SENTENCING ACADEMY

MENTAL DISORDER, DISABILITY AND SENTENCING

A review of policy, law and research

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June 2022

EXECUTIVE SUMMARY

- This paper addresses sentencing practices and policies in respect of convicted offenders with mental disorders, disabilities or impairments.
- It considers the alternatives to custody available at sentencing that allow sentencing courts to divert convicted offenders away from punishment in prison and, where appropriate, towards treatment in the mental health system or in the community. It also considers hybrid disposals, which have both punitive and therapeutic elements.
- There is a lack of up-to-date and robust data available on rates of mental disorder amongst defendants and sentenced populations. Studies show high rates amongst prisoners when compared to the general population. However, it is difficult to establish a causal connection between mental disorder and offending and empirical evidence suggests that the relationship is complex.
- There is a long-standing policy of diverting mentally disordered individuals in contact with the criminal justice system away from punishment in prison and towards treatment in psychiatric hospitals and in the community. This can happen at any stage of the criminal justice system, from arrest to sentencing and even after a sentence has begun.
- Courts have five main options for sentencing offenders with mental disorder: guardianship orders, community orders with or without a mental health treatment requirement attached, hospital orders with or without restrictions, hospital and limitation directions ('hybrid orders') coupled with a prison sentence, and a prison sentence alone.
- Despite efforts to reduce barriers to the uptake of alternatives to custody, court usage of orders under the Mental Health Act (MHA) 1983 and mental health treatment requirements remains low.
- Between 1984 and 2016, the use of hospital orders with or without restrictions declined by 49%. During the same period, transfers from prison to hospital increased by 710%. This suggests that powers to divert convicted offenders from imprisonment are being under-utilised.
- Good quality research is available on the barriers to courts passing community orders and mental health treatment requirements. However, equivalent research on the barriers to making orders under the MHA 1983 is lacking.
- Current sentencing guidance states that mental disorders, disabilities and impairments can affect culpability at sentencing or warrant mitigation of penalties where a sentence may be expected to have a disproportionate impact upon the individual.
- Case law emphasises the need to ensure that the sentence adequately reflects culpability and the need for punishment. Recently, however, the Court of Appeal has adopted a more flexible approach that allows sentencing courts to give greater weight to the offender's therapeutic interests and the protection of the public.
- There is a lack of robust research on differences in outcome between community sentences, orders under the MHA 1983, and prison sentences. More research is needed to inform sentencing decisions and policy.

CONTENTS

1. SCOPE OF REVIEW

The presence of a mental disorder or disability 'can affect the normal processes of the criminal justice system at several points' (Hale 2017, p. 5001). This includes at the point of arrest, interrogation, charge, prosecution, trial, conviction, sentencing or disposal, treatment, and release (Peay 2017). At several points in the system, an individual can be dealt with by means of 'diversion' – commonly interpreted as either diversion away from the criminal justice system or diversion away from prison (Bradley 2009, p. 15). Taken in its broadest sense, therefore, diversion not only includes decisions not to prosecute or proceed with a trial, but also court-ordered mental health disposals after conviction, or even transfer from prison to hospital after a person has begun their sentence (Bradley 2009, p. 16).

The focus of this paper is on diversion from prison at the point of sentence. It will also consider 'hybrid' disposals that mandate treatment as well as punishment and powers to transfer mentally unwell prisoners to hospital. In addition, there will be some consideration of mitigation of sentence on the grounds of mental disorder. Police powers, diversion from prosecution, and powers relating to those awaiting trial or sentence or those on remand fall outside the scope of this review.

This paper primarily addresses the sentencing of individuals who meet the broad criteria for mental disorder in the Mental Health Act (MHA) 1983: 'any disorder or disability of the mind' apart from dependence on alcohol or drugs.[1] A learning disability is not regarded as a mental disorder for the purposes of detention and involuntary treatment under the MHA 1983 unless it is 'associated with abnormally aggressive or seriously irresponsible conduct'.[2] This paper will also consider community sentences and mental health treatment requirements for offenders who do not meet the criteria for a disposal under the MHA 1983.

Examples of common mental disorders, disabilities and impairments amongst offender populations are supplied by the Sentencing Council's (2020) Guideline for Sentencing Offenders with Mental Disorders, Developmental Disorders, or Neurological Impairments:

- 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.

1 MHA 1983, s.1(1) and s.1(3).

2 MHA 1983, s.1(2)(A).

2. BACKGROUND

The prevalence of mental disorder amongst sentenced offenders

There have been no large-scale studies of rates of mental disorder amongst criminal defendants or newly sentenced offenders and information is therefore patchy and variable. More information is available on the prevalence of mental health problems amongst sentenced and remand prisoners in England and Wales but the highest quality and most comprehensive studies date from the 1990s (National Audit Office 2017, p. 10). Data on prisoner mental health are neither routinely collected nor reported.

While the available evidence has limitations, it indicates a high prevalence of mental disorder amongst individuals in contact with the criminal justice system and amongst sentenced prisoners in England and Wales. It is estimated that 39% of people detained in police custody have a mental health condition, compared to about 20% of the general population (National Institute for Health and Care Excellence 2017, p. 17). In a recent study of prisoners, 48.8% of participants reported previous contact with mental services in prison or in the community and 42.4% reported having previously been diagnosed with a mental illness (Tyler et al. 2019, p. 1146). In 2021, HM Chief Inspector of Prisons reported that 52% of prisoners surveyed said that they had mental health problems but only 22% reported that it was easy to see mental health workers in prison (HM Chief Inspector of Prisons 2021, p. 42).

Studies suggest that rates of specific mental disorders, disabilities and impairments are significantly higher amongst prisoners than amongst the general population, as can be seen in Table 1.

Table 1: Estimates of Prevalence of Mental Disorder: Prisoners and the General Population

	Prisoners	General population
Psychotic disorders	18%	1%
Learning disability	7%	2%
Traumatic brain injury	50%	0.56%
Personality disorder	55%	12%
Anxiety	36%	7%
Mood disorders	24.5%	5%
PTSD	16%	2%

Sources: Tyler et al. (2019) and National Institute for Health and Care Excellence (2017)

The uncertain relationship between crime and mental disorder

While rates of mental disorder are high amongst prisoners, it is difficult to establish a causal connection between mental disorder and offending. The evidence is more supportive of the view that mental disorder is one factor amongst many that contribute to offending and that the interaction between mental disorder and other factors such as social deprivation, unemployment, homelessness and substance misuse is complex (National Institute for Health and Care Excellence 2017, p. 20). For those already suffering from mental illness, prison can 'exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide' (Bradley 2009, p. 7). High rates of mental disorder amongst prisoners are therefore likely to be a combination of pre-existing vulnerabilities and the impact of the prison environment.

