affective disorder. Prison is unlikely to lead to an improvement in these conditions, and may exacerbate the problem, particularly when such prisoners are held in inappropriate locations such as segregation units. This report makes clear that prison is not the most appropriate place for many of these individuals to be living."[137]

England and Wales

The approach to sentencing mental disorders south of the border can serve to inform debates in Scotland. Indeed, comparative research between Scotland and England and Wales has found that "factors related to the offender's condition that made community sentencing more likely included: … physical and mental health problems."[138] Consequently, while the two jurisdictions have distinct legal systems, English and Welsh practices are still relevant for Scotland. Previously, guidance on sentencing offenders with mental disorders has been found in case law, sections of offence specific guidelines and in expanded explanations.[139] The Sentencing Council's guideline is based on the leading decisions of the Court of Appeal (Criminal Division) in *R. v Vowles*[140] and *R. v. Edwards*.[141] Ashworth and Mackay argued that two key themes could be discerned in *Vowles*:

> "the first is that the court should ensure that a mentally disordered offender is punished for any element or particle of responsibility for her or his wrongdoing; the second is that the court should focus on finding the sentence or disposal

[137] HM Chief Inspector of Prisons for Scotland, 2008. (n9) at p. 1. This is not a unique issue to Scotland. See also: McConnell, P. and Talbot, J., 2013. *Mental Health and Learning Disabilities in the Criminal Courts*. London: Prison Reform Trust.
[138] Millie, A., Tombs, J. and Hough, M., 2007. Borderline Sentencing: A Comparison of Sentencers' Decision Making in England and Wales, and Scotland, *Criminology & Criminal Justice*, 7(3): 243-267, p. 256.
[139] For an overview see *R. v PS R. v Dahir (Abdi) R. v CF* [2019] EWCA Crim 2286.
[140] [2015] EWCA Crim 45.
[141] [2018] EWCA Crim 595.

> with the most suitable release provisions, taking account of the risk presented by D."[142]

The judgment in *Vowles* seemed to establish a presumption in favour of punishment over treatment, holding that "there must always be sound reasons for departing from the usual course of imposing a penal sentence".[143] The judgment further emphasised that the choice between a wholly therapeutic sentence and a sentence with a penal element should turn not on "'clinical advantage' per se, but rather whether successful medical treatment is expected to reduce the risk to the public."[144]

Vowles emphasised the need for sentencing judges choosing between a prison sentence and a hospital order with restrictions to have regard to the regime that would apply upon release. The Court in *Vowles* seemed to direct judges to give priority to indeterminate prison sentences coupled with hospital and limitation directions under s.45A of the MHA 1983 (equivalent to the Scottish hospital direction). Peay explains why:

> "First, the Parole Board needs to be satisfied that the defendant is no longer a danger to the public for any reason and is not at risk of relapsing into dangerous crime; whereas under the hospital order regime release depends on there being no danger which arises from the offender-patient's medical condition. Secondly, recall from licence arrangements can occur if a danger to the public arises from criminal activity; whereas recall to hospital is available only if the offender's medical condition relapses."[145]

The reasoning in *Vowles* has come under sustained academic criticism. Peay[146] and Ashworth and Mackay[147] question the emphasis in *Vowles* on punishment for any element of culpability, and the seeming priority given to prison sentences and hospital and limitation directions.[148] Ashworth and Mackay argue that the judgment in *Vowles* "fails to insist that hospital and limitation directions should be received for offenders who pose a serious risk to the public and merit punishment as a result of a high degree of culpability".[149] Indeed, as Peay highlights, the judgment in Vowles seems to advocate prison sentences in cases in which the offending was "wholly or in significant part attributable to the mental disorder" and where culpability was therefore low or absent.[150]

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[142] Ashworth, A. and Mackay, R., 2015. *R v Vowles* [2015] EWCA Crim 45 – case comment, *Criminal Law Review*, 7, 542-548, p. 545.
[143] *R. v Vowles* [2015] EWCA Crim 45 at para. 51.
[144] Ashworth, A. and Mackay, R., 2015. (n142) at p. 546.
[145] Peay, J., 2016. (n135) at p. 157.
[146] Peay, J., 2016. (n135).
[147] Ashworth, A. and Mackay, R., 2015. (n142) at p. 545.
[148] On the criteria for these orders, see Chapter 3 below.
[149] Ashworth, A. and Mackay, R., 2015. (n142) at pp. 547-548.
[150] Peay, J., 2016. (n135) at p. 158.

Vowles was expected to prompt a shift from hospital orders with restrictions in favour of hospital and limitation directions. This was expected to exacerbate the problems experienced by prisons in dealing with prisoners with serious mental disorders.[151] This is because individuals serving indeterminate prison sentences coupled with a hospital and limitation direction could be transferred to prison to finish out their sentences or to await release by the Parole Board.

Subsequent cases, however, broke away from the emphasis in *Vowles* on prioritising hospital and limitation directions. In *Edwards*, the Court of Appeal held that *Vowles* did not "provide a 'default' setting of imprisonment" and that judges should consider all options at their disposal. While *Edwards* maintained that a court "must have 'sound reasons' for departing from the usual course of imposing a sentence with a penal element", it extended the circumstances in which a ss.37/41 order would be warranted:[152]

> "sound reasons may include the nature of the offence and the limited nature of any penal element (if imposed) and the fact that the offending was very substantially (albeit not wholly) attributable to the offender's illness."[153]

O'Loughlin argues that *Edwards* has not wholly remedied the deficiencies of *Vowles*, as the judgment imposes limits on the use of hospital orders with restrictions that are not warranted by the relevant legislation. In addition, the guidance in *Edwards* and *Vowles* does not take account of the risks prison sentences pose to the safety of vulnerable individuals.[154]

Some decisions by the Court of Appeal after *Vowles* and *Edwards* have taken a more flexible approach.[155] In these cases, the Court has used the four factors set out in *Vowles* to determine sentence, rather than seeking to prioritise punishment:

> "(1) the extent to which the offender needs treatment for the mental disorder from which the offender suffers,
> (2) the extent to which the offending is attributable to the mental disorder,
> (3) the extent to which punishment is required and
> (4) the protection of the public including the regime for deciding release and the regime after release."[156]

In *Cleland*, the Court of Appeal held that *Vowles* set out "factors which are relevant to be considered, rather than inflexible criteria or pre-conditions of the court's imposing

[151] Peay, J., 2016. (n135) at p. 159.
[152] O'Loughlin, A., 2021. (n117) at p. 106.
[153] Edwards [2018] EWCA Crim 595.
[154] O'Loughlin, A., 2021. (n117) at p. 106.
[155] O'Loughlin, A., 2021. (n117).
[156] *R v Vowles* [2015] EWCA Crim 45 at para. 51. See also *Cleland* [2020] EWCA Crim 906 and *Nelson* [2020] EWCA Crim 1615.

a particular form of sentence".[157] Consequently, sentencing decisions would "necessarily be fact-specific".[158]

While much of this remains relevant, the Sentencing Council for England and Wales has recently issued a guideline for *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments* (hereinafter "the mental disorder guideline").[159] The mental disorder guideline is a general guideline and applicable to any offence where the offender has a relevant disorder.

The guideline is not a radical departure from the previous position in the case law – rather, it seeks to bring together existing principles. However, it does provide new information as a resource for sentencers and this may have an impact on practice. Precisely how the guideline will affect sentencing practice, therefore, remains an open question. Indeed, as the Council's resource assessment makes clear, one risk in predicting the effects is that "so little information is available on current sentencing practice."[160] Yet, if nothing else, it does provide a more accessible resource than ever before and an opportunity for key points to be communicated.

The form of the guideline

The English and Welsh mental disorder guideline works in tandem with other offence specific guidelines. This is possible because the English and Welsh offence-specific guidelines follow a step-by-step approach. This format is consistent throughout offence specific guidelines. Therefore, while starting points and aggravating and mitigating factors vary, the basic steps are similar. The mental disorder guideline takes advantage of this by directing consideration of mental disorders be made at Step 1 of an offence specific guideline (where the impairment or disorder is linked to the offence) or at Step 2 of an offence specific guideline (where it is not linked to the offence).[161]

The guideline includes several annexes covering matters such as forms of mental disorder, relevant legislative provisions, and disposal options for such cases. Annex A sets out, in relative brevity, clinical details of various mental disorders that offenders coming before the court may present with. This summary may assist sentencers, and perhaps other legal practitioners, in understanding expert reports and the complex

[157] *Cleland* [2020] EWCA Crim 906, at [50].
[158] *Cleland* [2020] EWCA Crim 906, at [50].
[159] Sentencing Council for England and Wales, 2020. (n3).
[160] Sentencing Council for England and Wales, 2020. *Final Resource Assessment: Overarching Principles: Sentencing Offenders with Mental Disorders, Developmental Disorders, or Neurological Impairments*, p. 10.
[161] Guidelines produced by the Sentencing Council for England and Wales usually have nine steps in total. At Step 1, the court considers the primary factors relating to harm and culpability which are provided by the guideline. Once this is established the guideline provides a starting point sentence and a sentence range. At Step 2, the court adjusts this starting point sentence, up or down, to reflect aggravating and mitigating factors other than those considered at Step 1. The first step is more important than the second, as it determines the appropriate sentence range for the case, whereas at Step 2 the court is simply adjusting the sentence within that range.

medical science in this area. Moreover, the guideline should be read alongside the Equal Treatment Bench Book.[162]

The guidance on mental disorders reflects the wide range of mental disorders, the interaction of multiple (mental and physical) disorders (comorbidities), their variable effects on culpability, equality considerations, and the disposals the court may consider. However, even given its length, the guideline has been criticised as not comprehensive enough: for example, by failing to offer guidance "as to why and when certain forms of order may be preferable over others (which at least in a piecemeal fashion [caselaw has done])."[163] These gaps mean that there will likely be continued reliance on case law.

The English and Welsh guidance has been considered by the appellate courts in *Baldwin*.[164] For present purposes, this case is useful to illustrate the complexity of sentencing where multiple guidelines overlap. Where there are multiple applicable guidelines, judges will have to consider a broad range of factors, which can become challenging. These different guidelines may suggest numerous aggravating and mitigating factors for a particular case that courts will have to consider and reconcile in deriving the appropriate sentence. In *Baldwin* there were considerations around the offence specific guideline; the mental disorder guideline; the sentencing for domestic abuse guideline; and considerations of guidance for sentencing children and young people. How courts reconcile these guidelines is beyond our present scope. We only note the potential for difficulty.

Key features of the guideline: causal links

In its draft guideline, *Sentencing Offenders with Mental Health Conditions or Disorders*, the Sentencing Council for England and Wales initially proposed to advise sentencers to adopt causal reasoning in determining culpability. The draft guideline stated that "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."[165] This part of the guideline is likely to have been based on *Vowles*. In that case, the Court of Appeal appeared to confine the use of hospital orders to cases in which there was a causal connection between the offence and the defendant's mental disorder, and where the risk of reoffending arose from a treatable mental disorder. This included in sentencing cases in which offenders were not convicted of manslaughter by reason of diminished responsibility. This approach has been criticised, as a causal connection is not required by legislation and could inappropriately limit the availability of hospital orders after conviction.[166] In particular,

[162] Judicial College, 2021. *Equal Treatment Bench Book*.
[163] Walker, S., 2020. Sentencing Council's guideline on overarching principles, *Criminal Law Weekly*, 20/28/60. See also *Fisher* [2019] EWCA Crim 1066.
[164] *R. v Baldwin* [2021] EWCA Crim 417.
[165] Sentencing Council for England and Wales, 2019. *Sentencing Offenders with Mental Health Conditions or Disorders - Draft guideline for consultation* at [8].
[166] O'Loughlin, 2021. (n117).

reliance on a causal connection requirement would leave a significant gap in sentencing jurisprudence: "how should courts approach sentencing an offender whose offending was not caused by mental disorder but for whom a prison sentence would pose a real risk of serious harm?"[167]

In addition, as Mackay and Hughes report, "it is difficult for the [psychiatric] expert to tease out exactly what factors in a complex series of events that led to the killing contributed to it in a causal way."[168]

Child, Crombag and Sullivan similarly highlight the problems with causal requirements in the law of insanity, automatism and intoxication: "the sharp causal distinctions required by the law are ill-equipped to deal with (far from uncommon) cases where cause is uncertain; where symptoms are non-specific, comorbid conditions exist, and tools for differential diagnosis are poor or altogether unavailable."[169] They further highlight the mismatch "between expert medical diagnosis that is frequently multi-factorial and probabilistic, and the entrenched legal requirement for simple, clear-cut causal identification."[170]

In the final guideline, this terminology was revised, and it now states: "culpability will only be reduced if there is sufficient connection between the offender's impairment or disorder and the offending behaviour." This takes into account the difficulties in establishing a direct causal connection between a given condition and offending.
These arguments suggest that sentencing law ought not to require a clear causal connection between mental disorder and offending before a reduction in culpability or in the need for punishment can be recognised. These difficulties may be avoided by adopting the Sentencing Council for England and Wales's "sufficient connection" requirement, or Mackay and Hughes' suggestion that the mental disorder should have played a part that was "more than trivial or minimal" in order for culpability to be reduced.[171]

Key features of the guideline: culpability and prior fault

A version of the prior fault principle has been incorporated into the sentencing case law in England and Wales. The guideline for sentencing offenders with mental disorders, developmental disorders, or neurological impairments suggests that indications of prior fault can be taken into account when determining culpability:

> "Medication: Where an offender was failing to take medication prescribed to them at the time of the offence, the court will need to consider the extent to

[167] O'Loughlin, 2021. (n117) at p. 105.
[168] Mackay, R. and Hughes, D., 2021. Explaining the "explanation" requirement in the new diminished responsibility plea, *Criminal Law Review*, 6, 461-477, at 476.
[169] Child, J. J., Crombag, H. S. and Sullivan, G. R., 2020. Defending the delusional, the irrational, and the dangerous, *Criminal Law Review*, 4, 306-324.
[170] Child, J. J. et al., 2020. (n169) at p. 310.
[171] Mackay, R. and Hughes, D., 2021. (n168) at p. 473.

> which that failure was wilful or arose as a result of the offender's lack of insight into their impairment or disorder"
> "Self-medication". Where an offender made their impairment or disorder worse by "self-medicating" with alcohol or non-prescribed or illicit drugs at the time of the offence, the court will need to consider the extent to which the offender was aware that would be the effect." [172]

The Sentencing Council for England and Wales's guideline warns that evidence that the offender had insight into their impairment or into the importance of medication does not automatically increase culpability. Rather, "any insight, and its effect on culpability, is a matter of degree for the court to assess."[173]

Mackay and Hughes highlight difficulties with the prior fault principle in the doctrine of insanity. They argue that "in some cases it will be difficult to make a clear distinction between the types of behaviour resulting from lack of insight or forgetfulness and behaviour to which fault might be attached."[174] These criticisms can be extended to the use of a prior fault principle in sentencing, as the same empirical problems are likely to arise.

