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Editorial

# Sentencing offenders with mental disorders, developmental disorders or neurological impairments: what does the new *Sentencing Council Guideline* mean for psychiatrists?

Pamela J. Taylor, Nigel Eastman, Richard Latham and Josanne Holloway

**Summary**

The new *Sentencing Council Guideline* on sentencing offenders with mental disorders, effective from 1 October 2020, is essential reading for all psychiatrists who give evidence in the criminal courts, revealing something of required judicial thinking, our common ground on public safety concerns but differences in focus on culpability and punishment.

**Keywords**

Psychiatry and law; mentally disordered offenders; sentencing guideline; culpability; post sentence safety.

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**Pamela Taylor** (pictured) is Professor of Forensic Psychiatry at Cardiff University and immediate past Chair for the Royal College of Psychiatrists' Forensic Psychiatry Faculty. **Nigel Eastman** is Emeritus Professor of Law and Ethics in Psychiatry at St George's, University of London. **Richard Latham** is a Consultant Forensic Psychiatrist at East London NHS Foundation Trust. **Josanne Holloway** is a Consultant Forensic Psychiatrist and Associate Medical Director for Specialist Services in the Northwest of England; and is Chair for the Royal College of Psychiatrists' Forensic Psychiatry Faculty.

## The new guideline

Sentencing is enshrined in law but, mandatory sentences apart, it is open to interpretation. The Sentencing Council for England and Wales prepares sentencing guidelines to promote consistency in sentencing, while maintaining the independence of the judiciary, and to increase public understanding of sentencing. A new guideline on sentencing adults with mental disorder in England and Wales became effective from 1 October 2020 (*The Guideline*; https://www.sentencingcouncil.org.uk/). It reflects substantial thought and wide consultation. It asserts the centrality of mental disorder to judicial deliberation, while noting this 'will not necessarily have an impact on sentencing', reflecting the well-guarded independence of the judiciary in this, as in all matters: '….. the court is not bound to follow expert opinion ….' (para 13), although will generally offer reasons when not (para 14).

*The Guideline* is essential reading for all psychiatrists who give evidence in criminal courts in England or Wales. It raises questions for such experts anywhere. It reveals something of what may be in a judge's mind when sentencing – and what unites our respective professions and what separates us.

It is welcome that a wide range of illness, developmental disorder and neurological impairment is recognised *and* that each may present singly or in combination *and* that mental state fluctuates. *The Guideline* also acknowledges that problem alcohol or other drug use – with or without failures to access treatment – may mask ultimately treatable disorders. It notes the reluctance of some offenders to add the stigma of mental disorder to that of offending, perhaps influenced by culture or gender, and the importance of considering all this. *The Guideline* refers to the Judicial College *Equal Treatment Bench Book*. We, in turn, commend it to clinicians, notwithstanding its 471 pages. (https://www.judiciary.uk/wp-content/uploads/2018/02/ETBB-February-2018-amended-March-2020.pdf). In its commitment to fairness, *The Guideline* also affirms that victims, as well as offenders, must be able to understand sentencing.

## Differences on culpability

An important difference between judicial and medical approaches becomes evident in 'assessing culpability'. The Criminal Justice Act 2003 requires that culpability is a pillar of sentencing. Thus, judges must consider it and be seen to do so, while it is not in medical vocabulary. It is in the inevitable link to punishment where tensions may arise, with concerns that requirements to punish may even outweigh public safety considerations. Notwithstanding reference throughout *The Guideline* to both, focus on safety has a single, short bullet point, whereas culpability has its own substantial section. Thus, sentencing constraints mean that punishment is prioritised; for community sentences: '….. at least one requirement must be imposed for the purpose of punishment ….' (Para 21) and for institutional sentences: 'Before making a hospital order … the court must consider if it would be more appropriate to pass a sentence of imprisonment … If a hospital order is made, the court must give reasons as to why the sentence has no penal element.' (Para 24.b).

What is the evidence for emphasising punishment, or on the impact of apportioning culpability, on the offender's reoffending or capacity for change? For preferring a prison sentence in all but name (section 45A, Mental Health Act 1983/2007) over a hospital order? What is the evidence on the effect of responding to recovery from disorder during initial hospital admission by sending the patient to prison? How does explicit part-punishment of a mentally disordered offender help victim recovery?

## Gaps in evidence for sentencers and psychiatrists

In, effectively, raising such questions, however, *The Guideline* forces us to consider the dearth of relevant clinical research into them, albeit treatment of offender–patients includes offence-related work, helping the patient to shift from any denial or justification



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towards a position of: 'I am responsible for what happened (guilty); I regret what I have done; I apologize to the victim(s); and I will not do it again'. It seems logical to expect that someone who becomes genuinely remorseful would be less likely to reoffend and more likely to become a good citizen but evidence is slight that remorse or 'self-culpability' is associated with good outcomes.[1] Of interest, however, is that, although blaming external factors for a crime reduces guilt feelings, blaming mental illness does not;* perhaps an offender's accurate attribution of an offence to mental disorder facilitates his/her true acceptance of treatment needs, and improved safety through treatment. Such processing, however, takes time and therapy; it is unlikely at the time of sentencing.

## Reducing the impact of being victimised

By contrast, there is much evidence on what ameliorates problems related to criminal victimisation* this does not include punishment of offenders with mental disorder. More investment in truly effective help for victims of crime is needed.

## Hybrid order

*The Guideline* seems to treat 'a hospital and limitation direction under section 45a' of the Mental Health Act 1983/2007, the so-called 'hybrid order', as a hospital order with a penal element; but it is a sentence of imprisonment, despite initial direction to hospital.