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' (Peay 2017, p. 646). While some mental disorders are associated with an elevated risk of violent offending, alcohol and drug abuse are stronger predictors of criminal conduct than mental disorders. 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. For those diagnosed with personality disorders and schizophrenia spectrum disorders, the rate increased to 6–10%. For those diagnosed with substance misuse disorders, the rate was more than 10% (Whiting et al. 2021, p. 150). This compares to an estimated general population rate of violent offending of between 0.6% and 0.9% over a 10-year period (Sariaslan et al. 2020, p. 363). 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 (National Confidential Inquiry into Suicide and Safety in Mental Health 2021, p. 35).[3]

Policy of diversion

There is a long-standing policy in England and Wales of diverting mentally disordered individuals away from the criminal justice system and away from imprisonment. In 1990, a Home Office circular stated that 'wherever possible, mentally disordered persons should receive care and treatment from the health and social services' (Home Office 1990, p. 2). Where prosecution was considered necessary, the circular stressed that 'it is important to find suitable non-penal disposals wherever appropriate' (Home Office 1990, p. 15). In 2008, the Ministry of Justice went further, stating that 'mentally disordered people who commit offences should receive specialist mental health treatment rather than being punished, wherever that can safely be achieved' (Ministry of Justice 2008, p. 2).

Review recommendations

In 2007, the Government commissioned Lord Bradley to conduct a review of people with mental health problems in contact with the criminal justice system. In 2009, the Bradley Review recommended increasing early identification and diversion from prison where appropriate at all stages of the criminal justice process, including sentencing.

3 For a more detailed review of the relationship between violent offending and mental disorder, see O'Loughlin et al. (2022), Chapter 1.

Like Baroness Corston's 2007 report on women in the criminal justice system, the Bradley Review recommended that local liaison and diversion services be established to provide mental health assessments for offenders and information to judges about defendants' mental health needs (Bradley 2009, p. 74; Corston 2007, p. 78). Bradley further recommended that the judiciary should undertake mental health and disability awareness training and that liaison and diversion services should share information about defendants' learning disabilities and local health and learning disability services with judges (Bradley 2009, p. 74). Separately, the Corston Report recommended training for judges on how community sentences can meet the needs of women.

In some ways, the Bradley Review indicated a shift away from the 2008 position of prioritising treatment over punishment. On the one hand, the Bradley Review recommended that offenders should receive community sentences where appropriate and recognised the detrimental effect of imprisonment on individuals with mental ill-health. On the other, it remarked that even if all opportunities for diversion were utilised, there would still be some individuals with mental health problems for whom prison is appropriate (Bradley 2009, p. 98). The report further implied that those with less severe ill-health should be cared for in prisons, recommending that mental health screening and mental health care in prisons be improved with a view to providing better care for those with mild to moderate mental health problems (Bradley 2009, p. 103).

Implementation

Liaison and diversion (L&D) services have since been rolled out across England and Wales (NHS England 2021). L&D services provide information to sentencing courts, including written reports outlining the person's vulnerabilities and how these vulnerabilities may impact upon their behaviour (including offending) and on sentencing (NHS England and NHS Improvement 2019, p. 15).

A recent evaluation of L&D services found that successful referral reduced the possibility of a prison sentence by 45% (Disley et al. 2021, p. 97). 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.[4]

While there have been some improvements to mental health care in prisons since the Bradley Report, HM Inspectorate of Prisons reported that prisoner access to mental health assessments and treatment was inadequate at half of all prisons it inspected in 2020 and 2021. Restrictive regimes introduced due to Covid-19 have worsened this situation, with prisoners spending an average of 22.5 hours a day locked in their cells and experiencing a decline in their physical and mental health (HM Inspectorate of Prisons 2021).

Steep rises in rates of self-harm and self-inflicted deaths in prison in over the last decade (Ministry of Justice 2022a) suggest that mental health and wellbeing in prison has declined (National Audit Office 2017). Investigations by the Prisons and Probation Ombudsman found that 70% of prisoners who died by self-inflicted means between 2012 and 2014 had been identified as having mental health needs at the time of their death (Prisons and Probation Ombudsman 2016, p. 12).

In April 2021, the Justice Committee launched an inquiry into mental health in prisons, prompted by serious increases in self-harm incidents in prison and poor levels of information about mental

4 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 et al. 2021, p. 97).

health in detention.[5] In its report, the Committee concluded that the unavailability of community orders with mental health treatment requirements in many areas meant that sentencers were forced to send offenders with mental health difficulties to prison (House of Commons Justice Committee 2021, para. 43). It also concluded that severely mentally ill individuals were still being inappropriately held in prisons, sometimes in segregation, due to a shortage of appropriate secure inpatient facilities (House of Commons Justice Committee 2021, para. 78).

3. SENTENCING: THE AVAILABLE ORDERS

Purpose of alternative disposals

Special pleas and other processes are available at trial for offenders who suffer from mental disorder but there is evidence that these provisions are little used. Insanity and unfitness to plead can allow an individual to avoid a criminal conviction and can result in an order for treatment in psychiatric hospital. The numbers found unfit to plead at their trial are low, with an average of 104 annual findings between 2002 and 2006 (Law Commission 2010). Very few offenders are found not guilty by reason of insanity each year, as very strict legal rules mean that most mentally disordered offenders do not qualify for insanity (Mackay, 1995, p. 100). The latest available figures for England and Wales show that an average of just 24 individuals were found not guilty by reason of insanity each year between 2002 and 2012 (Mackay 2014, Table 1).

Between 2010 and 2020, an average of 84.3% of offenders brought to trial on any offence were convicted.[6] For most offenders brought to trial, therefore, their mental disorder is most likely to be dealt with at sentencing. Here, it may be taken into account as a mitigating factor in determining sentence, or as grounds for a therapeutic disposal under the MHA 1983.

Judges in England and Wales are legally obliged to obtain and consider a medical report before imposing a prison sentence on an offender who appears to suffer from mental disorder.[7] Judges have the possibility of making orders under the MHA 1983 before or after conviction where a person meets specific statutory criteria. Orders cannot be made under the MHA 1983 without reports from two registered medical practitioners, and courts typically consider a pre-sentence report by a probation officer at sentencing.[8]

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5 Justice Committee (2021) Mental Health in Prison Inquiry Launched. News article published on 21 April 2021. Available at: https://committees.parliament.uk/committee/102/justice-committee/news/154695/mental-health-in-prison-inquiry-launched/

6 This figure is an average of the annual conviction ratio for all offences between 2010 and 2020. The conviction ratio is the number of offenders convicted as a proportion of the number prosecuted in a given year, expressed as a percentage. Statistics taken from Ministry of Justice (2020b) Table Q3.4 Conviction ratio at all courts by offence group, 12 months ending December 2010 to 12 months ending December 2020.