Mitchell argues that a knowing failure to take medication should result in a conviction, as this would yield "greater concordance with common-sense notions of justice".[175] Other commentators, however, have questioned "whether there is a clear moral distinction to be drawn between defendants on the basis of the reasons for their non-compliance with medication. In reality, there may be numerous reasons for non-compliance including inter alia the stigma attached to certain medications, religious beliefs, paranoia, side effects, and depression."[176]

Mackay and Hughes suggest that prior fault can be taken into account in sentencing, based on the case of *Lall*[177] and the English and Welsh guideline. But their arguments against including a prior fault principle in insanity could also be applied to sentencing. In the sentencing context, a conviction will already have been registered and it is for the court to determine whether a punitive sentence is required. In this context, a prior fault principle is likely to act as a blunt tool that will prevent sentencers from taking into account factors other than insight that may render an individual less culpable. Thus, Mackay and Hughes argue that "to introduce fault and "blame" into mental illness is

[172] Sentencing Council for England and Wales, 2020. (n3) at [15].
[173] Sentencing Council for England and Wales, 2020. (n3) at [15].
[174] Mackay, R. and Hughes, D., 2022. Insanity and blaming the mentally ill - a critique of the prior fault principle in the Law Commission's discussion paper, *Criminal Law Review*, 1, 21-40.
[175] Mitchell, E. W., 2003. *Self-Made Madness-Rethinking Illness and Criminal Responsibility*. Farnham: Ashgate, Ch. 3. Cited in Mackay, R. and Hughes, D., 2022. (n174).
[176] Loughnan, A. and Wake, N., 2014. 'Of Blurred Boundaries and Prior Fault: Insanity, Automatism and Intoxication' in Reed, A. and Bohlander, M. *General Defences in Criminal Law: Domestic and Comparative Perspectives*, p. 131. Farnham: Ashgate.
[177] *Lall* [2021] EWCA Crim 404.

troubling and seems unwarranted".[178] In their view, "rather than blaming the mentally ill for non-adherence to the medication regime (or overdosing) by using a fault doctrine which is both clumsy and complex, a better approach is to try to help and support those individuals whose conditions are leading to such problems."[179] Thus, they posit, a better approach might be "to permit the judge to decide which form of disposal is most appropriate in the light of D's medication problems".[180]

Key features of the guideline: formal diagnosis

The guideline makes clear that a formal diagnosis of a mental disorder is not always necessary for the court to consider it a live issue in sentencing. In part, this reflects a pragmatic approach. Not all mental disorders will be diagnosed and, in some communities, under-diagnosis may be more prevalent creating greater potential for sentencing disparities. Therefore, if a formal diagnosis were required, some groups may be less able to benefit from having their mental disorder taken into account where it might be a mitigating factor. Moreover, this feature is in keeping with previous trends. While case law has demonstrated expert opinions are valuable, the Sentencing Council for England and Wales' mental disorder guideline expressly states that assessment of culpability is a matter for the sentencer, not the expert:

> "The sentencer, who will be in possession of all relevant information, is in the best position to make the assessment of culpability. Where relevant expert evidence is put forward, it must always be considered and will often be valuable. However, it is the duty of the sentencer to make their own decision, and the court is not bound to follow expert evidence if there are compelling reasons to put it aside".[181]

Other jurisdictions

While the precise formulations vary,[182] many jurisdictions parallel the Scottish approach and provide defences based on the most severe mental disorders, mitigation at sentencing, and special mental health disposals for severe mental disorders. Most common law jurisdictions also experience relatively high incidences of people with mental disorders in the criminal justice system and prison systems: "The global facts are clear and startling: of the nine million prisoners world-wide, at least one million suffer from a significant mental disorder, and even more suffer from common mental health problems such as depression and anxiety. There is often co-morbidity (dual diagnosis) with conditions such as personality disorder, alcoholism and drug dependence."[183]

[178] Mackay, R. and Hughes, D., 2022. (n174) at p. 39.
[179] Mackay, R. and Hughes, D., 2022. (n174) at p. 40.
[180] Mackay, R. and Hughes, D., 2022. (n174) at p. 39.
[181] Sentencing Council for England and Wales, 2020. (n3) at [13].
[182] For example, some jurisdictions (for a discussion of this in the USA see Castellano, U. and Anderson, L., 2013. Mental Health Courts in America: Promise and Challenges, *American Behavioral Scientist*, 57(2): 163-173) have made use of mental health courts while others (e.g. Ireland) have not.
[183] World Health Organisation, 2007. *Trenčín Statement on Prisons and Mental Health*, p. 5.

In terms of mental disorders as a mitigating factor, various jurisdictions consider this in different ways, which have changed over time. For example, previously the USA's federal guidelines noted that "mental and emotional conditions are not ordinarily relevant in determining whether a departure is warranted." However, since November 2010 the guidelines note that mental disorders may justify reduced sentences: "Mental and emotional conditions may be relevant in determining whether a departure is warranted, if such conditions, individually or in combination with other offender characteristics, are present to an unusual degree and distinguish the case from the typical cases covered by the guidelines."[184]

In Australia, mitigation when sentencing offenders with mental disorders has classically been a matter for common law to determine: "Most of Australia's sentencing legislation has nothing specific to say about the principles to be applied when sentencing mentally impaired offenders. The issue has therefore been left to be resolved in accordance with the common law."[185]

In doing so, the courts in the various jurisdictions have had to consider the various principles and purposes of sentencing in the context of those with mental disorders. For example, the Court of Appeal in Victoria established ways in which a mental disorder may be a relevant consideration at sentencing. These are known as the "Verdins principles."[186] It was held that "impaired mental functioning can be relevant to sentencing in six ways. It can:

i. Reduce the offender's moral culpability;
ii. Influence the kind of sentence to be imposed;
iii. Moderate or eliminate the need for general deterrence;
iv. Moderate or eliminate the need for specific deterrence;
v. Make a sentence weigh more heavily on the offender than on a person in normal health; or
vi. Create a serious risk of imprisonment having a significant adverse effect on the offender's mental health."[187]

In 2020, in *Brown v. the Queen*,[188] the Victorian Court of Appeal overturned *DPP (Vic) v. O'Neill*.[189] In *O'Neill*, the Victorian Court of Appeal had excluded offenders with personality disorders from the scope of the *Verdins* principles on the basis that a

[184] §5H1.3 - MENTAL AND EMOTIONAL CONDITIONS (POLICY STATEMENT).
[185] Edgely M,. 2009. Common Law Sentencing of Mentally Impaired Offenders in Australian Courts: A Call for Coherence and Consistency, *Psychiatry, Psychology and Law*, 16(2): 240-261, p. 244.
[186] *R v Verdins & Ors* [2007] VSCA 102.
[187] Walvisch, J., Carroll A. and Marsh, T., 2021. Sentencing and mental disorder: the evolution of the *Verdins Principles*, strategic interdisciplinary advocacy and evidence-based reform, *Psychiatry, Psychology and Law*. Online first. DOI: 10.1080/13218719.2021.1976299, p.8. For further details such as how these principles have been applied, see Walvisch, J. and Carroll, A., 2017. Sentencing Offenders with Personality Disorders: A Critical Analysis of DPP (Vic) v O'Neill, *Melbourne University Law Review*, 41(1): 417-444.
[188] [2020] VSCA 212.
[189] (2015) 47 VR 395.

personality disorder does not constitute an "impairment of mental functioning". In *Brown v. the Queen*, the Victorian Court of Appeal held that this aspect of *O'Neill* should no longer be followed. Instead, "whether and to what extent the offender's mental functioning is (or was) relevantly impaired should be determined on the basis of expert evidence rigorously scrutinised by the sentencing court". Thus, rather than focusing on the diagnostic label attached to the offender, courts should scrutinise the level of impairment resulting from it.[190]

In Victoria, the Sentencing Act 1991 (Vic) has several provisions relevant to sentencing those with a mental disorder.[191]

In summing up, while many jurisdictions have similar specialised mental health disposals or sentencing considerations to Scotland, in some instances, there is criticism. For example, in Ireland at the sentencing stage "legislation does not provide for hospital treatment on culmination of a case, save for limited circumstances"[192] and there have been calls for change in this area.[193] In other instances, even where there are various disposal options theoretically available, they may be under-used. For instance, concerning imprisonment in the USA:

> "Untreated mental illness and co-occurring substance abuse disorders propel "the revolving door between jail and the street for individuals who have committed relatively minor crimes - many of them "nuisance crimes." Public perceptions about the dangerousness of people with mental illness are often unsubstantiated. Violent behavior is most likely to occur when people with mental illness have a co-occurring substance abuse problem."[194]

While considerations such as those noted in the guidance above may be beneficial, sentencing those with mental disorders remains an active area of discussion in various jurisdictions.

Conclusion

Mental disorders vary in terms of their significance for sentencing. Some disorders may have little bearing on culpability or on sentence. This may be the case where there is no relationship at all between the offending and the disorder, and/or where the disorder is mild and manageable in a prison setting and unlikely to cause undue hardship. In other cases, disorders can affect culpability and warrant a reduced

[190] See for further discussion of the history of the development of the principles in *Verdins* and *Brown*, Walvisch, J. et al., 2021. (n187).
[191] Victoria has a "Sentencing Advisory Council" but this is not a guideline creating body.
[192] Gulati, G. and Kelly, B. D., 2018. Diversion of Mentally Ill Offenders from the Criminal Justice System in Ireland: Comparison with England and Wales, *Irish Medical Journal*, 111(3): 719.
[193] For a discussion of this and the possibility of a mental health court, see Finnerty, S., 2021. *Access to the Mental Health Services for People in the Criminal Justice System*. Dublin: Mental Health Commission.
[194] Moyd, O., 2003. Mental Health and Incarceration: What a Bad Combination, *UDC Law Review*, 7(1): 201-212, p. 212.

sentence. Or there may be little or no relationship between the mental disorder and the offence, but the nature of the mental disorder may mean that the usual punishment will have a disproportionately punitive effect on the individual, or even compromise their welfare and human rights. Cases coming before the courts are likely to present a combination of these factors.

Beyond these points, broad generalisations are difficult, and sentencing will necessarily be a finely balanced exercise based on the facts and evidence presented in the case. England and Wales has developed a generic guideline that covers key principles relevant to passing a sentence in cases involving a person with a mental disorder. This guidance offers an accessible resource to promote consistency of approach. Additionally, some inspiration might be drawn from other jurisdictions. For example, the 'Verdins' principles set out in Victoria provide another perspective on how guidance may be provided.

To summarise, this chapter has set out the principles that govern, or could govern, sentencing offenders with mental disorder in Scotland. These principles are relevant both in cases in which a mental health disposal is available, and in the perhaps more common cases in which the criteria for such an order are not met but where a mental health condition is present.

We now turn to examine the available disposals and the criteria that apply to mental health based orders.

Chapter 3: Disposals available when sentencing defendants with mental disorders

This chapter examines the mental health disposals available after conviction. It presents an overview of the available orders and their effects, focusing on compulsion orders, restriction orders, hospital directions, guardianship orders and mental health treatment requirements attached to community and suspended sentences powers to discharge/release (Mental Health Tribunals). The chapter also considers monitoring and recall mechanisms in the community, outcome studies of impact of disposals on recidivism and mental health outcomes, barriers to the use of alternative disposals, and trends in usage.

Definition of mental disorder

Under section 328 of the Mental Health (Care and Treatment) Scotland Act 2003 (MH(CT)(S)A 2003), "mental disorder" is defined as any—

(d) mental illness;
(e) personality disorder; or
(f) learning disability, however caused or manifested.

A person is not mentally disordered by reason only of any of the following—

(h) sexual orientation;
(i) sexual deviancy;
(j) transsexualism;
(k) transvestism;
(l) dependence on, or use of, alcohol or drugs;
(m) behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person;
(n) acting as no prudent person would act.[195]

In England and Wales, by contrast, mental disorder is defined very broadly "any disorder or disability of the mind".[196] By contrast to England and Wales, the definition of mental disorder in Scotland does not exclude those with learning disability whose behaviour is not seriously aggressive or irresponsible. However, additional exclusions over and above those in England and Wales apply in Scotland.

[195] Section 328(2) of the MH(CT)(S)A 2003.
[196] Section 1(2) of the Mental Health Act 1983. There are two exceptions to this broad definition. Under section 1(2A), "a person with learning disability shall not be considered by reason of that disability to be - (a) suffering from mental disorder…unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part." In addition, under section 1(3), "dependence on alcohol or drugs is not considered to be a disorder or disability of the mind".

Disposals after conviction

The focus of this chapter is on disposals after conviction. It should be noted that pre-trial diversion practices by the police, the Crown Office and the Prosecutor Fiscal filter some individuals with mental disorders out of the court case load, and that this has an impact on the composition of the convicted population coming before the courts to be sentenced.[197]

Disposals are also available without conviction and similar disposals are available where a person has been found to lack criminal responsibility by virtue of mental disorder under section 51A of the Criminal Procedure (Scotland) Act 1995 (CP(S)A 1995).[198] The CP(S)A 1995, section 51B provides a separate plea of diminished responsibility, which avoids the mandatory life sentence for murder and allows judges to choose from a range of disposals, including mental health disposals.

In Scotland, where a person with a mental disorder has been convicted of an offence, courts can choose from the following:

- An interim compulsion order;
- A compulsion order, detaining the offender in hospital or making him/her subject to controls in the community;
- A compulsion order with restrictions, detaining the offender in hospital for an indefinite period;
- A hospital direction: a prison sentence coupled with detention in hospital;
- An order for lifelong restriction;
- Guardianship or an intervention order;
- A community payback order;
- A deferred sentence.

The orders available under the CP(S)A 1995 differ in their effects, and the choice of disposal has a decisive impact on the person's journey towards discharge or release and on their subsequent care and supervision. The order made by a judge determines which authorities will have the power to discharge or release the person; which authorities will be responsible for supporting and supervising him or her in the community; and whether the person will remain liable to be re-detained in prison or in hospital post-release.

Policy in relation to mentally disordered offenders

The Scottish Policy Office set out the principles for the delivery of mental health services to mentally disordered offenders in 1999. According to the policy: "mentally disordered offenders should be cared for: -

[197] On pre-trial diversion policies in Scotland, see further Community Justice Scotland, 2020. *National Guidelines on Diversion from Prosecution in Scotland*. Edinburgh: Community Justice Scotland. For a review of the evidence base for pre-trial diversion, see Centre for Justice Innovation, 2019. *Pre-court diversion for adults: an evidence briefing*. London: Centre for Justice Innovation.
[198] Disposals are available without conviction under sections 52K and 52L of the CP(S)A 1995.

- with regard to quality of care and proper attention to the needs of individuals;
- as far as possible in the community rather than in institutional settings;
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- as near as possible to their own homes or families if they have them."[199]

The policy states that "prisoners who do not meet the criteria for hospital admission need to be treated in prison under a suitable regime".[200] Those who meet the criteria for hospital admission should be transferred to hospital.[201]

The available orders

Guardianship or intervention orders

Courts in Scotland have the option of imposing a guardianship order after conviction.[202] As an alternative to guardianship, the court can make a welfare intervention order.[203]

Under section 58(1)(A) of the CP(S)A 1995, the court has the power to place the offender's personal welfare under the guardianship of a local authority or a person approved by a local authority. The guardianship may last for three years, for a period specified by the court, or indefinitely.[204] Similar powers exist in England and Wales under section 37 of the Mental Health Act 1983.

Community payback orders and other non-custodial disposals

Scotland has a wide range of non-custodial disposals. Relatively minor offences may be dealt with by means of an absolute discharge, an admonition, or a fine. Other ancillary or civil orders may be appropriate.[205] For more serious cases, the court may choose to defer sentence subject to conditions with a structured deferred sentence (SDS).[206] Where an SDS is insufficient, the court may consider a community payback order. The community payback order is a highly flexible disposal that can entail a range of requirements than can be tailored to the needs of a particular case – both in terms of retributive and consequentialist objectives. The rest of our focus here will be on community payback orders.

