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Sentencing offenders with mental disorders, developmental disorders, or neurological impairments

Guideline effective from: 1 October 2020

Guideline users should be aware that the Equal Treatment Bench Book covers important aspects of fair treatment and disparity of outcomes for different groups in the criminal justice system. It provides guidance which sentencers are encouraged to take into account wherever applicable, to ensure that there is fairness for all involved in court proceedings.

Applicability

Section one: General approach

1. This guideline applies when sentencing offenders who at the time of the offence and/or at the time of sentencing have any mental disorder, neurological impairment or developmental disorder, such as those listed within **Annex A**.
2. The fact that an offender has an impairment or disorder[1] should always be considered by the court but will not necessarily have an impact on sentencing.
3. There are a wide range of mental disorders, neurological impairments and developmental disorders and the level of any impairment will vary between individuals. Accordingly, in assessing whether the impairment or disorder has any impact on sentencing, the approach to sentencing should be individualistic and focused on the issues in the case.
4. Sentencers should note the following:

   - some mental disorders can fluctuate and an offender's state during proceedings may not be representative of their condition at the time the offence was committed,
   - care should be taken to avoid making assumptions. Many mental disorders, neurological impairments or developmental disorders are not easily recognisable,
   - no adverse inference should necessarily be drawn if an offender had not previously either been formally diagnosed or willing to disclose an impairment or disorder,
   - offenders may be unaware or unwilling to accept they have an impairment or disorder and may fear stigmatisation if they disclose it,
   - it is not uncommon for people to have a number of different impairments and disorders. This is known as 'co-morbidity',
   - drug and/or alcohol dependence can be a factor, and may mask an underlying disorder,
   - difficulties of definition and classification in this field are common. There may be differences of expert opinion and diagnosis in relation to the offender or it may be that no specific disorder can be identified,
   - a formal diagnosis is not always required, and
   - where a formal diagnosis is required, a report by a suitably qualified expert will be necessary.
5. It is important that courts are aware of relevant cultural, ethnicity and gender considerations of offenders within a mental health context. This is because a range of evidence suggests that people from ethnic minority backgrounds 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 MHA. In addition, female offenders are more likely to have underlying mental health needs and the impact therefore on females from ethnic minority backgrounds in particular is likely to be higher,

given the intersection between gender and ethnicity. Moreover, refugees and asylum seekers may be more likely to experience mental health problems than the general population. Further information can be found at Chapters six and eight of the Equal Treatment Bench Book.

6. In any case where the offender is or appears to be suffering from a mental disorder at the date of sentencing, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law, unless, in the circumstances of the case, the court considers that it is unnecessary (s.232 Sentencing Code). A report may be unnecessary if existing, reliable and up to date information is available. If considering making a hospital or interim order, the court can request information about a patient from the local health services (s.39 of the MHA). Further information about s.232 and requests for reports can be found at **Annex B** of this document.
7. Where a custodial sentence is passed the court should forward psychiatric, psychological, or other medical reports to the prison along with any other information relevant to the offender's physical and mental health, in accordance with rule 28.9 of the Criminal Procedure Rules. This will ensure that the prison has appropriate information about the offender's condition and can ensure their welfare.
8. Courts should always be alive to the impact of an impairment or disorder on an offender's ability to understand and participate in proceedings. Courts should ensure that offenders understand their sentence and what will happen if they reoffend and/ or breach the terms of their licence or supervision. Courts should also ensure that any ancillary orders, such as restraining orders, are capable of being understood and fulfilled by the offender. Courts should therefore put the key points in a clear and straightforward way. Clarity of explanation is also important for victims in order that they too can understand the sentence. Further information can be found at Chapter four of the Equal Treatment Bench Book.

Section two: Assessing culpability

9. Culpability may be reduced if an offender was at the time of the offence suffering from an impairment or disorder (or combination of impairments or disorders) such as those listed in **Annex A.**
10. The sentencer should make an initial assessment of culpability in accordance with any relevant offence-specific guideline, and should then consider whether culpability was reduced by reason of the impairment or disorder.
11. Culpability will only be reduced if there is sufficient connection between the offender's impairment or disorder and the offending behaviour.
12. In some cases, the impairment or disorder may mean that culpability is significantly reduced. In other cases, the impairment or disorder may have no relevance to culpability. A careful analysis of all the circumstances of the case and all relevant materials is therefore required.
13. 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 very valuable. However, it is the duty of the sentencer to make their own decision, and the court is not bound to follow expert opinion if there are compelling reasons to set it aside.
14. The sentencer must state clearly their assessment of whether the offender's culpability was reduced and, if it was, the reasons for and extent of that reduction. The sentencer must also state, where appropriate, their reasons for not following an expert opinion.
15. Courts may find the following questions a useful starting point. They are not exhaustive, and they are not a check list as the range of offenders, impairments and disorders is wide.