7 Sentencing Act 2020, s.232.

8 For a more detailed review of the role of expert reports in sentencing processes for convicted offenders with mental disorders, see O'Loughlin et al. (2022), Chapter 4.

The available orders under the MHA 1983 differ significantly 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 often 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.[9]

Some disposals, such as hospital orders under s.37 of the MHA 1983, divert the person into the mental health system and away from the criminal justice system entirely. Others, such as hospital orders with restrictions under s.37/41 of the MHA 1983, accord decisive powers regarding detention and release to both health and criminal justice authorities.

If an order under the MHA 1983 is not available or is not considered appropriate, sentencing courts have the option of passing a custodial sentence or, if available, a community sentence with a mental health treatment requirement attached. Or, the court may decide to combine a prison sentence with a hospital and limitation direction under s.45A of the MHA 1983, sending the person first to hospital but giving the Justice Secretary the power to later transfer him or her to prison.

There has been a long-term pattern of decline in the use of court orders under the MHA 1983. Between 1984 and 2016, the use of hospital orders with or without restrictions declined by 49%. During the same period, transfers from prison to hospital increased by 710% (Keown et al. 2019, p. 2). These figures, coupled with the decline in prisoner mental health, suggest that not enough mentally disordered offenders are being filtered out at the trial or sentencing stages. Below, details on the effects of each order are provided along with an analysis of sentencing trends.

Guardianship orders

A guardianship order is available after conviction under section 37 of the MHA 1983. The order places the offender under the guardianship of the local social services authority or a person approved by the local authority. The guardian has the authority to determine where the person lives, to require him or her to attend for medical appointments, work, education or training, and to require that a doctor or other mental health professional visits the person at home.[10] Guardianship ends where the person is discharged by the local authority, the responsible clinician authorised by the local authority, or by the person's nearest relative.[11]

The order has been little used. The latest available statistics are for 2017-18, when just five new section 37 guardianship orders were made in England (NHS Digital 2018, Table 1).

There is no empirical research available on the barriers to making a guardianship order. Potential 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.[12] In addition, by contrast to a hospital order, a person cannot be treated without his or her consent in the community

9 For a comparison of the orders available in England and Wales and in Scotland and a more detailed review of the barriers to the uptake of these orders, see O'Loughlin et al. (2022), Chapter 3.

10 MHA 1983, s.40 and s.8(1)(c).

11 MHA 1983 Code of Practice, para. 30.17.

12 MHA 1983, s.37(6).

under a guardianship order. Guardianship may therefore appear to be a less attractive option than a hospital order for courts sentencing offenders with severe mental health problems.

Community orders, suspended sentence orders and fines

If an order under the MHA 1983 is not available or not appropriate, judges can pass a community order[13] or suspended sentence order.[14] A community order can only be made where the person has committed an imprisonable offence[15] and a suspended sentence order is only available for prison terms of between 14 days and two years.[16] If the offence is not sufficiently serious to warrant a community order or suspended sentence, the judge may decide to deal with the offence by way of a fine or a conditional or absolute discharge.

A fine is the most frequently used sentencing option, with 75.3% of convicted offenders sentenced in 2021 given a fine.[17] By comparison, in 2021, 7.9% of convicted offenders were given a community order, 4.7% were given a suspended sentence, and 7% were sentenced to immediate custody.[18]

Community orders and suspended sentence orders can both be coupled with treatment requirements under Schedule 9 of the Sentencing Act 2020. These include the mental health treatment requirement, drug rehabilitation requirement, alcohol treatment requirement, and the alcohol abstinence and monitoring requirement. These requirements can be imposed in addition to other requirements intended to punish or prevent reoffending, such as unpaid work requirements or curfews.

Mental health treatment requirements (MHTRs) are for convicted offenders whose offences fall below the threshold for a prison sentence and who have mental health needs that do not require treatment in a secure hospital setting (National Offender Management Service 2014, p. 1). Under an MHTR, the court can require the offender to submit to mental health treatment for a particular period. This treatment may be (a) in-patient treatment, (b) institution-based out-patient treatment, or (c) practitioner-based treatment.[19]

An MHTR can only be made where the individual's mental condition (a) requires treatment, (b) may be susceptible to treatment, and (c) does not warrant the making of a hospital order or guardianship order under the MHA 1983. In addition, the Court must be satisfied that arrangements (a) have been made, or (b) can be made, for the treatment intended to be specified in the order. Finally, the offender must consent to the order.[20]

If the offender is suspected of breaching an MHTR, he or she can be referred to a court. If the court finds the order has been breached without reasonable excuse, it can (a) impose a fine of up to

13 Sentencing Act 2020, s.202.

14 Sentencing Act 2020, s.277.

15 Sentencing Act 2020, s.202.

16 Sentencing Act 2020, s.277 (a) and (b).

17 These figures have been calculated by the author based on statistics taken from Ministry of Justice (2022b), Table Q1.1. The comparable figure for 2019 (pre-Covid 19) is slightly higher, at 77.6%.

18 These figures have been calculated by the author based on statistics taken from Ministry of Justice (2022b), Table Q1.1. The comparable figures for 2019 are slightly lower: 7.7% received a community order, 3.3% a suspended sentence order, and 6.4% were sentenced to immediate custody.

19 Sentencing Code, Schedule 9, Part 9, s.16(1).

20 Sentencing Code, Schedule 9, Part 9, s.17.

£2,500, (b) change the terms of the community order to make them more demanding, or (c) re-sentence the offender for the original offence. If the offender is found to have 'wilfully and persistently' breached the MHTR, the court may choose to impose a custodial sentence.[21]

While it is estimated that 40% of offenders serving community sentences have a diagnosable mental health condition, MHTRs are little used (Judicial College 2021, Chapter 4, para. 127). In 2019, MHTRs accounted for just 0.4% of requirements commenced under community orders or suspended sentence orders (Ministry of Justice 2020a, para. 108). This is despite recommendations from the Bradley and Corston reviews for measures to encourage the uptake of these orders.

Studies have noted that barriers to 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

(Sources: Scott and Moffatt 2012 and Molyneaux et al. 2021).

A further barrier noted by the Justice Committee is that MHTRs are not available in some parts of England and Wales. As a result, judges in these areas are obliged to hand down a prison sentence where the person does not meet the criteria for a disposal under the MHA 1983. The Committee concluded that 'the Government's target that community orders with mental health treatment requirements should be available across 50% of England and Wales by 2023 is insufficiently ambitious' (House of Commons Justice Committee 2021, para. 43).