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[199] The Scottish Office, 1999. *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland*, [1.5]. London: HMSO.
[200] The Scottish Office, 1999. (n199) at [4.4].
[201] The Scottish Office, 1999. (n199) at [4.5].
[202] This order is available under section 58 of the CP(S)A 1995, as amended by para. 26 of Schedule 5 to the Adults with Incapacity (Scotland) Act 2000 and para. 8(4) of Schedule 4 to the Mental Health (Care and Treatment) Act 2003.
[203] CP(S)A 1995, section 60A.
[204] CP(S)A 1995, sections 58(1) and (5).
[205] These are not dealt with here. Examples include antisocial behaviour orders or sexual offences prevention orders.
[206] CP(S)A 1995, section 202.

Community payback orders can include requirements to participate in rehabilitative programmes, mental health treatment or drug or alcohol treatment.[207] A mental health treatment requirement (MHTR) obliges the offender to submit to medical or psychological treatment with a view to improving his or her mental health. An MHTR can only be made if the court is satisfied:

1. on the written or oral evidence of an approved medical practitioner,[208] that
(a) the offender suffers from a mental condition,
(b) the condition requires, and may be susceptible to, treatment, and
(c) the condition is not such as to warrant the offender's being subject to –
(i) a compulsory treatment order under section 64 of the [MH(CT)(S)A 2003], or
(ii) a compulsion order under section 57A of [the CP(S)A 1995].

2. on the written or oral evidence of the registered medical practitioner or registered psychologist by whom or under whose direction the treatment is to be provided, that the treatment proposed to be specified in the order is appropriate for the offender.

3. that arrangements have been made for the proposed treatment.[209]

The offender may be required to receive treatment in a hospital (other than the State Hospital)[210] or in the community.[211] The offender must understand and agree to comply with the order.[212] If the order is breached, the offender may be arrested or ordered to appear before the court, and may receive a fine or prison sentence.[213]

Similar powers to attach an MHTR to a community order exist in England and Wales, and similar criteria apply under Schedule 9 to the Sentencing Act 2020.

Compulsion orders

Courts have the power to impose an interim compulsion order on a convicted offender under section 53 of the CP(S)A 1995 for the purposes of assessing his or her mental condition. Under section 57A of the CP(S)A 1995,[214] courts can make a compulsion order in respect of an offender convicted in the High Court or the sheriff court of an offence punishable by imprisonment.[215]

[207] CP(S)A 1995, section 227A. These requirements cannot be imposed by a Justice of the Peace.
[208] Within the meaning of the MH(CT)(S)A 2003.
[209] CP(S)A 1995, section 227R(4)-(7).
[210] The State Hospital is a high secure forensic hospital in Carstairs, South Lanarkshire, Scotland.
[211] CP(S)A 1995, section 227R(3).
[212] CP(S)A 1995, section 227B(9).
[213] The prison sentence can be up to a maximum period of 60 days by a Justice of the Peace court or three months by other courts.
[214] As inserted by section 133 of the MH(CT)(S)A 2003.
[215] Except where the sentence is fixed by law – i.e. in murder cases, where a mandatory life sentence applies.

To make a compulsion order, the court must be satisfied, on the written or oral evidence of two medical practitioners:

(a) that the offender has a mental disorder;
(b) that medical treatment which would be likely to –
  (i) prevent the mental disorder worsening; or
  (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the offender;

(c) that if the offender were not provided with such medical treatment there would be a significant risk –
  (i) to the health, safety or welfare of the offender; or
  (ii) to the safety of any other person; and
(d) that the making of a compulsion order in respect of the offender is necessary.

The court must also be satisfied that the order is appropriate, having regard to:

(a) the mental health officer's report;
(b) all the circumstances, including –
  (i) the nature of the offence of which the offender was convicted; and
  (ii) the antecedents of the offender; and
(c) any alternative means of dealing with the offender.

As the legislation requires judges to have regard to alternative means, there is no duty to make a compulsion order in every case in which the criteria are met.

The equivalent in England and Wales is the hospital order, available under section 37 of the Mental Health Act (MHA) 1983.[216] The requirements under the MHA 1983 are less stringent, as courts are not required to evaluate whether there is a 'significant risk'. In addition, the 'appropriate treatment' requirement under the MHA 1983 sets a lower standard than the CP(S)A 1995.[217]

The compulsion order can be tailored to the offender. In addition to the option of detaining the offender in hospital, courts have the option (*inter alia*) of requiring the offender to submit to medical treatment in the community;[218] attend a specified place

[216] MHA 1983, section 37.2(a). Hospital orders are available to Crown Courts and Magistrates' Courts sentencing an offender convicted of any imprisonable offence except murder. To make a hospital order, the sentencing court must be satisfied, on the written or oral evidence of two registered medical practitioners, that the offender "is suffering from mental disorder [...] of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and appropriate medical treatment is available for him".
[217] Under the MHA 1983, treatment is not required to be likely to have the effect of alleviating or preventing a deterioration in the person's condition. Rather, it need only have the 'purpose' of alleviating etc. See MHA 1983, section 72(1)(b) and section 145(4).
[218] CP(S)A 1995, section 57A(8)(b).

for treatment;[219] reside at a specified place;[220] or allow relevant personnel or services to visit his or her residence.[221] There is no equivalent power in England and Wales.

Courts can order detention in hospital under a compulsion order for up to six months, subject to the following requirements: the Court must be satisfied under Section 57A(5), on the written or oral evidence of the same two medical practitioners mentioned in subsection (2)(a) that:

(a) the medical treatment…can be provided only if the offender is detained in hospital;
(b) the offender could be admitted to the hospital to be specified in the order before the expiry of the period of 7 days beginning with the day on which the order is made; and
(c) the hospital to be so specified is suitable for the purpose of giving the medical treatment to the offender.

In addition, a compulsion order to detain the offender in a state hospital[222] under Section 57A(5) of the CP(S)A 1995 can only be made if it appears to the court, based on the medical evidence:

(a) that the offender requires to be detained in hospital under conditions of special security; and
(b) that such conditions of special security can be provided only in a state hospital.

Compulsion orders divert offenders into the mental health system and avoid punishment entirely. There are no powers to combine these orders with other punishments (e.g. prison sentences, fines or community sentences).

In Scotland, courts making a compulsion order can also make a restriction order under 57A(7) of the CP(S)A 1995. Similarly, a hospital order can be made subject to restrictions in England and Wales.[223] A restriction order is not intended as a punishment but as a risk management tool.

In Scotland, a restriction order is available where it appears to the court:

(a) having regard to the nature of the offence with which he is charged;
(b) the antecedents of the person; and
(c) the risk that as a result of his mental disorder he would commit offences if set at large, that it is necessary for the protection of the public from serious harm so to do.[224]

[219] CP(S)A 1995, section 57A(8)(c).
[220] CP(S)A 1995, section 57A(8)(e).
[221] CP(S)A 1995, section57A(8)(f).
[222] The State Hospital is a high secure forensic hospital in Carstairs, South Lanarkshire, Scotland.
[223] MHA 1983, section 41.
[224] CP(S)A 1995, section 59(1).

The Court must hear oral evidence from an approved medical practitioner before making a restriction order[225] and from a mental health officer.[226]

If a restriction order is made, then the compulsion order and restriction order are without limit of time. If a patient is subject to a restriction order, the patient cannot be given leave of absence or transferred to another hospital without the consent of the Scottish Ministers.[227]

The Mental Health (Care and Treatment) Act Code of Practice advises that, in order for a restriction order to be recommended to a sentencing court, "a significant link between the specified mental disorder and the offence and/or the future risk posed" would be expected.[228] Furthermore, "the mental disorder should play a substantial part in determining risk to others".[229] In cases in which the link is absent or weak, a hospital direction under section 59A should be recommended.[230]

Hospital directions

Hospital directions are available under section 59A of the CP(S)A 1995 in respect of adult offenders convicted on indictment in the High Court or the sheriff court of an offence punishable by imprisonment. The criteria are the same as for a compulsion order, and patients subject to hospital directions are also subject to restrictions.[231] A hospital direction is combined with a prison sentence. Before the court can make a hospital direction, two medical reports and a mental health officer report confirming that the criteria for a hospital direction are met are required. The court must be satisfied that the offender can be admitted to a suitable hospital within seven days.[232]

Hospital directions are recommended where the person meets the criteria for a compulsion order but "where there is little relationship between the specified mental disorder and the index offence or where treating the specified mental disorder is unlikely to significantly reduce the risk that the person poses to the public as a result of mental disorder."[233]

In England and Wales, judges have a similar power to make a 'hospital and limitation direction' under section 45A of the MHA 1983. The criteria for making a section 45A order are very similar to the criteria for a section 37 order.[234]

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[225] CP(S)A 1995, section 59(2).
[226] Patrick, H. and Stavert, J., 2016. (n95) at chapter 46.10.
[227] Mental Health (Care and Treatment) (Scotland) Act 2003, sections 224 and 218.
[228] Scottish Executive, 2005. *Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 3: Compulsory Powers in Relation to Mentally Disordered Offenders*, Chapter 5, at [59]. Edinburgh: Scottish Executive.
[229] Scottish Executive, 2005. (n228) Chapter 5, at [82].
[230] Scottish Executive, 2005. (n228) Chapter 5, at [59].
[231] Patrick, H. and Stavert, J., 2016. (n95) at chapter 46.15.
[232] CP(S)A 1995, section 59A(4).
[233] Scottish Executive, 2005. (n228) Chapter 5, at [103].
[234] MHA 1983, section 45A(2).

Offenders given hospital directions are not fully diverted into the mental health system as their prison sentence determines the date and conditions of their release. Rather than a diversionary measure, the hospital direction ensures that a mentally unwell offender can go straight to hospital for treatment. Once the person recovers, he or she can be transferred to prison.

Custodial sentences

Where a compulsion order or hospital direction is not available or the court decides such an order is not appropriate, the court may choose to impose a prison sentence alone. The prisoner may be later transferred to hospital by the Scottish Ministers under a transfer for treatment direction.[235] There is no power to treat a prisoner without their consent in prison under the MH(CT)(S)A 2003. The prisoner must be transferred to hospital before treatment can be administered without consent.[236]

A decision to transfer the prisoner may be made where compulsory treatment in hospital is necessary and where the prison cannot cater for the person's treatment needs. The criteria are similar to a compulsion order. Where there are doubts surrounding the treatability of the offender's mental disorder or an order is not necessary on risk grounds, a transfer order is not available. Thus, the Scottish legislation presents a barrier to the use of this order for the purposes of post-sentence preventive detention.[237]

Order for lifelong restriction

The order for lifelong restriction (OLR) is unique to Scotland. An OLR is a sentence of imprisonment, or detention, for an indeterminate period.[238] An OLR is available where a person is convicted in the High Court of a serious sexual, violent or life-endangering offence, or is convicted of an offence that, it appears to the court, shows that the person has a propensity to commit a serious sexual, violent or life-endangering offence.[239] If the court is satisfied, on the balance of probabilities, that the risk criteria are met, the court should make a compulsion order or an OLR.[240]

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[235] MH(CT)(S)A 2003, section 136.
[236] If the prisoner is incapable of making a decision to have medical treatment, the treatment may, in limited circumstances, be administered under section 47(2) of the Adults with Incapacity (Scotland) Act 2000. Where the person is incapable of making the decision, this section gives certain individuals the "authority to do what is reasonable in the circumstances, in relation to the medical treatment in question, to safeguard or promote the physical or mental health of the adult".
[237] The MHA 1983 contained a similar 'treatability' test to the Scottish legislation, but this was abolished by the Mental Health Act 2007 to facilitate the preventive detention of individuals categorised as 'dangerous and severely personality disordered' or 'DSPD' in hospital where there were doubts surrounding the effectiveness of treatment for personality disorder. This step was not taken in Scotland, as the OLR was introduced instead. See further Ferguson, E.A., 2021. '*A Sentence of Last Resort': the order for lifelong restriction and the sentencing of dangerous offenders in Scotland*. PhD thesis. University of Glasgow.
[238] CP(S)A 1995, section 210F(2).
[239] CP(S)A 1995, section 210B.
[240] CP(S)A 1995, section 210F(1).

The risk criteria are "that the nature of, or the circumstances of the commission of, the offence of which the convicted person has been found guilty either in themselves or as part of a pattern of behaviour are such as to demonstrate that there is a likelihood that he, if at liberty, will seriously endanger the lives, or physical or psychological well-being, of members of the public at large."[241] The court may choose to combine an OLR with a hospital direction.

OLR prisoners are subject to a risk monitoring plan for the rest of their lives. The Scottish Risk Management Authority (RMA) is responsible for the accreditation of Accredited Risk Assessors, who carry out risk assessments for courts considering making an OLR. The RMA is responsible for approving all Risk Management Plans prepared during the nine months following the imposition of an order for lifelong restriction, and for reviewing annual reports on the implementation of approved Risk Management Plans for the duration of the sentence.[242] In 2019/20, 14 OLRs were imposed.[243]

Discharge and release powers

Compulsion orders

The Mental Health Tribunal for Scotland reviews compulsion orders. In short, if the criteria for making a compulsion order are no longer satisfied, then the Tribunal must order the patient's discharge, even if the patient still poses a risk to the public.[244] This is because detention of individuals on the basis of "unsound mind" under Article 5.1(e) of the ECHR must conform to the criteria set out by the European Court of Human Rights in *Winterwerp*.[245]

The main difference between the discharge criteria in England and Wales and in Scotland is that a tribunal in Scotland may be required to order discharge where treatment is unlikely to alleviate the person's symptoms.[246]

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[241] CP(S)A 1995, section 210E.
[242] Risk Management Authority, *Order for Lifelong Restriction FAQs*.
[243] Scottish Government, 2022. *Orders for Lifelong Restrictions statistics: FOI release FOI/202200278254*.
[244] The full release criteria are as follows: The Tribunal must discharge the patient if it is not satisfied that the patient has a mental disorder. If the Tribunal is satisfied that the patient has a mental disorder, it must discharge the patient if: it is not satisfied (i) that, as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment; and (ii) either— (A) that that medical treatment which would be likely to— (i) prevent the mental disorder worsening; or (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the patient; and (c) that if the patient were not provided with such medical treatment there would be a significant risk— (i) to the health, safety or welfare of the patient; or (ii) to the safety of any other person. Or (B) that it continues to be necessary for the patient to be subject to the compulsion order.
[245] A person can only be detained in hospital on the grounds of unsoundness of mind if they are suffering from a 'mental disorder […] of a kind or degree warranting compulsory confinement.' *Winterwerp v Netherlands* [1979] ECHR 4, at [39].
[246] In England and Wales, so long as the other criteria for detention continue to be met, detention can continue for as long as 'appropriate medical treatment' is 'available', and that this treatment has the

If the patient is subject to restrictions, the Tribunal must choose whether to discharge the patient absolutely or subject to specific conditions. The consent of the Scottish Ministers is required for any suspension of the restriction order and to any transfer of to another hospital.