- **At the time of the offence did the offender's impairment or disorder impair their ability:**
  - to exercise appropriate judgement,
  - to make rational choices,
  - to understand the nature and consequences of their actions?
- At the time of the offence, did the offender's impairment or disorder cause them to behave in a disinhibited way?
- Are there other factors related to the offender's impairment or disorder which reduce 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 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,
- **Insight**. Courts need to be cautious before concluding that just because an offender has some insight into their impairment or disorder and/or insight into the importance of taking their medication, that insight automatically increases the culpability for the offence. Any insight, and its effect on culpability, is a matter of degree for the court to assess.

Section three: Determining the sentence

16. **General principles**.

    - Impairments or disorders experienced by the offender are factors which sentencers are required to consider at Step 1 (where the impairment or disorder is linked to the offence) or at Step 2 (where it is not linked to the offence) when considering the stepped approach set out in offence-specific guidelines,
    - Impairments or disorders may be relevant to the decision about the type of sentence imposed, in particular a disposal under powers contained in the MHA,
    - Impairments or disorders may be relevant to an assessment of whether the offender is dangerous as that term is defined for sentencing purposes in Chapter 6 of Part 10 of the Sentencing Code.

17. **Fines/ discharge.** Many offences committed by an offender with an impairment or disorder may not require any therapeutic intervention or the offence may be so minor that the appropriate disposal is a fine or discharge.

18. **Community orders**. When passing a community order (only available if the offence is imprisonable), it will be important to ensure 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. Community orders can fulfil all the purposes of sentencing and consideration should be given to all of the options for community orders, including Mental Health Treatment Requirements (MHTR), Rehabilitation Requirement (RAR), Alcohol Treatment Requirement (ATR), and Drug Rehabilitation Requirement (DRR) in light of what is available locally. A MHTR with either an ATR and or a DRR can be made for offenders with dual diagnosis. A RAR can offer targeted work with the individual and may be more appropriate than a MHTR.

19. MHTRs provide a useful option for offenders who would not otherwise qualify for treatment under the MHA. For offenders with mental health issues, such orders may result in reductions in offending compared with short custodial sentences. Where the offender's culpability is reduced by their mental state and/or the public interest is served by ensuring they receive appropriate treatment, a MHTR may be more appropriate than custody. Even where the custody threshold is crossed, a community order with a MHTR may be a proper alternative to a short or moderate custodial sentence. A community order with a MHTR may be appropriate where the offence is not serious enough to cross the custody threshold. A MHTR is not suitable for an offender who is unlikely to comply with the treatment, for example if they have a chaotic lifestyle. See the Imposition of Community and Custodial Sentences definitive guideline.

20. **Drug and alcohol treatment orders.** Where the offender is dependent on or has a propensity to misuse drugs or alcohol and there is sufficient prospect of success, a community order with a DRR or an ATR may be a proper alternative to a short or moderate custodial sentence. Courts should be mindful that where an offender has failed to comply with a DRR or ATR in the past, that does not necessarily mean that they will fail now. Courts will need a thorough assessment about the offender's current motivation and ability to tackle their addiction in a pre-sentence report or addendum report provided by the alcohol or drug treatment order provider.

21. With all community orders, at least one requirement must be imposed for the purpose of punishment and/or a fine in addition to the community order – unless there are exceptional circumstances relating to the offence or the offender that would make it unjust in all the circumstances to do so. It is a matter for the court to decide which requirements amount to punishment in each case.

22. **Custodial sentences.** Where an offender is on the cusp of custody or detention, the court may consider that the impairment or disorder may make a custodial sentence disproportionate to achieving the aims of sentencing and that the public are better protected and crime reduced by a rehabilitative approach. Where

custody or detention is unavoidable, consideration of the impact on the offender of the impairment or disorder may be relevant to the length of sentence and to the issue of whether any sentence may be suspended. 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. In accordance with the principles applicable in cases of physical ill-health, impairments or disorders can only be taken into account in a limited way so far as the impact of custody is concerned. Nonetheless, the court 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.

23. **Mental health disposals.**
Further detailed information about disposals specific to mental health can be found at Annex C.
Decisions as to the various mental health sentences are always fact specific and in some cases no mental health disposal may be appropriate. The court will need to weigh up a number of factors, which may include, but are not limited to:

- The nature of the offence for which the offender is being sentenced,
- The offender's antecedents,
- The offender's behaviour when unwell,
- The offender's insight into their condition,
- The offender's level of compliance with any previous treatment and medication,
- The speed at which risk factors may escalate,
- The need to protect the public. In deciding on a sentence, courts should also carefully consider the criteria for and regime on release. It should not be assumed that one order is better than another, or that one order offers greater protection to the public than another. Careful analysis of all the facts is required in each case, including what is practically available, before deciding on the appropriate disposal. The graver the offence, and the greater the risk to the public on release of the offender, the greater the emphasis the court must place upon the protection of the public and the release regime,
- Other protective factors that are available.