Research commissioned by the Ministry of Justice indicates that MHTRs result in a significant reduction in reoffending (Ministry of Justice 2020a, paras. 110-13; Hillier and Mews 2018). Offenders with significant psychiatric problems given a community order or suspended sentences had a lower odds of reoffending compared to similar offenders who had been given short-term prison sentences (Hillier and Mews 2018, p. 6). The Ministry of Justice is keen to increase the use of MHTRs following these favourable results. It is currently rolling out the Community Sentence Treatment Requirement (CSTR) Programme to promote the use of MHTRs and other treatment requirements (Ministry of Justice 2020a, para. 114).

Hospital orders and hospital orders with restrictions

Under section 37 of the MHA 1983, hospital orders are available to the Crown Court and to magistrates' courts when sentencing an offender convicted of any imprisonable offence except murder.

Where a defendant is charged with murder but was affected by mental disorder at the time of the killing, he or she can plead guilty to manslaughter by reason of diminished responsibility at trial.[22] A

21 Sentencing Code, Schedule 10, Part 2, s.10-11.

22 Homicide Act 1957, section 2.

manslaughter conviction avoids the mandatory life sentence for murder and opens up the possibility of an order under the MHA 1983.

A hospital order diverts the person into the mental health system and avoids punishment entirely. The role of criminal justice agencies is limited to transporting the person to hospital or detaining him or her on remand until he or she can be transferred to hospital (Hale 2017, p. 5029). Hospital order patients are detained in hospital until discharged by their responsible clinician, the hospital managers or the First Tier Tribunal (Mental Health) in England or the Mental Health Tribunal for Wales. While in hospital, the person can be given treatment for mental disorder without the need for their consent, subject to certain criteria and safeguards.[23]

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'.[24] Mental disorder is defined broadly under the MHA 1983 as 'any disorder or disability of the mind'.[25]

When making a hospital order under s.37 of the MHA 1983, the court may make the patient subject to 'restrictions' on release under s.41 of the MHA 1983 if this is necessary to protect the public from serious harm.[26] A restriction order is not intended as a punishment but as a risk management tool.

Restricted patients may not take leave of absence or be transferred to another hospital without the agreement of the Justice Secretary and can only be discharged from hospital by the Justice Secretary or a tribunal.

The tribunal has a duty to discharge a detained hospital order patient:

> 'if it is *not* satisfied: (i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (ii) that it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment; or (iia) that appropriate medical treatment is available for him.'[27]

If the medical criteria for the patient's detention in hospital are no longer met, the tribunal is obliged to order discharge. This is the case even where the person still poses a risk to the public.

If the patient is subject to restrictions, the tribunal must choose whether to discharge the patient absolutely or subject to specific conditions. Discharge does not require the agreement of the Justice Secretary. While the restriction order accords significant powers to the Justice Secretary, it remains a mental health disposal, and continued detention must be justified under Article 5(1)(e) of the European Convention of Human Rights, which governs the detention of those of 'unsound mind'.

Conditionally discharged restricted patients are monitored in the community by the Ministry of Justice. Unlike prisoners released on licence, such patients cannot be recalled to hospital for simply breaching a condition. The Justice Secretary can only recall a conditionally discharged restricted

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23 MHA 1983, ss.56 and 63. The safeguards are contained in s.57 – 58A.

24 MHA 1983, s.37.2(a).

25 MHA 1983 s.1(2).

26 MHA 1983, s.41(1).

27 MHA 1983, s.72(1)(b). Emphasis added. Note that the MHA 1983 uses 'he' throughout but applies equally regardless of gender.

patient to hospital if independent medical evidence demonstrates that the person is suffering from a 'mental disorder […] of a kind or degree warranting compulsory confinement.'[28]

There is evidence to suggest that patients admitted to secure hospitals are less likely to reoffend on release than prisoners (Fazel et al. 2016). This finding was confirmed when patients with histories of violent offending were compared to prisoners who had served long sentences (Fazel et al. 2016). However, the researchers argued that 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. More research is needed to determine whether prison sentences or hospital orders provide better overall protection for the public, or which orders perform best for which groups of patients.

In 2021, 235 individuals were admitted to psychiatric hospital on a hospital order with restrictions. This accounts for 13.9% of all restricted patients admitted that year. By comparison, only 56 restricted patients were admitted to hospital following a finding of unfitness to plead and seven were admitted following a finding of insanity. As can be seen from Table 2 below, this represents a decline compared to previous years.

The use of hospital orders with restrictions has declined over time. While the numbers of restricted patients admitted to hospital each year are relatively stable, the use of hospital orders with restrictions has declined over the past decade, as seen in Table 2.

Table 2: Recent Trends in Admissions under Hospital Orders with Restrictions (ss.37 and 41 MHA 1983), 2015-2021

Year	Restricted patients admitted (n)	Admitted under ss.37 and 41 (n)	Proportion of restricted patients admitted under ss.37 and 41
2021	1691	235	13.9%
2020	1520	183	12%[29]
2019	1639	250	15.3%
2018	1553	252	16.2%
2017	1503	266	17.7%
2016	1610	273	17%
2015	1686	321	19%

Source: Ministry of Justice 2022b, Table 7. Percentages calculated by the author.

28 *Winterwerp* [1979] ECHR 4, para. 39. Affirmed in *K v UK* (1998) 40 BMLR 20 and *R(B) v MHRT* [2002] All ER (D) 304.

29 The sharper decline seen in 2020 may be attributable to the impact of Covid-19 restrictions on the capacity of the criminal justice system to process cases.

This follows a longer-term pattern of a 49% decline in the use of hospital orders with or without restrictions between 1984 and 2016 (Keown et al. 2019, p. 2). By comparison, in 2021, 504 sentenced prisoners were admitted to hospital as restricted patients.[30]

These numbers suggests that hospital orders with restrictions may be under-used at sentencing. However, there are no empirical studies investigating the reasons why prisoners are transferred to hospital, or whether a hospital order with restrictions was an option at sentencing for these prisoners.

A significant barrier to the making of hospital orders highlighted by Grounds (2019) 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. There is no such limitation on the making of community orders or prison sentences (Grounds 2019). Hospitals are not obliged to accept patients 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.

Pressure on hospital beds may be driving the gradual decline in hospital orders with restrictions. Occupancy of mental health beds is currently at 90% and the Royal College of Psychiatrists has warned that in-patient mental health beds are under unsustainable pressure in some areas (The Strategy Unit 2019, p. 36 and p. 6).