Only the Tribunal can discharge a restricted patient, and the agreement of the Scottish Ministers is not required.[247] While a restricted patient is on a conditional discharge, the responsible medical officer and the Scottish Ministers are responsible for regular reviews of the person's condition, with a view to making an absolute discharge.[248]

The Scottish Ministers have the power to recall a conditionally discharged restricted patient to hospital if his or her detention in hospital is required. Unlike prisoners released on licence, such patients cannot be recalled to hospital for simply breaching a condition. A decision to recall based solely on risk will violate Article 5.1(e).[249]

Hospital directions

The Scottish Ministers may revoke a hospital direction without any recourse to the tribunal, either after reviewing the patient's case or following a recommendation from the patient's responsible medical officer.[250]

If a person subject to a hospital direction still has time left to serve on their sentence, the Scottish Ministers must 'direct that the person is admitted to prison or another institution or place in which he/she would have been liable to be detained if he/she had not been admitted to hospital under the direction'.[251] In practice, prisoners are often returned to prison to finish their sentences.[252]

Life sentenced prisoners and OLR prisoners can only be released after serving the punishment part of their sentences if the Parole Board for Scotland is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined.[253] Where a patient still requires treatment in hospital after the expiry of his or her prison sentence, an application can be made to the tribunal for a compulsory treatment order.[254]

There is a risk that a person who no longer meets the criteria for detention in hospital could be transferred to prison and suffer a deterioration in their mental health. In

purpose of alleviating or preventing a deterioration in the person's condition. MHA 1983, section 72(1)(b).

[247] Patrick, H. and Stavert, J., 2016. (n95) at chapter 46.11.
[248] Patrick, H. and Stavert, J., 2016. (n95) at chapter 48.33.
[249] Again the *Winterwerp* [1979] ECHR 4 criteria apply here.
[250] Under sections 210(2) or 212(3) or (4) of the MH(CT)(S)A 2003.
[251] MH(CT)(S)A 2003, section 216(2).
[252] Patrick, H. and Stavert, J., 2016. (n95) at chapter 48.38.
[253] Prisoners and Criminal Proceedings (Scotland) Act 1993, section 2(4) and (5).
[254] MH(CT)(S)A 2003, section 71 and Schedule 3.

England and Wales, this has resulted in a "revolving door" problem. Some prisoners who recover sufficiently in hospital are transferred back to prison and then suffer a deterioration in their condition that necessitates a transfer back to hospital. Some appellants successfully appealed against a prison sentence on the grounds of fresh psychiatric evidence that their mental condition is at risk of deteriorating in prison. In such cases, the Court of Appeal has seen fit to substitute a hospital order with restrictions, applying the factors set out in *Vowles*.[255]

As set out in Chapter 2, courts should take into account the risks a prison sentence poses to an offender's rights under Article 3 when deciding sentence. A compulsion order or community sentence may be chosen where a transfer to prison would, in itself, breach Article 3.

There is no published policy on the exercise of the Scottish Ministers' power to return a patient to prison. If this policy were clarified to ensure that an individual would not be returned to prison if this was likely to be detrimental to his or her mental health, this would allow sentencing courts to ensure that the right disposal could be chosen in difficult cases.

Use of disposals, effectiveness, and barriers

Non-custodial sentences

According to Audit Scotland, "the Scottish Government has long had an objective to shift the balance of sentencing, from prison sentences to community-based sentences."[256]

Community payback orders are associated with lower rates of re-offending and cost significantly less per year than a prison place. In 2017/18, 49% of those released from prison in Scotland serving a sentence of one year or less reoffended, compared to 30% of those who completed a community sentence.[257] According to the Scottish Association for Mental Health Scotland (SAMH), the average cost of a community payback order including requirements is around £2,400, approximately half the cost of a three-month prison sentence.[258] A package of mental health support for a community sentence is likely to reach around £4,300 per year.[259] By comparison, a prison place costs £37,334 per year.[260]

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[255] See further O'Loughlin, A., 2021, (n117), and the cases cited within, particularly *Turner* [2015] EWCA Crim 1249; *Hoppe* [2016] EWCA Crim 2258; *Ahmed* [2016] EWCA Crim 670.
[256] Audit Scotland, 2021. *Community justice: Sustainable alternatives to custody*, p. 3. Edinburgh: Audit Scotland.
[257] Audit Scotland, 2021. (n256) at p. 3.
[258] Scottish Association for Mental Health Scotland, 2014. *The Right Road: Making Diversion Work for People with Mental Health Problems*, p. 7. Glasgow: Scottish Association for Mental Health Scotland.
[259] Scottish Association for Mental Health Scotland, 2014. (n258) at p. 6.
[260] According to Audit Scotland, a community payback order costs £1,894 per year compared to £37,334 per prisoner place. Audit Scotland, 2021. (n256) p. 3.

Research in England and Wales commissioned by the Ministry of Justice indicates that MHTRs result in a reduction in reoffending.[261] Offenders with significant psychiatric problems given a community order or a suspended sentence order had a lower likelihood of re-offending compared to similar offenders who had been given short-term prison sentences.[262]

Despite new community justice legislation in Scotland,[263] the intended shift has not occurred: "In cases where offenders received either a community or custodial sentence, the proportion who received a community sentence fell from 59 per cent in 2016/17 to 55 per cent in 2018/19, before rising again to 59 per cent in 2019/20." [264]

The number of offenders who receive MHTRs in Scotland are "extremely small and no research has yet been undertaken on its impact on mental health or offending outcomes".[265] In 2020-2021 there were 17 mental health treatment requirements compared to 11,805 unpaid work or other activity supervision. This number is lower than previous years and COVID-19 disruption may be a factor. However, even between 2017-2020 there were only about 43 mental health treatment requirements per year.[266] MHTRs are similarly little-used England and Wales. In 2019, MHTRs accounted for just 0.4% of requirements commenced under community sentences.[267]

Studies in England and Wales have noted that barriers to courts making MHTRs include:

- Poor understanding and awareness of MHTRs amongst health professionals
- Limited screening for mental health problems in criminal justice settings
- Uncertainty amongst professionals as to who should receive an MHTR
- A tendency to exclude certain groups from MHTRs due to their diagnosis
- Difficulties in accessing suitable community mental health care
- Uncertainty as to how to manage breaches by offenders and ethical concerns
- The need to obtain the offender's consent to the requirement.[268]

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[261] Ministry of Justice, 2020. *A Smarter Approach to Sentencing*, paras. 110-13. London: Ministry of Justice; Hillier, J. and Mews, A., 2018. *Do offender characteristics affect the impact of short custodial sentences and court orders on reoffending? Analytical Summary 2018*. London: Ministry of Justice.
[262] Hillier, J. and Mews, A., 2018. (n261) at p. 6. A further recent study of Community Sentence Treatment Requirements in England found statistically significant positive changes in relation to global distress, anxiety and depression and noted that: "the preliminary evidence demonstrates how most individuals experience a significant positive change following intervention, suggesting that MHTR programmes are very promising." Callender, M., 2021. *Community Sentence Treatment Requirements – Exploring Health Outcomes: Preliminary Findings Policy Brief – July 2021*, p. 1. Northampton: Institute for Public Safety, Crime and Justice.
[263] Community Justice (Scotland) Act 2016.
[264] Audit Scotland, 2021. (n256) at p. 3.
[265] Scottish Association for Mental Health Scotland, 2014. (n258) p. 6.
[266] Scottish Government, 2022. *Criminal Justice Social Work Statistics: 2020 – 2021*. Edinburgh: The Scottish Government.
[267] Ministry of Justice, 2020. (n261) at para. 108.
[268] Scott, G. and Moffatt, S., 2012. *The Mental Health Treatment Requirement: Realising a better future*. London: Centre for Mental Health; Molyneaux, E., Vera San Juan, N., Brown, P., Lloyd-Evans,

Research has highlighted that barriers to service user engagement with MHTRs include the service user having poor insight into their mental health difficulties, drug use, high levels of distress, and having at least one previous recorded offence.[269]

Audit Scotland has recommended that the Scottish Government consider, *inter alia*, the factors influencing sentencing pathways and decisions and factors contributing to the overall slow progress in shifting the balance from custody to community sentencing.[270]

Guardianship orders

Between 2011-12 and 2020-21, for each year there is available data, there were fewer than five section 58 guardianship orders each year.[271] These orders may be little-used in Scotland as there is overlap with compulsion orders, which allow treatment in the community. Possible barriers include the fact that an order can only be made where the court is satisfied that the local authority or approved person is willing to receive the offender into guardianship.

Compulsion orders and hospital orders

Evidence suggests that patients admitted to secure hospitals are less likely to reoffend after discharge than prisoners.[272] This finding was confirmed when patients with histories of violent offending were compared to prisoners who had served long sentences.[273] However, these differences could be due to the characteristics of the patients and prisoners rather than due to differences in treatment or release and supervision measures.

There is evidence that diversion from punishment into mental health treatment is associated with reductions in recidivism. An Australian study using a matched cohort of defendants with a diagnosis of psychosis estimated that treatment accounted for a 28% reduction in the estimated risk of reoffending.[274] A metanalysis conducted in 2012 found interventions with mentally ill offenders effectively reduced symptoms of distress

B. and Oram, S., 2021. A Pilot Programme to Facilitate the Use of Mental Health Treatment Requirements: Professional Stakeholders' Experiences, *British Journal of Social Work*, 51, 1041–1059.

[269] Kotterbova, E. and Lad, S., 2022. Predictors of engagement in female offenders accessing mental health treatment requirements, *The Journal of Forensic Psychiatry & Psychology*, 33:1, 53-67.

[270] Audit Scotland, 2021. (n258) at p. 10.

[271] Mental Welfare Commission for Scotland, 2021. (n101) at Table A17.

[272] Fazel, S., Fimińska, Z., Cocks, C. and Coid, J., 2016. Patient outcomes following discharge from secure psychiatric hospitals: Systematic review and meta-analysis, *The British Journal of Psychiatry: the Journal of Mental Science*, 208, 17–25.

[273] Fazel, S. et al., 2016. (n272).

[274] Weatherburn, D., Albalawi, O., Chowdhury, N., Wand, H., Adily, A., Allnutt, S. and Butler, T., 2021. Does mental health treatment reduce recidivism among offenders with a psychotic illness? *Journal of Criminology*, 54(2): 239-258.

and improved behaviour, and interventions targeting offending produced "significant reductions in psychiatric and criminal recidivism".[275]

While there are often concerns that patients given compulsion orders will be released too early, or released while they still pose a risk to the public, the average stays in forensic mental health services in Scotland are lengthy and progress towards release is slow.[276] Forensic patients are generally required to move down through levels of security before being released into the community, and delays in the Scottish system means that this can take many years.

According to the Independent Forensic Mental Health Review, the mean length of admission to high secure settings is 6.01 years, to medium secure is 2.73 years, and to low secure is 4.34 years.[277] Data is not routinely gathered on the average journey time towards release, but the Review estimates that it would take an average of 13 years for a patient to progress from high secure to low secure conditions before consideration for release.[278] Delays are common in releasing patients from low secure conditions into the community due to a shortage of suitable accommodation and care packages.[279]

More research is needed to determine whether prison sentences or compulsion orders provide better overall protection for the public, or which orders perform best for which groups of patients.

There are concerns that people with learning disabilities are being detained for longer than necessary in secure hospitals, and that these individuals would likely have spent a shorter time in prison. The Independent Forensic Mental Health Review recommends that offenders with learning disabilities should be supported to go through the criminal justice system where appropriate, and they should only be diverted to hospital where this is not possible.[280] A community payback order with a treatment requirement attached may be a suitable alternative to a prison sentence, but care should be taken to ensure that the person understands the conditions of the order to maximise prospects of success.[281]

[275] Morgan, R. D., Flora, D. B., Kroner, D. G., Mills, J. F., Varghese, F., Steffan, J., 2012. Treating offenders with mental illness: A research synthesis, *Law and Human Behaviour*, 36(1): 37–50.
[276] Scottish Government, 2021. (n48) at p. 37.
[277] Scottish Government, 2021. (n48) at p. 37.
[278] Scottish Government, 2021. (n48) at p. 37.
[279] Scottish Government, 2021. (n48) at p. 40.
[280] Scottish Government, 2021. (n48) at p. 69. See also Bowden, K., Douds, F. and Simpson, Y., 2011. *People with Learning Disabilities and the Criminal Justice System*, p. 31. Edinburgh: The Scottish Government.
[281] Scottish Government, 2019. *Community Payback and Scottish Government, Community Payback Order Practice Guidance*. Edinburgh: The Scottish Government.

Between 2011-12 and 2020-21 there were at most 60 section 57A(2) compulsion orders issued in a year.[282] This was the most common type of compulsion order and others, e.g. in the community or under section 57(2), were less common.[283]

A significant barrier to the making of hospital orders in England and Wales is the requirement that the court must be satisfied that arrangements have been made for the person's admission to that hospital within 28 days of the making the order.[284] In Scotland, the time limit in respect of compulsion orders is even shorter, at seven days. There is no such limitation on the making of community orders or prison sentences. Hospitals are not obliged to accept patients under a compulsion order and may refuse admission on clinical grounds, for example where the hospital cannot provide appropriate treatment or an appropriate level of security for the person, or where a bed is simply not available.

Pressures on beds in Scotland suggests that the 7-day period is likely to pose a barrier to the making of these orders. The Independent Forensic Mental Health Review heard reports that the forensic mental health service in Scotland is operating at 100% of capacity, that patients are being held in conditions of excessive security and that there are long delays in transferring patients to lower security.[285]

A shortage of beds is a particular problem for female offenders. There are no high secure forensic mental health places for women in Scotland, and women are therefore sent to Rampton Hospital in Nottinghamshire for treatment.[286] The Rampton secure pathway is unfit for purpose, and women spend long periods in medium secure care (often in segregation) awaiting arrangements for transfer to Rampton.[287] The Independent Forensic Mental Health Review concluded that this arrangement raises human rights concerns and recommended that a high secure service for women be established in Scotland as a matter of urgency.[288] There is a shortage of low secure inpatient facilities for young people, which can result in young people being housed in adult units. Young people who require medium secure care are placed in England, away from their support networks.[289]

Hospital directions / hospital and limitation directions

Little information is available on the outcomes of hospital directions in Scotland or in England and Wales. Psychiatrists in England and Wales appear concerned that there is a lack of outcome data for patients sentenced to section 45A orders and that it is

[282] Mental Welfare Commission for Scotland, 2021. (n101) at Table A17.
[283] Mental Welfare Commission for Scotland, 2021. (n101) at Figure 32.
[284] Grounds, A., 2019. Discrimination against offenders with mental disorder, *Crim Behav Ment Health*, 29: 247–255.
[285] Scottish Government, 2021. (n48) at p. 33.
[286] Scottish Government, 2021. (n48) at p. 26.
[287] Scottish Government, 2021. (n48) at p. 26.
[288] Scottish Government, 2021. (n48) at p. 27.
[289] Scottish Government, 2021. (n48) at p. 75.

therefore difficult to know if these orders provide better protection for the public than hospital orders with restrictions under sections 37 and 41. Some further expressed concerns that a return to prison could undo therapeutic progress achieved in hospital, while some had ethical concerns about recommending an order that involved punishment.[290]

As with some other mental health disposals in Scotland, hospital directions are not commonly used. Between 2011-2012 and 2020-2021, where figures are available, there were less than five hospital directions each year.[291] Little research is available on the use of hospital directions in Scotland. In England and Wales, hospital and limitation directions have only seen a modest increase over time.[292] In 2019, 1.6% of restricted patients admitted to hospital were section 45A patients, whereas section 37/41 patients accounted for 15.3 per cent.[293] Thus, hospital orders with restrictions are a more popular option with courts in England and Wales. As with compulsion orders, problems with finding a suitable bed may pose a barrier to judges who wish to make a hospital direction in Scotland.