The hybrid order was introduced into the Mental Health Act 1983 by the Crime (Sentences) Act 1997, exclusively for those under the legal category of 'psychopathic disorder', without sentencing guidance.* Sound psychiatric arguments were advanced against it.[2] The context was a successful challenge in the European Court of Human Rights to the then absence of right of appeal against restrictions on discharge under section 41 of this Act (*X v UK*) coupled with recognition that a ground for such an appeal might be untreatability of 'psychopathic disorder'. This led to fear (unrealised) of floods of dangerous patients being released from secure hospitals. Revision of this legislation in 2007 removed the treatability clause and introduced a catch-all definition of 'mental disorder', making the hybrid order available for anyone, however ill, after conviction for an imprisonable offence.

*The Guideline* (para 26b) raises the prospect of increased use of the hybrid order by suggesting that sentencers should prioritise it and presenting it as a hospital disposal: 'If the criteria are met for a hospital order, with or without a s.41 restriction order, the court must consider if it would be more appropriate to pass a sentence of imprisonment with a direction that the offender is detained in hospital rather than prison. This is a hospital direction.'

In part this follows from the Court of Appeal discussion in a multi-case appeal against indefinite sentences for people with mental disorder, *Vowles*. Several hybrid orders have since been overturned on appeal and replaced with hospital orders – for people with psychosis (*Edwards, Fisher*), autism spectrum disorder (*Cleland*) and personality disorder (*Fuller*) – but some have not. Some psychiatrists, worried about the length of treatment for some offenders under hospital orders, also perhaps recognising insufficient skills or resources, may prefer this provision but, as highlighted elsewhere: 'Psychiatrists who *recommend* a Hybrid Order (Section 45A) … accept that the convicted individual, as well as being mentally disordered and in need of treatment, is also culpable and deserving of criminal punishment'[3] [emphasis added].

Psychiatrists risk ethical transgression if they give an opinion concerning punishment. The conclusion by Beech and colleagues[3] that 'the majority of consultants considered the hybrid order to be a valuable disposal option when used under specific circumstances' cannot be supported by their small, qualitative study as it was not designed for frequency estimates. Further, in wide consultation by the Forensic Psychiatry Faculty of the Royal College of Psychiatrists to inform the Wessely review of mental health legislation (www.gov.uk/government/publications/modernising-the-mental-health-act-final-report), no forensic psychiatrist came forward to commend the order.

## Community orders

We welcome *The Guideline's* emphasis on community orders with treatment requirements. This resonates with the Government's White Paper *A Smarter Approach to Sentencing* issued soon afterwards (https://www.gov.uk/government/publications/a-smarter-approach-to-sentencing). The UK has a higher imprisonment rate than any other European country.* Mental disorder rates are high among prisoners.* Prisoner death rates in England and Wales were rising until 2019; self-harm rates in the year to March 2020 were the highest ever recorded.* Further, short-term prison sentences do not reduce reoffending.*

Community orders, under the Criminal Justice Act 2003, are for imprisonable offences. They may be customised by adding specific 'requirements'. Thus, a mental health treatment requirement (MHTR) may be added alone or with an alcohol or drug treatment requirement and a rehabilitation requirement. This provision is, in essence, a contract between the court, a probation officer, a registered psychiatrist or psychologist and the offender. Crucially, the offender must agree to the order, and then comply or face sanctions. Psychiatrists have been slow to recommend such orders, perhaps through a lack of experience,* but also many require adult general psychiatry involvement, where resources are overstretched. In 2006 there were 725 MHTRs among 128 336 community orders – 0.56%; use was falling until 2016.*

Government health and criminal justice departments have now come together to fund sites to support their use and take-up is growing (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810011/cstr-process-evaluation-summary-report.pdf). A Royal College of Psychiatrists' position statement is imminent. Offender–patients appear to understand them, and there is a theoretical model of how they may work.[4] A Ministry of Justice analysis found MHTRs were associated with significantly less reoffending for people with 'significant psychiatric problems' than short prison sentences (https://www.gov.uk/government/publications/do-offender-characteristics-affect-the-impact-of-short-custodial-sentences-and-court-orders-on-reoffending).

Broadly comparable USA provisions have been shown to hold promise,[5] but the framework there, with wide availability of mental health courts, is different. US mental health courts take an active, non-adversarial role in ensuring the offender understands the sentence and hold regular reviews in court, regardless of progress; intensive, weekly reviews in the court may be offered for those who failed previous orders. It has been reported that offenders in such arrangements increasingly felt that they had a respectful relationship with the court, and improved compliance followed.

## Conclusions

The Royal College of Pscyhiatrists' response to the Sentencing Council consultation on *The Guideline* was limited by a dearth of

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research-quality data. We must be ready to assist the Sentencing Council in its next review of sentencing for people with mental disorder with substantial evidence on optimal practice. Then we might make real progress in achieving the surely shared goals of fairness and public safety.

**Pamela J. Taylor**, Division of Psychological Medicine and Clinical Neurosciences, School of Medicine, Cardiff University, UK; **Nigel Eastman**, St Georges Hospital Medical School – IMBE, UK; **Richard Latham**, East London NHS Foundation Trust - Forensic Psychiatry, UK; **Josanne Holloway**, Greater Manchester West Mental Health NHS Foundation Trust, UK

**Correspondence:** Pamela J. Taylor. Email: taylorpj2@cardiff.ac.uk

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## Supplementary material

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## Author contribution

P.J.T. drafted the editorial. N.E., R.L. and J.H. helped develop and edit it. All authors approved the final version.

## Declaration of interest

The authors are members of the executive committee of the Royal College of Psychiatrists' Forensic Psychiatry Faculty and in this capacity contributed to the consultation on the Guideline.

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EXTRA CONTENT ONLINE



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