Another contributing factor is that significant growth in the prison population has taken place at the same time as a fall in the number of mental health beds. Between 1986 and 2016, the prison population of England and Wales increased by 70% while the number of mental health hospital beds in England fell by 86% (Keown et al. 2019, p. 3). Researchers have found a strong association between the decline in hospital beds and the rise in transfers to hospital from prison: for every 135 fewer psychiatric hospital beds between 1986 and 2016, there was one more transfer to hospital from prison (Keown et al. 2019, p. 4). The reduction in mental health beds is largely due to a policy of de-institutionalisation: moving those with mental health conditions and those with learning disabilities out of long-stay hospitals and expanding mental health care in the community. The evidence suggests, however, that this policy may have resulted in prisons taking on increasing numbers of mentally ill prisoners.

A further possible explanation for the decline in hospital orders with restrictions is that rates of detention under the civil sections of the MHA 1983 have increased over time. This means that more people are entering and being detained in psychiatric hospitals from the community rather than through the courts. Between 1986 and 2016, as civil detentions in hospital increased, the use of hospital orders at sentencing decreased: for every 72 civil detentions, one fewer court order was made (Keown et al. 2019, p. 4). This may mean that civil detentions are preventing individuals from committing offences and coming into contact with the criminal justice system (Keown et al. 2019). However, there are concerns that rising levels of civil detentions may mean that people are not receiving adequate mental health care to prevent them from reaching a crisis point where detention is necessary (Department of Health and Social Care 2018, p. 52).

30 Ministry of Justice 2022b, Table 7.

Hospital and limitation directions (hybrid orders)

Judges in England and Wales have the option of making a 'hospital and limitation direction' under section 45 of the MHA 1983. This order was introduced in 1997 and was based on proposals for a 'hybrid' order put forward by the Reed Review (Reed 1994). Originally, s.45A orders were available only for offenders who met the legal criteria for psychopathic disorder under the MHA 1983 as originally enacted.

Since 2008, hospital and limitation directions have been available for convicted offenders suffering from any disorder or disability of the mind. A hospital direction, placing the offender in a specific hospital, and a limitation direction, subjecting him to restrictions, may be attached by the Crown Court to any custodial sentence (except a mandatory life sentence for murder). Offenders given these orders 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, therefore, the hospital and limitation direction is a means of ensuring that a mentally unwell offender can go straight to hospital for treatment and, once he or she recovers, can be later transferred to prison for the purposes of punishment.

The criteria for making a s.45A order are very similar to the criteria for a s.37 order[31] but there are significant practical differences. Like s.37 patients, s.45A patients are sent straight to hospital and can be treated there for mental disorder without the need for consent. By contrast, the tribunal has no power to discharge a s.45A patient from hospital while the prison sentence remains in force. The patient may only be discharged from hospital by the Justice Secretary, who may transfer the patient to prison.[32] The timing and conditions of the patient's release then depends on the terms of the prison sentence. A prisoner serving an indeterminate or life sentence will not be released until the Parole Board is 'satisfied that it is no longer necessary for the protection of the public that [he or she] should be confined'.[33]

Hospital and limitation directions are uncommon. Between 2003 and 2009, an average of just three restricted patients were admitted to hospital under s.45A each year. Although the numbers increased to a high of 31 in 2018, s.45A patients account for just a small fraction of restricted patients admitted to hospital each year. This can be seen in Table 3.

31 MHA 1983, s.45A(2).

32 MHA 1983, s.50(1).

33 Crime Sentences Act 1997, s.28(6)(b).

Table 3: Recent Trends in Admissions under Hospital and Limitation Directions (s.45 MHA 1983), 2015-2020

Year	Restricted patients admitted (n)	Admitted under s.45A (n)	Proportion of restricted patients admitted under s.45A (%)
2021	1691	18	1.1%
2020	1520	19	1.3%
2019	1639	26	1.6%
2018	1553	31	2%
2017	1503	25	1.6%
2016	1610	28	1.7%
2015	1686	23	1.4%

Source: Ministry of Justice 2022b, Table 7. Percentages calculated by the author.

It was expected that the numbers admitted under s.45A would increase significantly following the judgment of the Court of Appeal in *R. v. Vowles*,[34] which encouraged judges to consider making a s.45A order before making a hospital order with restrictions under ss.37 and 41 (Grounds 2019; Beech et al. 2019). The orders have, however, only seen a modest increase since 2015 and now appear to be falling again.

As is the case with s.37 orders, a court can only make a s.45A order if it is satisfied that arrangements have been made for the person's admission to hospital within 28 days. Thus, problems with finding a suitable bed for the person may pose a barrier to judges who wish to make an order under s.45A.

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

A recent interview study of 12 consultant psychiatrists with experience of making sentencing recommendations suggests that psychiatrists are likely to recommend s.45A at sentencing only in a narrow set of cases (Beech et al. 2019). While a majority of the consultants interviewed were not in favour of the prioritisation of s.45A orders over hospital orders in *Vowles*, they were all of the view that s.45A orders were useful in certain circumstances. 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. Psychiatrists were concerned that there is a lack of outcome data for patients sentenced to s.45A orders and that it is therefore difficult to know if these orders provide better protection for the public than hospital

34 *R. v. Vowles and others* [2015] EWCA Crim 45.

orders with restrictions under ss. 37 and 41. Some further expressed concerns that a return to prison could undo therapeutic work achieved in hospital, while some had ethical concerns about recommending an order that involved punishment.

Custodial sentences

Where an order under the MHA 1983 is not available or not appropriate at sentencing, the court may choose to hand down a prison sentence. There is no power to treat a prisoner for mental disorder in prison without their consent under the MHA 1983. These powers only apply to patients detained in hospital. More limited powers are available under the Mental Capacity Act (MCA) 2005. The MCA 2005 permits the treatment of individuals who lack capacity to make decisions for themselves so long as treatment is in the person's best interests (see further Department for Constitutional Affairs 2007). If treatment is not available in prison, the prisoner should be transferred to hospital. Where a convicted prisoner is in immediate need of treatment in hospital, a s.45A order or a hospital order with restrictions will be more appropriate, if a suitable bed can be found.

The Justice Secretary has the power to transfer a sentenced offender to hospital for treatment under s.47 of the MHA 1983. The Justice Secretary must be satisfied, based on reports from two medical practitioners, that the prisoner is suffering from a mental disorder 'of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment' and 'that appropriate medical treatment is available for him'.[35] In addition, the Justice Secretary should be 'of the opinion having regard to the public interest and all the circumstances that it is expedient' to make the order.[36]

A transfer direction has the same effect as a hospital order[37] and, under s.49, the Justice Secretary may also make the prisoner subject to restrictions. Once in hospital, the person can be treated for mental disorder without their consent, subject to safeguards.