24. **S.37- Hospital order and guardianship orders.**

a. A hospital order provides for the offender to be detained in hospital for treatment. A guardianship order places the offender under the guardianship of the local social services authority or a person approved by the authority, usually in the community,

b. If the offender has been convicted in the Crown Court, and is aged 21 or over, before making a hospital order, (with or without a restriction order) the court must consider if it would be more appropriate to pass a sentence of imprisonment with a hospital and limitation direction under s.45A. If a hospital order is made, the court must give reasons as to why the sentence has no penal element,

c. The criteria for making such orders and the release regimes are set out in **Annex C.**

25. **S.41- Restriction order.**

a. Where a hospital order is made, the Crown Court may make a restriction order if it appears to the court that it is necessary to do so for the protection of the public from serious harm, having regard to the nature of the offence, the antecedents of the offender and the risk of their committing further offences if set at large,

b. In summary, a restriction order lasts indefinitely and means that only the Secretary of State (SoS) (and in certain circumstances the tribunal) can permit the offender to leave, transfer to another hospital, and be discharged from hospital,

c. The criteria for making such orders and their effect are set out in **Annex C**.

26. **S.45A- Imprisonment with hospital direction and limitation direction.**

a. These orders are only available where an offender aged 21 or over has been convicted of an offence before the Crown Court,

b. These orders are sometimes referred to as 'hybrid orders'. 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. This must be accompanied with a limitation direction which means that the offender is subject to the special restrictions of a s.41 order. This is known as a limitation direction,

c. The court will need to consider the different release regimes under s.37/s.41 order and a s.45A order. The court's conclusion as to which regime will better protect the public will depend on a careful assessment of the facts in an individual case,

d. The criteria for making such directions and the release regimes are set out in **Annex C.**

27. **Secretary of State transfer powers.**
If a sentenced prisoner becomes mentally unwell, prisons can ask the SoS to give permission to transfer the prisoner to hospital, s.47 MHA. The SoS can add a restriction direction to this transfer, s.49 MHA, which has the same effect as a restriction under s.41 MHA.

28. **Treatment outside of the NHS**
In all cases where the court is considering a mental health disposal, the court must be satisfied that treatment is available and will continue to be available and funded for the duration of the order. If the treatment proposed is not within a NHS hospital, courts should take particular care to confirm the proposed hospital/treatment centre has the appropriate level of security and specialist staff able to address the offending behaviour in addition to treating the mental disorder. Courts should always be very cautious before passing a hospital order or mental health treatment order in any case in which the cost of the treatment would be met from non NHS funds. This may result in wholly inadequate safeguarding processes. It should also be noted that probation will not monitor privately funded mental health treatment requirements.

This information provided in Annex A below is correct as of the date of the guideline coming into force on 01/10/2020. It does not form part of the guideline.

Annex A – main classes of mental disorders and presenting features

(This information is only intended as general assistance to sentencers in understanding common impairments and mental disorders.)

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

Sentencers may see references to DSM/ICD[2] classification systems in reports. This section is not concerned with classifications systems which aim to provide lists of recognised mental disorders and their symptoms.

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

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

Other disorders which may be relevant in court lie at the interface between psychiatry and neurology. Epilepsy in its various forms is an example, Acquired Brain Injury (ABI) is another example. ABI is an injury caused to the brain since birth, most often as a result of trauma, tumour, stroke, illness or infection.

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

Psychotic illnesses

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

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

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

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

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

People may also present with 'formal thought disorder' – when the form of thought, and thus speech is hard to follow and may include nonsensical, made-up words. Hallucinations most commonly take the form of 'third person hallucinations' when the person hears others talking about them, but when no-one is doing so. Delusions are beliefs which, in full form, are wholly impervious to reason, generally, but not always based on a false premise. Persecutory/paranoid delusions are probably the most common. Passivity delusions – when the individual 'knows' that his/her thoughts, feelings or actions are controlled by another person or an external system – may be particularly associated with violence. If hypochondriacal delusions occur, they tend to be bizarre and may be dangerous – for example a belief in a machine causing all the problems implanted in his/her eye. Many aspects of schizophrenia are treatable, but 'cure' is unlikely and deterioration over years quite common. Nevertheless, people with the condition can attain a good quality of life and safety if a full range of relevant treatments can be sustained.