There is evidence that the hospital and limitation direction (section 45A order) is unpopular amongst psychiatrists, and this may mean that they are reluctant to recommend the order to judges. The Royal College of Psychiatrists recommended abolishing the order in 2018 on the grounds that it posed risks to patient safety while failing to enhance the safety of the public.[294]

One interview study suggests that psychiatrists are likely to recommend a section 45A order at sentencing only in a narrow set of cases.[295] This included where the offender had a primary diagnosis of personality disorder, or a psychotic illness coupled with a personality disorder and/or substance misuse disorder that was less likely to respond to treatment.[296]

[290] Beech, V., Exworthy, T., Blackwood, N. J., Marshall, C. M. and Peay, J., 2019. Forty-five revolutions per minute: a qualitative study of Hybrid Order use in forensic psychiatric practice, *Journal of Forensic Psychiatry and Psychology*, 30, 3, 429-447.
[291] Mental Welfare Commission for Scotland, 2021. (n101) at Table A17.
[292] Ministry of Justice, 2021. *Offender management statistics quarterly: October to December 2020. Restricted Patients: 2020*. London: Ministry of Justice.
[293] Ministry of Justice, 2020. *Restricted Patients: 2019*. Statistical Tables, Table 7. London: Ministry of Justice.
[294] Royal College of Psychiatrists, 2018. *Review of the Mental Health Act 1983. The Royal College of Psychiatrists' submission of evidence*. London: The Royal College of Psychiatrists.
[295] Beech, V. et al., 2019. (n290).
[296] Beech, V. et al., 2019. (n290).

Custodial sentences

Studies demonstrate that in-prison rehabilitative programmes only have a small impact on re-offending rates.[297] While small studies of psychological interventions showed reduce reoffending outcomes, this effect was not present in larger studies.[298] Based on two studies, therapeutic community treatment was associated with reduced recidivism rates, but the effect was small.[299]

In-prison programmes used in England and Wales are associated with a small reduction in general re-offending but have no statistically significant impact on serious offending.[300] A recent evaluation of the Sex Offender Treatment Programme (SOTP) concluded that participation may have increased participants' propensity to re-offend. 10% of those who completed treatment and 8% of those who were untreated committed at least one sexual offence over an average follow-up period of 8.2 years.[301] SOTP has since been discontinued in England and Wales.

Imprisonment is associated with worse mental health outcomes for prisoners with severe and enduring mental disorders. HM Chief Inspector of Prisons for Scotland reports that prisoners with severe and enduring mental disorders cause significant difficulties for prison management. Moreover, "the fact and nature of imprisonment itself does real harm to people with severe and enduring mental health problems".[302] HM Chief Inspector of Prisons for Scotland concluded that: "the use of imprisonment is inappropriate for people with severe and enduring mental health problems. Their primary need is their mental health and the appropriate place to address this is a hospital."[303] Furthermore, a study of ex-prisoners in England found that mental disorders were more common amongst those who had been imprisoned compared to those who had never been, even after controlling for other factors, and concluded that "incarceration and the experience of release appear to have appreciable long-term psychiatric consequences".[304]

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[297] Beaudry, G., Yu, R., Perry, A. E., and Fazel, S., 2021. Effectiveness of psychological interventions in prison to reduce recidivism: a systematic review and meta-analysis of randomised controlled trials, *The Lancet Psychiatry*, 8(9): 759-773.
[298] Classified as studies with over 50 participants.
[299] Beaudry, G. et al., 2021. (n297).
[300] Robinson, C., Sorbie, A., Huber, J., Teasdale, J., Scott, K., Purver, M. and Elliott, I., 2021. *Reoffending impact evaluation of the prison-based RESOLVE Offending Behaviour Programme*. London: Ministry of Justice; Sadlier, G., 2010. *Evaluation of the impact of the HM Prison Service Enhanced Thinking Skills programme on reoffending Outcomes of the Surveying Prisoner Crime Reduction (SPCR) sample. Ministry of Justice Research Series 19/10*, i. London: Ministry of Justice.
[301] Mews, A., Di Bella, L. and Purver, M., 2017. *Impact Evaluation of the Prison-Based Core Sex Offender Treatment Programme*, p. 3. London: Ministry of Justice.
[302] HM Chief Inspector of Prisons for Scotland, 2008. (n9) at para. 3.38.4.
[303] HM Chief Inspector of Prisons for Scotland, 2008. (n9) at para. 8.8.
[304] Bebbington, P. E., McManus, S., Coid, J. W., Garside, R. and Brugha, T., 2021. The mental health of ex-prisoners: analysis of the 2014 English National Survey of Psychiatric Morbidity, *Social Psychiatry and Psychiatric Epidemiology*, 56:2083–2093, p. 2087.

A qualitative study in England & Wales has highlighted that there is often pressure on clinicians working in medium secure hospital units to agree to return transferred prisoners back to prison at the end of treatment due to shortages of beds or resources.[305] Sometimes patients were transferred back because they were serving a lengthy sentence and could not remain in the unit until their release date. For some patients, clinicians felt that a transfer to prison was appropriate, for example: where the patient was near their release date from prison; or refused to engage with treatment; or acted violently towards hospital staff; or had a primary personality disorder diagnosis. But clinicians acknowledged that transferring patients to prison sometimes resulted in a deterioration in their condition in the prison environment, and a revolving door pattern of referrals between prison and hospital. Clinicians also felt that mental health aftercare is often poorer for prisoners released directly from prison than for patients discharged from hospital into the community. For that reason, clinicians sometimes sought to hold on to patients to ensure they stayed on an appropriate care pathway.[306]

The European Committee for the Prevention of Inhuman or Degrading Treatment report on Scottish prisons in 2019 found that a lack of high secure forensic mental health places for women in Scotland meant that some seriously mentally ill prisoners were cared for in inappropriate prison environments.[307] There are also significant delays in transferring women to hospital, with an average of 43.2 days between referral and transfer.[308] Transfer times for men compared positively to England and Wales,[309] with an average of 11.4 days for urgent referrals and an average of 27.4 days for non-urgent referrals to be completed.[310]

Sentencing courts can make use of their powers to divert offenders who have identified severe mental disorders at sentencing to treatment in hospital under a compulsion order. Consideration should also be given to making greater use of community sentences with MHTRs attached for offenders with mental disorders who do not pose a serious risk to the public. Based on data from England and Wales, these may be more effective in reducing recidivism than short prison sentences (see above).

[305] Leonard, S. J., Sanders, C. and Shaw, J.J., 2021. Managing returns to prison from medium-secure services: qualitative study, *BJPsych Open*, 7, e111, 1–11.
[306] Leonard, S. J. et al., 2021. (n305).
[307] Report to the United Kingdom Government on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 14 to 18 October 2019, [36] – [37].
[308] Scottish Government, 2021. (n48) at p. 28.
[309] The latest available figures estimate transfer times of an average of 100 days. Department of Health and Social Care, 2018. *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion. Final Report of the Independent Review of the Mental Health Act 1983*. London: Department of Health and Social Care.
[310] Scottish Government, 2021. (n48) at p.51. The Review considered, however, that "the data collected by the Forensic Network on transfers from prison to forensic mental health services may be underestimating the time the process takes from start to end."

Orders of lifelong restriction

OLRs are not a common disposal in Scotland. Only 14 were imposed in 2019-20 and as of the 31st of March 2021 there were 206 individuals currently serving an OLR. 13 have been released into the community to date and 5 have been recalled to prison.[311] The Risk Management Authority note:

> "An initial report on OLR offending behaviour will be published… in 2021-22, followed by further research examining rates of psychopathy and personality disorder. This research will show if rates are as overrepresented in the population as is expected to be, which may then have implications in terms of progression pathways and the long term risk management of individuals with an OLR."[312]

At the time of writing these reports are not available. However, in due course, they will likely be relevant to the matters discussed in this report. No outcome studies were found relating to orders of lifelong restriction.

Substance misuse

Offenders given a community payback order and drug treatment and testing order (DTTO) have the highest reconviction rate and highest average number of reconvictions per offender of any disposal. This high reconviction rate may, however, be attributable to substance misuse rather than to the effectiveness of the order.[313]

According to Perry, "therapeutic community interventions and mental health treatment courts may help people to reduce subsequent drug use and/or criminal activity."[314] The evidence for other interventions is uncertain. Sirdifield et al. found that "evidence to suggest that [specialist] courts may have positive impacts in terms of engaging people in treatment and reducing substance misuse"; however, "there was huge variation in terms of eligibility criteria, programme content, programme structure, staffing, and graduation rates achieved. Thus, recommending any one model is problematic."[315]

Liaison and diversion services

Liaison and diversion (L&D) services have been rolled out across England and Wales[316] and provide information to sentencing courts, including written reports

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[311] Risk Management Authority, 2021. *Annual Reports and Accounts: 2020-2021*, p. 8 and p. 28. Paisley: Risk Management Authority.
[312] Risk Management Authority, 2021. (n311) at p. 16.
[313] Scottish Government, 2021. *National Statistics Reconviction Rates in Scotland: 2018-19 Offender Cohort*, p. 25. Edinburgh: The Scottish Government.
[314] Perry, A. E., Martyn-St James, M., Burns, L., Hewitt, C., Glanville, J. M., Aboaja, A., Thakkar, P., Santosh Kumar, K. M., Pearson, C., Wright, K. and Swami, S., 2019. Interventions for drug-using offenders with co-occurring mental health problems, *Cochrane Database of Systematic Reviews*, 10. Art. No.: CD010901.
[315] Sirdifield, C., Brooker, C., and Marples, R., 2020. Substance misuse and community supervision: A systematic review of the literature, *Forensic Science International: Mind and Law*, (1) 100031, p. 10.
[316] Fazel, S. et al., 2016. (n272).

outlining the person's vulnerabilities and how these vulnerabilities may impact upon their behaviour (including offending) and on sentencing.[317]

Structured deferred sentence schemes have been piloted in Scotland and have received favourable evaluations.[318] The providers of local L&D schemes in Scotland are positive about the impact the schemes have on the mental health of clients, and one service reported a reduction in the number of custodial sentences. However, as robust evaluation data is not available it is difficult to provide an assessment of the impact of these schemes on reoffending or costs.[319]

A recent evaluation of L&D services in England and Wales found that successful referral reduced the possibility of a prison sentence by 45%.[320] Diversion from custody after successful referral to L&D services was estimated to result in a net saving of £8.83 million to the state.[321] There is, however, no evidence available on the impact of L&D on reoffending. Nevertheless, national L&D services in Scotland would likely improve information sharing and the quality of reports for sentencing judges.

SAMH summarises the challenges faced by local L&D services in Scotland as follows:

- Dependence on good relationships with local Procurator Fiscal as the sole source of referrals for most schemes
- Frequent changes in Procurator Fiscal staff
- Dependence on local informal relationships
- Diversion often not an operational priority in statutory teams' work
- Lack of dedicated budgets for diversion
- Vulnerability to staffing and budgetary pressures, with few specific diversion budgets
- Time-limited interventions limit the extent of behaviour change that can be achieved
- Lack of research into long term impacts on client behaviour
- Ability of police to confidently identify possible mental health problems.[322]

[317] NHS England and NHS Improvement, 2019. *Liaison and Diversion Standard Service Specification 2019*, p. 15.
[318] Scottish Association for Mental Health Scotland, 2014. (n258) at p. 8.
[319] Scottish Association for Mental Health Scotland, 2014. (n258) at p. 9.
[320] Disley, E., Gkousis, E., Hulme, S., Morley, K., Pollard, J., Saunders, C., Sussex, J. and Sutherland, A., 2021. *Outcome Evaluation of the National Model for Liaison and Diversion*. Cambridge: Rand Europe
[321] This is based on an average prison sentence length of 222 days and on a saving of £38.14 million to the criminal justice system and L&D service costs of £29.31 million. Disley, E. et al., 2021. (n320) at p. 97.
[322] Scottish Association for Mental Health Scotland, 2014. (n258) at p. 8.

SAMH recommended that a national L&D service be rolled out in Scotland.

Conclusion

While the available evidence on outcomes is limited, the most promising disposal in terms of reducing recidivism and addressing mental health problems is a community sentence coupled with an MHTR. There is some evidence to support the diversion of mentally disordered offenders into the hospital system through a compulsion order, as hospital treatment is associated with better mental health outcomes and may reduce recidivism. However, as the criteria for a community sentence and MHTR differ from the criteria for a hospital disposal, the characteristics of offenders given these disposals are likely to differ. This makes it difficult to directly compare the outcomes of different disposals. Better quality large-scale studies with matched control groups are needed to determine the relative impact of these disposals on recidivism and mental health outcomes.

Data on length of stay in forensic mental health services suggests that high risk patients spend a long time progressing down through levels of security before release and transfers between services are subject to significant delays. There are problems with access to forensic mental health beds, which may pose a barrier to the making of compulsion orders. There are also serious concerns with the provision of secure mental health services to female prisoners.

There is evidence that treatment programmes in prisons may be effective in reducing general re-offending but are less likely to be effective in reducing serious reoffending. It is clear that prison sentences are detrimental to offenders with severe mental illness and most prisons are ill-equipped to cater to the needs of this group. Prison sentences may be suitable for offenders with less severe mental health disorders and learning disabilities who do not require hospitalisation. These cases should, however, be considered individually.

Limited data is available on the effectiveness of the hospital direction. These orders may be recommended where there is a weak link between the disorder and the offending. An OLR may be suitable for a person who is thought to pose a serious risk to the public. There are reasons, however, for avoiding prison sentences and OLRs coupled with hospital directions for offenders who suffer from severe mental disorders. Recovery in hospital may result in a transfer to prison and a deterioration in their condition. The use of these orders would therefore be better restricted to individuals who can be safely sent to prison after receiving treatment in hospital.

There is a need for clarification of the Scottish Ministers' policy in respect of transfers of patients to prison. If this policy were clarified to ensure that an individual would not be returned to prison if this would be detrimental to his or her mental health and human

rights, this would allow sentencing courts to ensure that the right disposal could be chosen in difficult cases. Such cases include offenders whose culpability is high, or who are thought to pose a high risk to the public that is unlikely to be reduced through hospital treatment, but for whom a transfer to prison is likely to be highly detrimental.

Chapter 4: The role of reports in sentencing defendants with mental disorders

Reports to the courts at sentencing provide important information about a defendant's mental health status, current and ongoing mental health treatment needs, and risk of reoffending. This chapter will consider the main sources of mental health expert evidence in Scotland: psychiatrists, social workers and specialist mental health officers (MHOs). It will also consider the role of psychiatrists and probation staff in England and Wales. Other relevant expert services include the Risk Management Authority (RMA) in Scotland and Liaison and Diversion (L&D) Services in England.

Psychiatric expert evidence is considered first, as a requirement of hospital disposals and the primary source of evidence to the courts on an offender's mental disorder and the availability of treatment. Social work and probation pre-sentence reports are then reviewed. In Scotland, the RMA was set up to consider the risk of all serious violent and sexual offenders prior to sentencing, regardless of mental disorder, and is therefore relevant here. Finally, L&D court services in England can provide additional or alternative information to the courts to inform sentencing decisions in respect of offenders with mental disorders.