The legal position of a s.47/49 patient is the same as for a s.45A patient: he or she cannot be discharged from hospital by a tribunal while the sentence is running, and his or her release date depends on the terms of the sentence. The patient may be transferred back to prison by the Justice Secretary during the sentence. If the prisoner is serving an indeterminate or life sentence, the timing of release will be determined by the Parole Board.

Transferred prisoners make up the majority of sentenced offenders admitted to psychiatric hospitals each year. Between 1984 and 2016, transfers from prison to hospital increased by 710% (Keown et al. 2019, p. 2). Since 2016, numbers admitted have been relatively stable as noted in Table 4.

35 MHA 1983, s.47(1).

36 MHA 1983, s.47(1).

37 MHA 1983, s.47(2).

Table 4: Recent Trends in Transfers from Prison to Psychiatric Hospital, 2015-2020

Year	Restricted patients admitted to hospital (n)	Admitted under s.47/49 (n)	Proportion of restricted patients admitted under s.47/49
2021	1691	504	29.8%
2020	1520	499	32.8%
2019	1639	510	31.1%
2018	1553	464	29.9%
2017	1503	462	30.7%
2016	1610	503	31.2%
2015	1686	444	26.3%

Source: Ministry of Justice 2022b, Table 7. Percentages calculated by the author.

In 2018, the Independent Review of the Mental Health Act 1983 (Wessely Review) voiced concerns that it took on average 100 days to transfer a prisoner to hospital, and that a prisoner's mental health was likely to deteriorate during that time. While the Department of Health and Social Care's good practice guidelines set a 14-day time-limit for transfers, only 34% of prisoners were transferred within 14 days in 2016-17 and 7% waited for more than 140 days (Department of Health and Social Care 2018, p. 199). While the Justice Committee recently welcomed the Government's proposal to introduce statutory time limits on transfers to hospital, it concluded that this would not solve the underlying problem: a shortage of appropriate secure hospital facilities (House of Commons Justice Committee, para. 78).

The Wessely Review also highlighted evidence that there were delays of months or even years between a decision by a tribunal to discharge a patient serving a prison sentence and a decision by the Parole Board (Department of Health and Social Care 2018, p. 203). The Review suggested that the powers of the Parole Board and tribunal be combined to streamline this process.

4. SENTENCING GUIDANCE

Despite the significant differences between the effects of the available disposals, judges have historically had very little statutory guidance to assist them in choosing between them. Until recently, sentencing courts have been reliant on the guidance handed down by the upper courts in appeals cases. In addition, the Sentencing Council's sentencing guidelines for specific offences generally regarded mental disorder or learning disability as a mitigating factor where this was linked to the commission of the offence.[38] Less frequently, mental disorder was regarded as affecting culpability. [39]

Now, sentencing judges have access to the Sentencing Council's recently issued Guideline for Sentencing Offenders with Mental Disorders, Developmental Disorders, or Neurological Impairments (Sentencing Council 2020). In addition, the recently updated Equal Treatment Bench Book issued by the Judicial College (2021) gives guidance to judges on how to make reasonable adjustments in court for individuals with mental disabilities and guidance on treating all defendants fairly and equally.[40]

Case law

Two key cases decided by the Court of Appeal form the bulk of guidance to judges on sentencing offenders with mental disorders: *R. v. Vowles*[41] and *R. v. Edwards*.[42] These cases brought together appeals against sentence by convicted offenders who were receiving treatment in hospital under s.45A or s.47 and who wanted their prison sentences to be replaced by hospital orders with restrictions.

In *R. v Drew*,[43] the House of Lords noted that the courts had a policy of prioritising hospital orders with restrictions for those defendants who met the relevant criteria in the MHA 1983. In *Vowles,* by contrast, the Court of Appeal signalled that the release regime that would apply to the offender was of 'primary importance' in sentencing decisions.[44] The Court also sought to promote the use of s.45A orders, which were under-used by sentencing judges despite previous guidance on when these orders were appropriate.

There were significant inconsistencies in the Court of Appeal's approach to sentencing in *Vowles* and judges in subsequent cases struggled to interpret the guidance (O'Loughlin, 2021). On the one hand, the Court in *Vowles* appeared to advocate prison sentences for all mentally disordered

38 For example: Sentencing Council (2013) Sexual Offences Definitive Guideline. Available from the Sentencing Council's archive: https://www.sentencingcouncil.org.uk/wp-content/uploads/Sexual-offences-definitive-guideline-Web.pdf; Sentencing Council (2015) Theft Offences: Definitive Guideline. Available from the Sentencing Council's archive: https://www.sentencingcouncil.org.uk/wp-content/uploads/Theft-offences-definitive-guideline-Web.pdf

39 See for example: Sentencing Council (2016) Robbery: Definitive Guideline. Available from the Sentencing Council's archive: https://www.sentencingcouncil.org.uk/wp-content/uploads/Robbery-definitive-guideline-Web.pdf.

40 For a more detailed review of the literature on sentencing rationales in respect of offenders with mental disorders in Scotland, England and Wales, and selected other common law jurisdictions, see O'Loughlin et al. (2022), Chapter 2.

41 *R. v. Vowles and others* [2015] EWCA Crim 45.

42 *R. v. Edwards and others* [2018] EWCA Crim 595.

43 [2003] UKHL 25.

44 *Vowles*, para. 12; para. 52.

offenders by advising judges to prioritise s.45A orders over hospital orders with restrictions under ss.37 and 41[45] and requiring judges to give 'sound reasons for departing from the usual course of imposing a penal sentence'.[46] Elsewhere, however, the Court noted that a hospital order with restrictions was likely to be the correct disposal if: 'the mental disorder is treatable; (2) once treated there is no evidence [the offender] would be in any way dangerous; and (3) the offending is entirely due to that mental disorder'.[47]

This set a high bar for orders under ss.37 and 41, seeming to reserve these orders for offenders whose culpability was very low or entirely absent (Peay 2016, p. 158).

The Court in *Vowles* also suggested that sentencer should have regard to four factors when deciding sentence:

> ' (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. '[48]

In *Edwards,* the Court of Appeal sought to clarify the guidance in *Vowles* in response to the 'level of misunderstanding' that had arisen following the judgment.[49] The Court advised that s.45A and *Vowles* '[did] not provide a "default" setting of imprisonment, as some have assumed'.[50] Rather, according to *Edwards*, sentencing judges are required to consider all the powers at their disposal, including s.45A, and should only then make a hospital order with restrictions under ss.37 and 41 if that is the most appropriate order.

The Court in *Edwards* reiterated the principle in *Vowles* that a sentence with a penal element is the 'usual course'[51] and required judges choosing a hospital order with restrictions to explain why a penal element is not appropriate.

Post-*Edwards*, the Court of Appeal has taken a more flexible approach to interpreting *Vowles* in some cases[52] (O'Loughlin 2021, p. 110). In *Cleland*, the Court of Appeal stated that sentencing decisions would 'necessarily be fact-specific' and that *Vowles* had merely set out 'factors which are relevant to be considered, rather than inflexible criteria or pre-conditions of the court's imposing a particular form of sentence'.[53]

Sentencing guidelines

The Guideline for Sentencing Offenders with Mental Disorders, Developmental Disorders, or Neurological Impairments (Sentencing Council 2020) is based on *Vowles*, *Edwards* and other cases

45 *Vowles*, para. 54 (i) – (ii).

46 *Vowles*, para. 51.

47 *Vowles*, para. 54 (iii).

48 *Vowles*, para. 51.

49 *Edwards*, para. 12.

50 *Edwards*, para. 12.

51 *Edwards*, para. 12.

52 Including *Fisher* [2019] EWCA Crim 1066; *Westwood* [2020] EWCA Crim 598; [2020] Crim. L.R. 973; *Stredwick* [2020] EWCA Crim 650.

53 *Cleland* [2020] EWCA Crim 906, para. 50. See further O'Loughlin 2021.

along with input from judges, lawyers, doctors, academics, charities and other interested parties. The 2020 Guideline recommends that sentencing judges take an individualised approach to sentencing and avoid making assumptions. While the decisions in *Vowles* and *Edwards* were focused on the choice between ss.37 and 41 and s.45A, the Guideline covers the broader range of available options, including fines, discharges, community orders and guardianship orders.

According to the 2020 Guideline, mental disorder may impact upon the offender's culpability for his or her offence and therefore the level of punishment he or she deserves. Separately, or in addition, mental disorder may constitute a mitigating factor for the purposes of determining sentence. While judges should always consider the fact that a person has a mental impairment or disorder, it will not necessarily impact upon sentencing (Sentencing Council 2020, para. 2). For example, a therapeutic disposal may not be available or appropriate, or the disorder may have had no effect on culpability. Or the offence may be minor and appropriately dealt with by way of a fine or an absolute discharge (Sentencing Council 2020, para. 17).

The Guideline should be read in conjunction with any offence-specific guidelines. For example, in a case of an offender convicted of sexual assault who has a relevant mental disorder or impairment, the court should read the sexual assault guideline in light of the 2020 Guideline. The court should first determine the offence category at Step 1 by assessing the harm caused and the offender's culpability. Then, it should consider whether culpability was reduced due to the person's impairment or disorder, bearing in mind that 'culpability will only be reduced if there is sufficient connection between the offender's impairment or disorder and the offending behaviour' (Sentencing Council 2020, paras. 10-11).

After determining the offence category, the court should then determine the starting point and category range for the sentence under Step 2 of the sexual assault guideline. Here, it should take into account the person's mental disorder even where it was not linked to the commission of the offence. It should also consider whether a community sentence, custodial sentence, or a disposal under the MHA 1983 is appropriate, where available. Finally, mental disorder may be relevant to the assessment of dangerousness at Step 5 of the sexual assault guideline, where the court is considering passing an extended sentence under Chapter 6 of Part 10 of the Sentencing Code.

Where culpability is concerned, the 2020 Guideline highlights that, in some cases, culpability may be significantly reduced, whereas in other cases the presence of a mental disorder or disability may have no impact upon culpability (Sentencing Council 2020, para. 12). Similarly, at Step 2, the presence of a mental disorder may be a mitigating factor warranting a reduction in the starting point of the sentence, or it may have little impact.

In respect of community orders, the Guideline draws sentencers' attention to the importance of ensuring 'that the conditions of any order are bespoke to the offender, taking account of any practical barriers to compliance that their condition or disorder may create'. It recommends that consideration be given to all available requirements, including Mental Health Treatment Requirements, Rehabilitation Requirements, Alcohol Treatment Requirements, and Drug Rehabilitation Requirements.

When considering whether to impose a prison sentence or a community order, the 2020 Guideline advises that courts can take into account the impact of the sentence on the offender and the merits of a rehabilitative approach. The court should also consider whether the offender's mental disorder means that a prison sentence would be disproportionate to achieving the aims of sentencing. Where

custody is considered unavoidable, it may take into account the impact of the offender's disorder when considering the length of sentence and whether to suspend the sentence. This is because 'an offender's impairment or disorder may mean that a custodial sentence weighs more heavily on them and/or because custody can exacerbate the effects of impairments or disorders' (Sentencing Council 2020).

Where the criteria for making a hospital order are met, the Guideline specifies that sentencers must consider if a prison sentence and s.45A direction would be more appropriate. Sentencers are also required to consider the different release regimes that apply under ss.37 and 41 and s.45A.

The new Guideline has been welcomed as giving judges much-needed guidance in sentencing in difficult cases. It has been praised by psychiatrists for recognising a wide range of conditions and for drawing attention to the need to consider the impact of gender, culture and ethnicity (Taylor et al. 2021). However, some psychiatrists have questioned the emphasis on culpability in the guideline, and have suggested that punishment seems to take priority over safety (Taylor et al. 2021).

5. CURRENT ISSUES

Barriers to orders under the Mental Health Act 1983

As highlighted above, the requirement for a hospital to agree to make arrangements to admit the patient may pose a barrier to the making of orders under ss.37 and 41 and s.45A orders. More research is, however, needed to establish in what circumstances this occurs, and whether it is a common problem.

The Bradley Report (2009, pp. 70-73) highlighted that delays in the provision of psychiatric reports to courts and problems with the quality of reports posed a significant barrier to the making of orders under the MHA 1983 and MHTRs. Now there is no longer a requirement for a medical opinion before an MHTR can be made but the MHA 1983 still requires courts to hear evidence from two registered medical practitioners.

Liaison and diversion services have been established to improve the quality of information provided to judges at sentencing and to reduce the need for courts to request psychiatric reports. It is not clear from recent evaluations, however, whether these services have addressed the problems with obtaining timely psychiatric reports (Disley et al. 2021).

Barriers to Mental Health Treatment Requirements

Initial findings of an evaluation of a pilot programme to facilitate MHTRs have been largely positive. The test sites saw a modest increase in the use of MHTRs and stakeholders in the judiciary, mental health services and probation felt that the initiative facilitated the use of MHTRs and made them available for a larger proportion of offenders. Judges said they were more likely to add MHTRs to community sentences due to increased confidence that they would be well coordinated by different agencies working together (Department of Health and Social Care 2019, p. 54). There was some

evidence that the initiative helped to reduce reliance on custodial sentences (Department of Health and Social Care 2019, p. 55).