The chapter reviews the limited availability of mental health and offending information needed to write reports, the wealth and limits of psychiatric evidence, the limits of social workers' mental health expertise, the limits of risk assessment measures, the inconsistent and limited use of expert mental health evidence by the courts, and the potential and current limits of available expert services.

Psychiatric expert evidence to the courts

In Scotland, the prosecutor or Scottish Ministers are required to apply to the court for an assessment where it appears the person may be suffering from a mental disorder.[323] In England and Wales, the court must consider a medical report before imposing a custodial sentence on a person suspected of suffering from a mental disorder, unless the court finds it unnecessary to do so.[324] Circumstances where it may be considered unnecessary include: if up-to-date medical evidence is available, if custodial time has already been served, or if a sentence is mandatory.

Where a compulsion order for hospital or community care is considered, medical evidence must be sought from two doctors, an approved medical practitioner (AMP) and the care provider.[325] Advice on report completion is contained in the Mental Health

[323] CP(S)A 1995, section 52.
[324] Criminal Justice Act 2003, section 157(1)-(2).
[325] Under the CP(S)A 1995 amended by the MH(CT)(S)A 2003, the Criminal Justice (Scotland) Act 2003 and Mental Health (Scotland) Act 2015, section 39.

(Care and Treatment) Act Code of Practice that stipulates doctors should recommend the least restrictive option, must explain why a community option is not appropriate and the level of secure accommodation must be proportionate to risk.[326]

Similarly, in England and Wales[327], the powers of the court to order remand to hospital for assessment or hospital admission for treatment are dependent on the evidence from two registered medical practitioners, although hospitalisation cannot take place without the written or oral evidence of the approved clinician who will be the care provider or a representative of the care provider. The approved clinician does not have to be a medical doctor.[328] Medical evidence can be difficult to obtain. Although reports must be ordered, psychiatrists are not obliged to respond and may have limited capacity.[329]

While courts must be satisfied on the basis of medical reports that the criteria for a mental health disposal are met, the same is not true of all psychiatric evidence or evidence from other mental health experts. The defence and prosecution may seek to introduce expert evidence on other matters. According to the Criminal Justice Joint Inspectorate in England and Wales, at sentencing the defence usually applies for psychiatric reports on culpability, or to assist in mitigation of sentence: "Very occasionally, the prosecution instructs a psychiatrist where culpability… is an issue."[330] Where such expert evidence is not required by legislation, courts will apply an admissibility test to determine whether the evidence should be heard and what weight it should be given.

Psychiatric evidence, admissibility, reliability and weight

McPherson's recent review of cases regarding Battered Woman Syndrome in Scotland, outlines the four-part test of admissibility regarding expert evidence, set out by the Supreme Court and adopted by the Scottish Court of Appeal, following *Kennedy*.[331] Experts can give evidence so long as:

> "(i) such evidence is necessary to assist the court in its task;
> (ii) they have the necessary knowledge and experience;
> (iii) the presentation and assessment of their evidence is impartial; and
> (iv) there exists a reliable body of knowledge or experience underpinning the discipline to which the expert is affiliated."[332]

[326] Scottish Executive, 2005. (n228)
[327] Under the Mental Health Act 1983, Part III.
[328] Amendments of Part II of 1983 Act in Mental Health Act 2007.
[329] Vaughan, P., Austen, C., LeFeuvre, M., O'Grady, J. and Swyer, B., 2003. Psychiatric Support to the Courts, *Medical Science Law*, 43(3), 255-259.
[330] Criminal Justice Joint Inspectorate, 2021. *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*, p. 81. Manchester: Her Majesty's Inspectorate of Probation.
[331] *Kennedy v Cordia (Services) LLP* [2016] UKSC 6.
[332] McPherson, R., 2019. (n88) at p. 388.

In Scotland, the evidence of a case is not routinely available to psychiatrists, and where this is the case, it should be stated.[333] It is essential that reports are "clear, concise" and "well written"[334] to facilitate non-expert understanding. There is extensive guidance[335] on this process, but limited research,[336] and problems inevitably remain.

Psychiatric evidence and ethical dilemmas in sentencing

The increased use of preventative detention for public protection raises ethical dilemmas for medical experts as their evidence can affect sentencing, both providing the evidence to justify a longer sentence and delay release.[337] In England and Wales, psychiatrists have expressed disquiet regarding their role in sentencing decisions involving prison sentences and hospital and limitation directions (equivalent to a hospital direction in Scotland).[338] Here, psychiatrists may be asked to give evidence as to the offender's culpability, or their evidence may be used by the court as grounds for a punitive sentence that goes against the psychiatrist's view of the patient's therapeutic interests. The role of the psychiatric expert witness is thus frequently in tension with traditional medical ethics, which aim to avoid harm to patients and to benefit them.[339]

The US solution is that those providing reports to the court are not involved in treating the defendant. However, in Scotland most treating psychiatrists will provide evidence to the courts.[340] Similarly, in England and Wales, forensic psychiatrists frequently provide reports to courts on patients they are also treating.[341] Whilst it is "good practice for treating psychiatrists not to provide expert testimony about 'their' patients",[342] the limited field and legal mandates make this impossible to adhere to. Furthermore, a survey of expert medical witnesses across the EU found "there is no single defensible

[333] Chiswick, D., 2003. Invited commentary in expert testimony in court, *Advances in Psychiatric Treatment*, 9, 187–189.
[334] Chiswick, D., 2003. (n333) at p. 188.
[335] See, for example, O'Grady, J. C., 2009. 'The Expert Witness in the Criminal Court: Assessment, Reports and Testimony' in Gelder, M., Andreason, N. C., Lopez-Ibor Jr J. J. and Geddes J. R. (eds.) *New Oxford Textbook of Psychiatry,* second edition. Oxford: Oxford University Press; Rix, K., Eastmand, N. and Adhead, G., 2015. *Responsibilities of psychiatrists who provide expert opinion to courts and tribunals*, College Report CR193. London: The Royal College of Psychiatrists.
[336] Gray, N., & Williams, T., 2008. 'The expert witness: professional practice and pitfalls' in Soothill, K., Rogers, P. and Dolan, M. (eds.) *Handbook of Forensic Mental Health*. Cullompton: Willan Publishing.
[337] O'Grady, J. (2002) Editorial, Psychiatric evidence and sentencing: ethical dilemmas, *Criminal Behaviour and Mental Health*, 12, 179-184.
[338] Beech, V. et al., 2019. (n290).
[339] O'Grady, J. C., 2002. Editorial, Psychiatric evidence and sentencing: ethical dilemmas, *Criminal Behaviour and Mental Health*, 12, 179-184. See further Peay, J., 2016. nX
[340] Chiswick, D., 2003. (n333).
[341] O'Grady, J. C., 2002. (n339).
[342] Rix, K. et al., 2015. (n335) at p. 13.

position" on best practice, finding transparency in role and awareness of potential bias to be most important.[343]

The difficult ethical framework within which psychiatrists must operate is highlighted in differences between prosecution and defence report writers in homicide cases. A study of psychiatric recommendations to the court on homicide cases found that agreement between prosecution and defence reports was moderate "on issues of diagnosis, impairment of responsibility, and disposal",[344] improving to very good levels where report writers were for the same party. This "raises an ethical dilemma" of whether psychiatrists should provide an opinion on "impairment of responsibility",[345] with over half in the study opting not to. The authors suggest reporting on symptoms only in order to improve agreement.

Psychiatric evidence and the choice between penal and hospital disposals

In England and Wales, since the Court of Appeal judgment in *Vowles*,[346] there have been disagreements in the case law as to what role psychiatric experts should have in the assessment of culpability, and thus the need for punishment.

Hallett reflects on the confusion in the case law.[347] *Vowles* raised the importance of establishing culpability as a determinant of the need to punish in the case of mentally disordered offenders. *Edwards*[348] put pressure on psychiatrists to explicitly comment on the effects of mental disorder on a defendant's culpability, to help determine type of disposal and sentence length. *Yusuf*[349] illustrated the difference in opinion that can occur, particularly where mental disorder and illicit substance use intersect. In *Ozone*,[350] the psychiatrist's assessment of culpability was rejected on the grounds that this was a matter for the judge.

This raises a question as to the influence of medical and non-medical factors on culpability. In Australia the case of *Weidlich*[351] explicitly links insight to culpability, suggesting psychiatric evidence is pivotal, however it does not state whether psychiatrists should comment on culpability. Hallett notes the draft mental disorder sentencing guidelines for England and Wales referred to insight – a psychiatric matter – but also to elements such as evidence of premeditation or planning, which may not

[343] Taylor, P. J., Graf, M., Schanda, H. and Vollm, B., 2012. The treating psychiatrist as expert in the courts: Is it necessary or possible to separate the roles of physician and expert, *Criminal Behaviour and Mental Health*, 22(4): 271-292, p. 285.
[344] Roscoe, A., Rodway, C., Mehta, H., While, D., Amos, T., Kapur, N., Appleby, L. and Shaw, J., 2009. Psychiatric recommendations to the court as regards homicide perpetrators, *The Journal of Forensic Psychiatry & Psychology*, 20(3): 366-377, p. 374.
[345] Roscoe, A. et al., 2009. (n307) at p. 373.
[346] [2015] EWCA Crim 45.
[347] Hallett, N., 2020. (n133).
[348] [2018] EWCA Crim 595.
[349] [2018] EWCA Crim 2162.
[350] [2018] EWCA Crim 1110.
[351] *DPP* v. *Weidlich* [2008] VSCA 203.

be a psychiatric matter. Insight remains in the final guidelines while questions of premeditation do not.

Hallett concludes that questions of mental disorder and culpability are debatable, and argues that psychiatrists should only comment on: "capacity and insight into their mental disorder, thinking skills, degree of choice, decision making abilities, help-seeking behaviour, use of illicit substances, disinhibition, risk-taking behaviours, the contribution of the mental disorder towards their offence and their insight into their risks to others."[352]

Rationality should not be discussed but instead, "the effect of a mental disorder on a person's thought processes".[353] Hallett and others argue that psychiatrists should stay within their area of expertise and not comment on culpability to reduce likelihood of involvement in miscarriages of justice.[354]

The case law in England and Wales indicates variable willingness to accept the views of psychiatrists for a hospital disposal. In *Vowles*, the Court of Appeal seemed to prefer a punitive or hybrid disposal and to advocate a sceptical approach to psychiatric evidence.[355] In *Vowles* it was argued "[the] fact that two psychiatrists are of the opinion that a hospital order with restrictions under s.37/41 is the right disposal is… never a reason on its own to make an order".[356] However, in *Westwood*,[357] the Court of Appeal concluded that the sentencing judge had been wrong to reject the 'compelling' conclusions of two psychiatrists. Thus, while sentencing judges are not required to adopt the conclusions of psychiatrists, sentencing decisions must have "a proper foundation in expert medical opinion, or in fact".[358]

The sentencing guideline for England and Wales reflects the principles from *Westwood* and *Vowles*. When assessing culpability, "the sentencer must also state, where appropriate, their reasons for not following an expert opinion."[359]

Psychiatric evidence and judicial decision-making

Henham's study of judicial decision-making for longer than commensurate sentencing reviewed the impact of psychiatric reports.[360] An earlier study found mental illness was a factor in judicial decision-making in over a third of cases but reasons were not

[352] Hallett, N., 2020. (n133) at p. 71.
[353] Hallett, N., 2020. (n133) at p. 71.
[354] Hallett, N., Smit, N. and Rix, K., 2019. Miscarriages of justice and expert psychiatric evidence: lessons from criminal appeals in England and Wales, *British Journal of Psychiatric Advances*, 25(4): 251-264.
[355] O'Loughlin, A., 2021. (n117).
[356] [2015] EWCA Crim 45 at para. 53.
[357] [2020] EWCA Crim 598.
[358] [2020] EWCA Crim 598 at para. 88.
[359] Sentencing Council for England and Wales, 2020. (n3) at [14].
[360] Henham, R., 2003. The policy and practice of protective sentencing, *Criminology & Criminal Justice*, 3(1): 57-82.

reviewed.[361] Henham found judges' "assessments of risk were rooted firmly in psychiatric report recommendations" while "harm prediction appeared a predominantly judicial decision".[362] Medical assessments "typically rationalized how defects in the defendants' personalities and their inability to rationalize past behaviour rendered them a continuing 'threat' to others".[363] 'Dangerousness' was determined by "the defendant's inability to control his violent and/ or sexual impulses".[364] Henham found that judges focused on "previous convictions and offence circumstances as the determinant factors to be extracted from any psychiatric report".[365] He concluded that judicial decision-making on mental health issues lacked transparency. Other research has shown that court officials, including magistrates and judges lack confidence or training in identifying mental health issues that may be addressed in joint training, alongside mental health professionals who lack confidence and knowledge in legal matters.[366]

Clinical risk assessment in psychiatric reports

The primary form of risk assessment in psychiatric medical reports to the courts in Scotland, and England and Wales is "clinical assessment", having "an ethically justifiable edge over other risk measures because they are individually sensitive and dynamic".[367] In the field of risk assessment where assessments are separated into clinical and actuarial, clinical assessments are considered to be less reliable.[368] However, clinical assessments range from unstructured to highly structured, with the latter shown to be as reliable as actuarial assessments.[369] They also provide individualised risk management information, such as the identification of risky behaviour and environmental stressors, that inform risk management plans for public protection purposes.[370]

Clinical assessments work well in clinical settings where they can be revised but their one-off use in courts is more problematic as they are designed to be dynamic and link to changes in insight and behaviour.[371] For individuals with schizophrenia, risk

[361] Flood-Page, C. and Mackie, A., 1998. *Sentencing practice: an examination of decisions in magistrates' courts and the Crown Court in the mid-1990's*. London: Home Office.
[362] Henham, R., 2003. (n360) at p. 69.
[363] Henham, R., 2003. (n360) at p. 69.
[364] Henham, R., 2003. (n360) at p. 69.
[365] Henham, R., 2003. (n360) at p. 69.
[366] Hean, S., Heaslip, V., Warr, J. and Standon, S., 2011. Exploring the potential for joint training between legal professionals in the criminal justice system and health and social care professionals in the mental-health services, *Journal of Interprofessional Care*, 25(3): 196-202.
[367] Eastman, N., Gunn, J. and Shooter, M., 2005. The psychiatrist, courts and sentencing: the impact of extended sentencing on the ethical framework of forensic psychiatry, *Psychiatric Bulletin*, 29(2): 73-77, p. 75.
[368] Kemshall, H., 2001. *Risk assessment and management of known sexual and violent offenders: A view of current issues*. Police Research Series, Paper 140. London: Home Office.
[369] Singh, J. P., Grann, M. and Fazel, S., 2011. A comparative study of violence risk assessment tools: a systematic review and meta-regression analysis of 68 studies involving 25,980 participants, *Clinical Psychology Review*, 31(3): 499-513.
[370] Kemshall, H., 2001. (n368).
[371] Eastman, N. et al., 2005. (n367).

assessment tools have been found to have little utility.[372] Risk assessment measures are most commonly reported in social enquiry reports (SERs) or pre-sentence reports (PSRs).[373]

Social Work and SERs in Scotland

Social workers in Scotland are mandated to write pre-sentence SERs for certain cases[374] to advance the use of community sentencing.[375] However, an increase in the quality[376] and quantity of reports, an 80 percent rise in SERs between 1991-1996 and 2001-2006 for a similar number of cases, did not result in greater use of community sentencing.[377] The SER "is to provide advice and information"[378] and risk assessments, on the suitability and feasibility of community disposals, and post-custody supervision requirements. Risk assessments are required to assess the likelihood of reoffending, as well as the risk of harm to others in more serious cases.[379] SERs must contain information on the offending behaviour, individual's circumstances and motivation to change, including information on mental health, substance use and risk of harm to self.[380]

A series of papers[381] report the findings of a four year study exploring social workers' and sentencers' views on report writing and sentencing for 'summary cases', which account for over 97 percent of all SERs.[382] The first paper reported that: questions on why individuals offend and motivation to change were informed by professional judgement and compliance with interview; the lack of access to witness statements and police reports meant greater reliance on interviews; and a lack of clarity on mental health diagnosis and engagement with services limited the information.[383] Reliance on interview information is particularly problematic for individuals with mental disorders

[372] Singh, J. P., Serper, M., Reinharth, J. and Fazel, S., 2011. Structured assessment of violent risk in schizophrenia and other psychiatric disorders: A systematic review of the validity, reliability, and item content of 10 available instruments, *Schizophrenia Bulletin*, 37(5): 899-912.
[373] Van Ginneken, E. F. J. C., 2019. 'The use of risk assessment in sentencing' in de Keijser, J. W., Roberts, J. V. and Ryberg, J. (eds.) *Predictive sentencing: Normative and empirical perspectives*. Oxford: Hart Publishing.
[374] For offenders under the age of 21 and for all adult offenders who may be sentenced to custody for the first time.
[375] Halliday, S., Burns, N., Hutton, N., McNeill, F. and Tata, C., 2008. Shadow writing and participant observation: A study of criminal justice social work around sentencing, *Journal of Law and Society*, 35(2): 189-213.
[376] Tata, C., Burns, N., Halliday, S., Hutton, N. and McNeill, F., 2008. Assisting and advising the sentencing decision-process: The pursuit of quality in pre-sentence reports, *British Journal of Criminology*, 48(6): 835-855.
[377] Halliday, S., Burns, N., Hutton, N., McNeill, F. and Tata, C., 2009. Street-level bureaucracy, interprofessional relations, and coping mechanisms: A study of criminal justice social workers in the sentencing process, *Law and Policy*, 31(4): 405-428.
[378] Halliday, S. et al., 2008. (n375) at p. 192.
[379] Halliday, S. et al., 2008. (n375).
[380] Halliday, S. et al., 2008. (n375).
[381] Halliday, S. et al., 2008. (n375); Tata, C. et al., 2008. (n376); Halliday, S. et al., 2009. (n377).
[382] Halliday, S. et al., 2008. (n375).
[383] Halliday, S. et al., 2008. (n375).

who may not disclose information[384] limiting SERs as a source of information on mental health matters.

SERs and judicial decision making

The second paper found the needs of sentencers were elusive and shifting.[385] The high concordance between sentencers and reports was, in part, a result of report writers second- guessing sentencers' expectations. This matched feedback from sentencers who acknowledged that they ignored reports that gave 'unrealistic' advice. According to Tata et al., sentencers "tended to look first at the end of the report… a report that suggested a sentence that the sheriff saw as unrealistic would risk being dismissed".[386] Sentencers were reliant on defence solicitors to draw their attention to other relevant information, such as learning difficulties. However, reports were often received on the day of a hearing and information was likely to be missed.[387] This is problematic when taken alongside the finding that there is a large emphasis on personal mitigation, including mental disorders, in defence pleas tipping the balance for non-custodial sentences with sentencers.[388]

Social workers and risk assessment

Social workers' views have been found to be largely absent from the risk assessment literature, despite being key providers; Barry's review, commissioned to look at effective approaches to risk assessment in social work, concluded social workers lacked support and confidence for risk assessment, and raised issues of stifled autonomy and risk aversion.[389] This was based in part on a piece of research commissioned to explore the use of risk assessment tools across criminal justice agencies, including social work, in Scotland.[390] It found social workers were more likely to use "easy to administer" tools,[391] validated on general not specific offender populations and reported only partial completion of risk assessments in SERs, owing to time-constraints. Tools used were "mostly inappropriate" for "offenders with mental health problems".[392] And there were "gaps in the availability of information to inform risk assessments, including witness statements and court records"[393] and "health workers – such as GPs and psychiatrists - were said to be reluctant to give access to information".[394]

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[384] Criminal Justice Joint Inspectorate, 2021. (n330).
[385] Tata, C. et al., 2008. (n376).
[386] Tata, C. et al., 2008. (n376) at p. 841.
[387] Tata, C. et al., 2008. (n376)
[388] Millie, A. et al., 2007. (n138).
[389] Barry, M., 2007. *Effective approaches to risk assessment in social work: An international literature review*. Edinburgh: Scottish Executive.
[390] McIvor, G. and Kemshall, H. with Levy, G., 2002. *Serious violent and sexual offenders: the use of risk assessment tools in Scotland*. Edinburgh: Scottish Executive Social Research.
[391] McIvor, G. et al., 2002. (n390) at p. ii.
[392] McIvor, G. et al., 2002. (n390) at p. i.
[393] McIvor, G. et al., 2002. (n390) at p. ii.
[394] McIvor, G. et al., 2002. (n390) at p. 22.

Thus, there are concerns regarding the quality of social workers reports for courts in Scotland. This may have a detrimental impact on justice in sentencing, as evidence that could be taken into account in mitigation may be missed in the report, or overlooked by judges due to time constraints. Report quality and timeliness may also be a barrier to the take-up of community sentences. This suggests that greater training for social workers in effective report-writing is needed, and steps should be taken to improve the timeliness of reports. In England and Wales, the Bradley Review[395] stressed the need for comprehensive information to be available to judges and for training for judges to raise awareness of mental disorders and learning disabilities amongst defendants and its relevance to sentencing. The Report's recommendations may also be relevant for Scotland.

Mental Health Officers and compulsory treatment in the community

Mental Health Officers (MHOs), specially trained social workers, are mandated to interview defendants and write reports for the courts when deciding on whether to make a compulsory treatment order.[396] Assessment must be made on the individual's mental health, whether available medical treatment will prevent worsening or alleviate their mental disorder, whether no treatment will put the individual or others at risk, and whether the order is necessary.[397] No literature has been found on MHOs' expert evidence and report writing for the courts. This is a significant gap in the available evidence, given the key role these reports play in the sentencing process.

Probation work and PRSs in England and Wales

In direct contrast to Scotland, there has been a significant decline in the number of PSRs recorded, with a fall from more than 212,000 in 2010 to fewer than 114,000 a year between 2010 and 2018.[398] In response to this decline an alternative delivery model is being piloted to increase the delivery of timely and quality PSRs, prioritising short format written reports for women, young adults, and those who are at risk of custody, if necessary, through a short five-day adjournment.[399] The Ministry of Justice Analytical Service is conducting an evaluation.

PSRs and mental health

PSRs appear in multiple formats and, as in Scotland, are used to inform on specific disposal options and availability, including the potential effect of custody on vulnerable individuals.[400] They can inform sentencers whether a medical report is needed.[401] According to the Criminal Justice Joint Inspectorate in England and Wales, whilst PSRs are required to include information on the health of defendants, they "do not

[395] Bradley, K. J. C., 2009. (n104).
[396] CP(S)A 1995, section 57C.
[397] CP(S)A 1995, section 57A(3).
[398] Ministry of Justice, HM Prison & Probation Service and National Probation Service, 2021. *Pre-Sentence Report (PSR) Pilot 2021: Defence Legal Representation Briefing*.
[399] Ministry of Justice, HM Prison & Probation Service and National Probation Service, 2021. (n398).
[400] McConnell, P. and Talbot, J., 2013. (n137).
[401] McConnell, P. and Talbot, J., 2013. (n137).

specifically screen for or assess mental conditions or learning disabilities"[402] and "mental health issues are often not recognized, or are only taken into limited consideration".[403] As a result, "far too many reports contain very little analytical information about mental health needs and disorders", including "exploration of trauma" and "individual's diverse needs".[404] "Probation practitioners are often hindered in their work by community mental health service providers who do not 'allow' them access to information"[405] so report writers "rely… on self-reporting" despite the reluctance of defendants to disclose mental health issues.[406] Probation workers report that they are not experts in mental health, and while personality disorder pathway services have increased mental health knowledge in some areas,[407] 70 percent report gaps in their knowledge.[408]

Thus, as in Scotland, there are concerns regarding the quality of PSR reports and access to community mental health information. A short adjournment may benefit this process alongside clear protocols. The joint inspectorate recommended greater training provision from the Offender Personality Disorder Pathway services having identified limited progress in probation's 2019 health and social care strategy.[409] In England and Wales personality disorder awareness training for probation has met with limited success in terms of sustained knowledge and application to practice,[410] and therefore any awareness training would need to be monitored. Awareness training on complex areas of learning may be insufficient to improve practice. Case formulation training for probation staff that combines use of structured clinical assessment with individual case management has met with some success but only when combined with ongoing supervision from mental health experts.[411]

PSRs and risk assessment

PSRs, like SERs, focus on assessments of risk and need. Unlike in Scotland, probation staff have ready access to Crown Prosecution Service documents and

[402] McConnell, P. and Talbot, J., 2013. (n137) at p. 40.
[403] Gough, K., Magness, L., and Winstanley, J., 2012. Auditing a court assessment and advice service for defendants with mental health difficulties: utilizing electronic patients records, *Medicine, Science and the Law*, 52(3): 169-173, p. 169.
[404] Criminal Justice Joint Inspectorate, 2021. (n330) at p. 9.
[405] Criminal Justice Joint Inspectorate, 2021. (n330) at p. 8.
[406] Criminal Justice Joint Inspectorate, 2021. (n330) at p. 9.
[407] Shaw, J., Minoudis, P., Craissati, J. and Bannnerman, A., 2012. Developing probation staff competency for working with high risk of harm offenders with personality disorder: An evaluation of the Pathways Project, *Personality and Mental Health*, 6(2): 87-96.
[408] Criminal Justice Joint Inspectorate, 2021. (n330).
[409] Criminal Justice Joint Inspectorate, 2021. (n330).
[410] Davies, J., Sampson, M., Beesley, F., Smith, D. and Baldwin, V., 2014. An evaluation of Knowledge and Understanding Framework personality disorder awareness training: Can a co-production model be effective in a local NHS mental health Trust?, *Personality and Mental Health,* 8(2): 161-168.
[411] Shaw, J. et al., 2012; Radcliffe, K., McMullan, E. and Ramsden, J., 2018. Developing offender manager competencies in completing case formulation: An evaluation of a training and supervision model, *Probation Journal*, 65(1): 27-38.

previous offending history.[412] The Offender Assessment System (OASys) is the primary probation structured clinical assessment tool designed to measure risk. It has been used for around 20 years and is reliability and validity tested.[413] However, these tests are reliant on the tool being used as designed. This has repeatedly been reported not to be the case, with the recent joint inspectorate on mental health needs finding 83 percent of short format PSRs without full OASys.[414] Of a sample of 60 PSRs, only 60 percent were considered of good quality, and more than 50 percent of reports with deficits in some areas. The electronic version of OASys (eOASys) used in PSRs has also been found to lead to stereotyping of mental disorders.[415] Again this research raises concerns that sentencing decisions based on low quality reports or inadequate information may lead to inappropriate disposals or sentences.

Probation workers' assessments and community mental health disposals

Mental Health Treatment Requirements are not dependent on a psychiatrist's recommendation and are usually suggested by probation or L&D services. They are rarely used, representing less than one percent of all community orders.[416] A recent government push to increase the use of all Community Sentence Treatment Requirement (CSTR) under the CSTR protocol, including MHTRs, in England and Wales is being monitored.[417] The most recent multi-site report on MHTRs reviewed 13 months of data to July 2021.[418] Simple psychometric screening tools indicate that anxiety and depression are the most common mental disorders in a largely medium risk group. Only 45 percent had a completed OASys assessment. Some referrals for mental health problems were considered unsuitable owing to the severity of the disorder, although it is unclear whether the assessment or a lack of provision was problematic.[419] The outcome of the research will be important in understanding how to improve uptake.

Other expert evidence services

RMA and personality disorder in Scotland

Scotland and England and Wales differ in their approach to the assessment and management of individuals with personality disorder. The Scottish approach entails *all*

[412] Criminal Justice Joint Inspectorate, 2021. (n330).
[413] Moore, R. (ed.), 2015. *A compendium of research and analysis of the Offender Assessment System (OASys) 2009-2013*, Ministry of Justice Analytical Series. London: National Offender Manager Service.
[414] Criminal Justice Joint Inspectorate, 2021. (n330).
[415] Fitzgibbon, W. and Green, R., 2006. Mentally disordered offenders: Challenges in using OASys risk assessment tool, *British Journal of Community Justice*, 35-45.
[416] Latham, R. and Williams, H. K., 2020. Community forensic psychiatric services in England and Wales, *CNS Spectrum*, 25(5): 604-617.
[417] Department of Health and Social Care, 2019. *Community Sentence Treatment Requirement Protocol: Process Evaluation Report*.
[418] Callendar, M. and Cahalin, K., 2021. *Community Sentencing Treatment Requirement Multisite Report July 2020-July 2021*. Northampton: Institute for Public Safety, Crime and Justice.
[419] Department of Health and Social Care, 2019. (n417).

serious violent and sexual offenders who pose a high risk of reoffending being dealt with under a general framework for assessment and sentencing,[420] with risk to be assessed independently of mental health.[421] The RMA was set up with statutory responsibility to set standards and publish guidelines[422] on Risk Assessment Reports (RAR) to be requested by the court prior to sentencing.[423] Assessments must be by an accredited assessor based on experience not profession.[424] Assessors include psychiatrists, and clinical and forensic psychologists.[425]

The Risk Assessment Tools Evaluation Directory (RATED) lists available validated assessment tools. There are no tools categorised as mental health specific, although the 'responsivity' category includes tools specific to personality disorder and psychopathy.[426] The Psychopathy Checklist-Revised (PCL-R) Factor 1, the part of the tool that focuses on personality traits as opposed to antisocial behaviour, predicts violence at no better than chance level in men.[427] Tools to predict violent offending perform better than those designed to predict sexual offending.[428] Systematic reviews[429] and meta-analyses[430] have repeatedly shown risk assessment tools to be moderate in their predictive ability. These studies caution that such tools are therefore "not to be used solely for… criminal justice decision-making that requires a very high level of accuracy such as preventive detention"[431] as "if used as sole determinants of sentencing… these instruments are limited by their positive predictive values".[432]

Studies demonstrates that current risk assessment tools return a high rate of 'false positives': that is, offenders judged to be at a high or moderate risk of reoffending who

[420] CP(S)A 1995, section 210B-E.
[421] Tuddenham, L. and Baird, J. (2007) The Risk Management in Scotland and the forensic psychiatrist as risk assessor, *Psychiatric Bulletin*, 31(5): 164-166.
[422] Risk Management Authority, 2018. *Standards and Guidelines: Risk Assessment Report Writing*. Paisley: Risk Management Authority.
[423] CP(S)A 1995, section 210B or 210D.
[424] Darjee, R., 2003. The reports of the Millan and MacLean committees: new proposals for mental health legislation and for high-risk offenders in Scotland, *The Journal of Forensic Psychiatry & Psychology*, 14(1): 7-25.
[425] Tuddenham, L. and Baird, J., 2007. (n421).
[426] Responsivity tools include the Psychopathy Check List-Revised (PCL-R), Psychopathy Check List Screening Version (PCL-R-SV), Psychopathy Check List-Youth Version (PCL-R YV), International Personality Disorder Examination (IPDE), The Comprehensive Assessment of Psychopathic Personality Symptom Rating Scale (CAPP SRS).
[427] Yang, M., Wong, S. and Coid, J., 2010. The efficacy of violence prediction: A meta-analytic comparison of nine risk assessment tools, *Psychological Bulletin*, 136(5): 740-767.
[428] Fazel, S., Singh, J. P., Doll, H. and Grann, M., 2012. Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24,827 people: systematic review and meta-analysis, *BMJ*, 2012; 345: e4692; Buchanan, A. and Leese, M., 2001. Detention of people with dangerous severe personality disorders: A systematic review, *Lancet*, 358(9297): 1955–1959.
[429] Buchanan, A. and Leese, M., 2001. Detention of people with dangerous severe personality disorders: A systematic review, *Lancet*, 358(9297): 1955–1959.
[430] Grove, W. M., Zald, D. H., Lebow, B. S., Snitz, B. E., and Nelson, C., 2000. Clinical versus mechanical prediction: A meta-analysis, *Psychological Assessment*, 12(1): 19-30.
[431] Yang, M., Wong, S. and Coid, J., 2010. The efficacy of violence prediction: A meta-analytic comparison of nine risk assessment tools, *Psychological Bulletin*, 136(5): 740-767, p. 740.
[432] Fazel, S. et al., 2012. (n428) at p. 4.

do not go on to reoffend. In one study, "41% of people judged to be at moderate or high risk by violence risk assessment tools went on to violently offend, 23% of those judged to be at moderate or high risk by sexual risk assessment tools went on to sexually offend".[433] By contrast, these tools are more effective at identifying low risk offenders.