The main barriers identified were issues with multi-agency working, concerns about insufficient capacity and funding and problems with service user engagement. Rolling out similar programmes nationally may be expected to increase use of MHTRs in appropriate cases, but the effectiveness of the programme will require careful monitoring.

Proposed reforms to the Mental Health Act 1983

In 2021, the Government published proposals to reform the MHA 1983 and has now responded to submissions to the consultation. Under the proposals, it was suggested that most of the reforms would apply only to patients detained under Part II of the MHA 1983, which addresses civil patients. This would mean that offenders admitted to hospital from court and those already in detention under Part III of the Act, which applies to forensic patients, would not benefit from the reforms.

Some of those who responded to the consultation highlighted that the proposals were potentially discriminatory and could give rise to a 'two-tier' system for individuals with disabilities. They could also have the effect of pushing individuals with a primary diagnosis of learning disability or autism into the criminal justice system, as powers to detain those individuals under the civil sections of the MHA 1983 would be curtailed. The Government's response indicates that it will consider these issues further (Department of Health and Social Care 2021). A Draft Mental Health Act Reform Bill was announced in the Queen's Speech on 10 May 2022.

A rising prison population

The prison population is expected to rise following government commitments to tougher sentencing and to providing 18,000 more prison places by the mid-2020s (Ministry of Justice 2021a). The latest projections are for the prison population to rise from 78,838 in November 2020 to 98,700 by September 2026 (Ministry of Justice 2021b). These increases are likely to put further pressure on the supply of beds within the mental health system. This may in turn prevent courts in some cases making orders under the MHA 1983 due to a shortage of places.

6. GAPS IN RESEARCH

How does diversion from custodial sentences affect outcomes for offenders?

There is a lack of longitudinal, appropriately matched or controlled studies of the impact of the various orders available on offender outcomes, including mental health, safety, quality of life and reoffending rates. The few studies that do exist are not based on matched samples (see Fazel et al. 2016). This makes it difficult to make an evidence-based case for the use of different sentencing options for specific groups of offenders. Future research should seek to establish which orders are associated with better outcomes for offenders with different characteristics.

Is the Parole Board or Tribunal better equipped to protect the public?

The case law indicates a level of disagreement amongst judges and psychiatric experts as to whether the mental health tribunal system or the parole system provides the best protection for the public. There is also some disagreement as to whether monitoring by mental health teams or probation post-release provides better protection for the public. The Court of Appeal in *Edwards* and the 2020 Guidelines suggest that courts should assess the available orders on a case-by-case basis. Robust research into the outcomes associated with the different pathways would assist judges and policymakers in determining this question.

Why has the use of hospital orders with restrictions declined over time? Are orders under the Mental Health Act 1983 under-used?

There is good evidence available on the reasons for the under-use of community sentences and MHRTs. However, very little research has examined the reasons behind the decline in hospital orders under the MHA 1983. While some suggestions have been put forward in this paper regarding the reasons for the decline, these possibilities have not been fully empirically investigated.

While the low numbers cited in this paper suggest that orders under the MHA 1983 are under-used, no data is available on cases in which such orders were available but were not made. It is therefore difficult to say whether current sentencing practices are not meeting the needs of defendants or whether other reasons explain apparently low uptake of these orders by sentencing courts.

What are the barriers to diversion at sentencing? What would encourage judges to use these orders more frequently?

Apart from the available case law and statutory provisions, we know very little about how judges approach sentencing cases involving defendants with mental health problems in practice. While there is some research available on the barriers to making MHTRs, we know very little about the barriers to making orders under the MHA 1983 or what provision is needed to encourage uptake of appropriate orders in appropriate cases. Future evaluations of liaison and diversion services should focus on the impact these services have had on encouraging judges to make use of available orders under the MHA 1983.

Why has the use of transfers to hospital increased since the 1980s? Does this reflect under-use of diversion at sentencing?

While some suggestions have been put forward in this paper to explain the increase in transfers to hospital since the 1980s, very little empirical research is available on the reasons behind this trend. In addition, we know very little about the factors that influence a transfer to hospital or the pathways from sentencing to transfer to hospital. Empirical research in this area would help to inform sentencing decision-making as it could help to identify the types of cases in which diversion from prison at sentencing would be more appropriate.

What are the true rates of mental disorder amongst those in contact with the criminal justice system? What is the severity of these mental disorders?

The last large-scale study of mental disorder amongst prisoners was conducted in 1997 (Singleton et al. 1998). The best quality data is therefore out of date. There is a need for a large-scale follow-up study to identify the prevalence of mental health needs amongst prisoners.

The prevalence of mental disorder amongst defendants sentenced by courts is very much under-studied. There is a need for a large scale, representative study of the prevalence and severity of mental disorders, disabilities and neurological impairments amongst defendants and sentenced offenders. This data would help to support policy-making and resource planning to ensure that adequate provision is made for vulnerable individuals within the criminal justice system and health systems.

7. CONCLUSION

It is clear that, while some progress has been made, many of the problems facing offenders with mental disorder identified by the Bradley Review in 2009 continue into the present day. In particular, this group is over-represented in the prison population and many prisons struggle to identify their needs and to provide them with adequate care. While sentencing courts have a range of options at their disposal for diverting convicted offenders with mental disorders away from custody, these powers continue to be under-used. Contributing factors to this trend include an under-supply of secure mental health beds; the unavailability of services to support community sentences with mental health treatment requirements in some parts of the country; and a growing prison population. But more research is needed to produce a clearer picture of why disposals under the MHA 1983 have declined while the proportion of restricted patients who arrive into hospital from prison has increased over time.

Recent government initiatives, such as the roll-out of Liaison and Diversion services across England and pilot programmes for supporting mental health treatment requirements, have started to make a difference. A further encouraging development is the publication of the Sentencing Council's first dedicated guideline for sentencing offenders with mental disorders, disabilities and impairments. The guideline has been broadly welcomed for drawing sentencers' attention to the range of available disposals and requiring courts to take mental disorder into account in a systematic manner at sentencing.

The Court of Appeal in *Vowles* suggested that sentencers should have regard to public protection when choosing between the different disposals available. But very little information is available on the practical effects of these disposals beyond the legal powers they confer on health or criminal justice authorities and the evidence provided by expert witnesses in sentencing cases. The question of whether release through the Parole Board or Tribunals provides better protection for the public remains unresolved. Large-scale, appropriately designed follow-up studies of cohorts of offenders affected by mental disorder and disabilities are needed to better inform both sentencing and mental health and criminal justice policies in this challenging area.

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