The RMA does not recommend that these tools are used in isolation but in combination using a case formulation-based approach.[434] Although this risk-focused approach was widely welcomed by the medical profession,[435] not all agreed with the explicitly risk based approach to psychiatric work.[436] The formulation approach is very time consuming, and difficult and costly for the defence to challenge.[437]

The RMA addresses concerns that risk assessment tools should not be used in isolation in sentencing. They have limited validity for violent offenders that is reduced further for sexual offenders and individuals with mental health disorders. The RMA case formulation approach has not been shown to have greater predictive validity and therefore should not be used as the sole determinant of sentencing. Transparency of risk assessment limitations is important. Research is needed on how the judiciary utilise these reports as existing research suggests judiciary prefer clinical testimony and are likely to reject research and statistical data.[438] Given the admissibility of RMA reports in courts the process of accreditation must be closely monitored and reports accessible to the defence to challenge.

L&D court services in England

L&D court reports in England are required to follow a nationally agreed format[439] and include information on an individual's "vulnerabilities… and how those vulnerabilities may impact on their… behaviour; ability to effectively participate in court proceedings; and case management, remand and sentencing".[440] Evaluations of the NHS England

[433] Fazel, S. et al., 2012. (n428) at p. 4.
[434] "The relevant information provided within the Risk Assessment Report will be analysed and organised in line with relevant empirically supported theory to provide an explanation of the onset, development, occurrence and maintenance of the offending behaviour. The formulation should articulate the pattern and nature of past offending, estimate the likelihood and seriousness of future harm, and identify the likely scenarios in which offending may occur. This will be communicated meaningfully through a narrative risk formulation." Risk Management Authority, 2018. (n422) at p. 18.
[435] Darjee, R., 2003. (n424).
[436] Eastman, N. et al., 2005. (n367).
[437] Tuddenham, L. and Baird, J., 2007. (n421).
[438] See Redding, R. E., and Murrie, D. C., 2010. 'Judicial decision making about forensic mental health evidence' in Goldstein, A. M. (ed.) *Forensic psychology: Emerging topics and expanding roles*. Hoboken: John Wiley & Sons Inc.
[439] The format was agreed with Senior Judiciary and Her Majesty's Courts and Tribunals Services. NHS England and NHS Improvement, 2019. *Liaison and Diversion Standard Service Specification 2019*.
[440] NHS England and NHS Improvement, 2019. (n439).

L&D scheme, working across the country[441], indicate that assessments completed by L&D staff in the courts are well received by the judiciary.[442] L&D staff can deliver on the day reports, as well as contribute to probation PSRs.[443] Information is obtained through direct interview and electronic NHS records, with the latter having been found to improve efficiency.[444] The provision of this information reduces the need for and delays associated with commissioning full psychiatric reports,[445] where they are not mandated.[446] L&D staff are confident in their ability to assess, inform and divert.[447]

However, interventions and uptake vary, delays remain significant and there is some statistically limited evidence that L&D services are associated with increased sentence length.[448] Some L&D services are not on site and information is not systematically shared with probation, the defence, the prosecution or the court.[449] One of the longest operating services, reviewing 25 years of referrals, found the service predominantly provided assessments on a small number of individuals with severe mental illness, with drug and substance misuse, and neurodevelopmental disorders underrepresented.[450] The addition of experts in neurodevelopmental disorders to an existing L&D scheme limited wrongful diagnosis of comorbidity, improved diagnosis of mental illness, and reduced custodial detention by 10 percent.[451] Thus, while L&D services have shown promise, improvements to coverage and expertise are needed.
In Scotland, similar services have also shown some promise and there is some limited evidence for their effectiveness. However, there is a lack of robust data on the impact of diversion, and a lack of strategic implementation. SAMH has published a set of recommendations for the development of these services based on research from Scotland.[452]

Conclusion

In conclusion, access to report writers and information is highly problematic, limiting the timeliness and usefulness of psychiatric and pre-sentencing reports on mental

[441] Ryland, H., Forrester, A., Exworthy, T., Gallagher, S., Ramsay, L. and Aditya Khan, A., 2021. Liaison and diversion services in South East London: referral patterns over 25 years, *Medico-legal Journal*, 89(3): 166-172.
[442] Disley, E., Taylor, C., Kruithof, K., Winpenny, E., Liddle, M., Sutherland, A., Lilford, R., Wright, S., McAteer, L. and Francis, V., 2016. *Evaluation of the Offender Liaison and Diversion Trial Schemes*. Santa Monica: RAND Europe; Disley, E. et al., 2021. (n320).
[443] Disley, E. et al., 2021. (n320).
[444] Gough, K. et al., 2012. (n403).
[445] Criminal Justice Joint Inspectorate, 2021. (n330).
[446] Gough, K. et al., 2012. (n403).
[447] Disley, E. et al., 2021. (n320).
[448] Disley, E. et al., 2021. (n320).
[449] Criminal Justice Joint Inspectorate, 2021. (n330).
[450] Ryland, H. et al., 2021. (n441).
[451] Chaplin, E., McCarthy, J., Marshall-Tate, K., Ali, S., Xenitidis, K., Childs, J., Harvey, D., McKinnon, I., Robinson, L., Hardy, S., Srivastava, S., Allely, C.S., Tolchard, B. and Forrester, A., 2021. Evaluation of a liaison and diversion Court Mental Health Service for defendants with neurodevelopmental disorders, *Research in Developmental Disabilities*, Volume 119, 1-7.
[452] Scottish Association for Mental Health Scotland, 2014. (n258).

disorders and treatment availability. In Scotland the lack of routine access to the evidence of the case for report writers limits their ability to assess the extent to which offending is attributable to the mental disorder, a primary focus of sentencing. SER writers also have limited access to community mental health information. Reports are only available to defence lawyers on the day, thereby limiting opportunities to draw the courts attention to mitigating mental disorders.

L&D court services can ameliorate some of the difficulties of timeliness of psychiatric reports, where psychiatric reports are not mandated, in providing courts access to expert evidence. However, these services need sufficient expertise to identify and assess less obvious mental disorders beyond active psychosis, such as neurodevelopmental disorders. And where L&D court services exist but do not share information systematically it is likely to obstruct recognition of mental disorders. Limits of L&D expertise need to be made clear, deficits addressed and information sharing protocols to all relevant parties put in place.

The limited pool of forensic psychiatric experts places psychiatrists in a difficult position with their patients and the extension of dangerousness legislation raises significant ethical issues. Psychiatric expert evidence is mandated in some areas and highly relevant to other areas of sentencing. Psychiatric diagnosis is not an exact science. And where risk assessments are based on research, they are moderately predictive for groups not individuals, and therefore not suitable for predictive sentencing. However, psychiatric evidence can and does provide expert knowledge on a wide range of complex issues, related to a defendant's insight and behaviour in relation to their mental disorder, offending and risk; and should therefore be both admissible and given weight in sentencing. The legal issues of culpability and impairment of responsibility are beyond medical expertise and ethical boundaries. The new sentencing guideline for England and Wales, and the existing case law make clear this distinction, whilst recognising the potentially compelling nature of psychiatric expert evidence.

Generic social work and probation pre-sentence report writers lack knowledge of mental health owing to the access issues raised above and lack of specific expertise and training in mental health. Appropriate use of risk assessment tools in SERs and PSRs is limited owing to time and tool constraints. Social workers and probation staff have welfare expertise in identifying vulnerabilities and trauma relevant to mental disorders, but this is not systematically utilized or identified as mitigation.

Sentencers prefer clinical evidence to research and statistical data. Given the limited validity of risk assessment tools this is perhaps preferable. However, it raises questions over the utility of the RMA in Scotland. The limited available research suggests that sentencers focus on past offending and the circumstances of the offence when reading psychiatric reports and SERs, regardless of mental disorder. This

potentially misses reference to mental health symptoms, individual vulnerabilities and the benefits of treatment disposals in both types of reports.

Conclusion

Purpose and scope of review

This report has reviewed the socio-legal literature on sentencing mentally disordered offenders. The primary focus has been on Scotland and England and Wales, due to the similarities in legal structures and sanctions across the two jurisdictions. We draw the following general conclusions from the published literature.

Prevalence of mental disorders and significance for sentencing

Mental disorders are common among the offenders appearing for sentencing, and higher than among members of the general population. Many offenders suffer from one or more of a range of mental disorders. This is true for both jurisdictions although there is some evidence that severe mental disorders are less common in Scottish prisoners. Male and female offenders often present with different mental health disorders.

Mental disorders can contribute, directly or indirectly, to the offending giving rise to the individual's appearance at sentencing. Mental disorders may cause or contribute to offending and re-offending. High levels of comorbidity of mental disorders can make it difficult to determine the relationship between mental disorder and offending in individual cases.

In light of the likely prevalence of mental disorders in the population of individuals appearing for sentencing – and the role that mental disorder may have played in the offence – courts need to be alive to the nature of mental disorders as they relate to crime. Courts need to have an understanding of the diversity of mental disorders and the particular effects these disorders have upon offenders.

The relevance and impact of mental disorders at sentencing will vary greatly. In some cases, they will have an important impact; for others the effect will be minimal. Courts of Appeal in both Scotland and England and Wales, and the Sentencing Council for England and Wales, have long recognised that mental illness or disability is a factor indicating lower culpability.

In addition to potentially reducing the offender's culpability, mental disorder may affect the relative importance of the sentencing objectives pursued by the court. Deterrence or denunciation may be less relevant when sentencing an offender suffering from a mental disorder.

In some cases, the offender will fulfil the criteria for a mental health disposal. These disposals increase the range of disposals available to the court at sentencing. A larger group of offenders suffer from a mental disorder but are not eligible for a mental health

disposal. Nevertheless, the court will still have to determine what effect, if any, the mental disorder should have on the sentence imposed.

When determining the appropriate sanction, a court should consider the nature and severity of the offender's mental disorder. In some cases, certain disposals may be impractical and should be avoided. For example, it may be impossible or very challenging for some mentally disordered offenders to comply with particular requirements of a community sentence.

Similarly, some sanctions, in particular immediate imprisonment, may be far more onerous or may exacerbate existing mental disorders. In such cases, courts attempt to ensure that the disposal ultimately imposed is not disproportionately severe.

The Sentencing Council for England and Wales has issued a guideline for courts sentencing offenders with a mental disorder. This guideline can serve as a useful point of departure for other bodies such as the Scottish Sentencing Council who may be contemplating a similar initiative. The guideline is designed to promote a more consistent approach to sentencing across courts, and functions alongside the Council's offence-specific guidelines. The mental disorder guideline takes advantage of this by directing consideration of mental disorders be made at Step 1 of an offence specific guideline (where the impairment or disorder is linked to the offence) or at Step 2 of an offence specific guideline (where it is not linked to the offence).

The guideline contains a range of information which may be useful for courts, including forms of mental disorder, relevant legislative provisions, and disposal options. The guidance on mental disorders reflects the wide range of mental disorders, the interaction of multiple (mental and physical) disorders (comorbidities), their variable effects on culpability, equality considerations, and the disposals the court may consider.

This guidance offers an accessible resource to promote consistency of approach. Additionally, some inspiration might be drawn from other jurisdictions where courts do not follow sentencing guidelines. For example, the ‘Verdins’ principles set out in the Australian state of Victoria provide another perspective on how guidance may be provided.

Reports

Sentencers are not trained in mental health issues. Accordingly, courts rely on reports provided by mental health and other categories of professional to assist when sentencing mentally disordered offenders. Psychiatric expert evidence is one source of advice for courts, particularly in cases where the court is contemplating imposition of a custodial sanction. Psychiatric reports may include clinical risk assessments and other information which will assist a court in determining the appropriate sanction.

SERs and PSRs provide information and advice for courts at sentencing. The range of information is wide and includes risk assessments, the suitability and feasibility of community disposals, and advice regarding post-custody supervision requirements. Risk assessments are required to assess the likelihood of reoffending, as well as the risk of harm to others in more serious cases. SERs must contain information on the offending behaviour, individual's circumstances and motivation to change, including information on mental disorders, substance use and risk of harm to self.

PSRs are used to inform on specific disposal options and availability, including the potential effect of custody on vulnerable offenders. They can inform sentencers whether a comprehensive medical report is needed. However, PSRs do not specifically assess mental conditions or disabilities and are limited in the extent to which they can inform the court about relevant mental disorders.

The research reviewed raised questions about the timeliness and utility of psychiatric and pre-sentence reports relating to mental disorders. Psychiatric experts may be conflicted in their roles of advising the court and also treating the patient. Social workers and probation officers may lack the necessary expertise and training in mental health. Time and financial constraints also play a role, and these may have become more pressing as a result of the pandemic.

Reports are only available to defence lawyers on the day, thereby limiting opportunities to draw the courts attention to mitigating mental disorders. Liaison and Diversion services can ameliorate some of the difficulties of timeliness of psychiatric reports, where psychiatric reports are not mandated, in providing courts access to expert evidence. However, these services need sufficient expertise to identify and assess less obvious mental disorders beyond active psychosis, such as neurodevelopmental disorders.

The literature suggests that the current provision of information and advice with respect to mental disorder is insufficient. As a result, an as yet unknown proportion of offenders experiencing mental disorders are sentenced without the court having an adequate picture of the mental health dimension. In addition to more, and more systematic information, courts in Scotland may well benefit from greater guidance with respect to sentencing mentally disordered offenders. The Sentencing Council for England and Wales's mental disorder guideline represents one approach to offering guidance to courts, but other models are also worth considering.

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