Delusional disorder is sometimes diagnosed when the only abnormality appears to be the presence of a single delusion and can be easily missed. Apart from the impact of the *delusion* or its ramifications, functioning is not markedly impaired, and behaviour is not obviously bizarre or odd.

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

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

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

Non-psychotic illnesses

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

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

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

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

Substance use disorders

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

Developmental disorders

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

Autism and autistic spectrum disorder (the latter sometimes referred to as Asperger's syndrome, but this term is now discouraged) are pervasive developmental disorders generally affecting people throughout life. It is estimated that about 1% of people in the UK are affected. Intelligence may be impaired as well, but is often not.

Given that these are spectrum conditions, although people diagnosed as being autistic or as being on the autistic spectrum may share certain characteristics, everyone will be different and it is important to note that there is considerable variation in how people are affected. Simply being 'on the spectrum' is not necessarily a disorder at all. As the opening comments to this Annex notes, – to qualify as a disorder the state or condition has to interfere in some way in the capacities of the person with it; this may be with their mood and wellbeing and/or it may be with their ability to function in society and/or as they would wish. This statement could be applied to almost any disorder, but it is particularly pertinent to developmental conditions.

Many people with autism or on the autistic spectrum show highly developed logical thinking and show strengths in problem solving. Some have extraordinary but atypical abilities, for example of memory. Terms like 'high functioning' and 'low functioning' autism have been used but are unhelpful. It is better to document and recognise the mix of abilities and difficulties in each individual. As understanding of some of the more specific underlying mechanisms in their development grows, identification of such disorders is increasingly being made for the first time in adulthood.

There may also be possible problems with language, which may include interpreting words or phrases very literally and having difficulty with vague or ambiguous questions or instructions or 'unwritten rules'. Other features may include difficulty in dealing with unexpected or sudden change, hypothetical thinking and making a decision about something which has not yet happened or intuitive thinking, which may rely in part on identifying emotional cues. Some people may be hypersensitive to stimuli including light, noise, temperature or touch.

The use of 'Autism' as a term has varied over time. The American DSM-5 no longer uses the term autism at all. It is still used in the UK and is generally used by psychiatrists to indicate the most pervasive and extreme incapacity to understand or empathise with others, to show any emotional reciprocity and to develop or maintain relationships. Generally, in such cases, the individual seeks 'sameness' and *may* be inflexible in routines or repeated, simple actions. If these are interrupted, extreme anxiety and/or aggression *may* follow. However, as stated earlier, there is considerable variation in how people are affected. In less formal usage, the term 'autism' may be used to cover a broader range of behaviours exhibited by less intrusive or pronounced character traits. This paragraph therefore notes some of the behaviours that *can* be seen within the autistic spectrum, it is not to say that everyone with autism will display these behaviours.

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

Attentional deficit hyperactivity disorder [ADHD] is similarly apparent from a very early age, although may not be completely recognised until the individual starts school. It is not uncommonly associated with other developmental disorders, but also occurs alone, when it is characterised by profound difficulties in concentrating in ordinary social situations or on tasks (many can focus on computer based activities) and very high levels of physical activity. Children are seen as 'disruptive' and can easily be made worse under conventional behavioural control efforts. As with all developmental disorders, it may persist into adult life.

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

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

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

Cluster A – the paranoid, eccentric, schizoid

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

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

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

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

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

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

The dementias

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

Evidence for dementia will come in several forms – the clinical examination, which should include asking the affected person about his/her experiences and for a history of the development of the condition; for obvious reasons it is more than usually important to get a history from relatives and friends too. People with dementia may retain the capacity to give a long and fascinating account of their problems which has little basis in reality (referred to as confabulation).

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

The dementias are progressive. People may be helped to manage their difficulties, sometimes the progress may be slowed, and sometimes worsening of some aspects of the condition may render other aspects less problematic or risky, but these are not conditions from which people recover. The most common dementias are a function of unhealthy aging. There has been an increase in offending among older people, so these are conditions increasingly likely to be seen in the courts. A few of the dementias, usually those with early onset, have a clear genetic cause; there is evidence that there is a genetic contribution to most.

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

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

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

Acquired brain injury (ABI)

ABI is an injury to the brain which has occurred since birth. Causes include: tumour, stroke, haemorrhage, encephalitis, carbon monoxide poisoning, hypoxic injury or trauma. Principal causes of trauma resulting in ABI are falls, road traffic collisions, workplace injuries, violent assault and sporting injuries. Even after a minor head injury, brain function can be impaired temporarily (concussion). Effects include headaches, dizziness, fatigue, depression, irritability and memory problems, lasting for weeks, months or even years.

Survivors of more severe brain injury are likely to have long term problems affecting their personality, relationships and ability to live independently. Issues can be compounded as the effects of ABI are often hidden and may fluctuate. The cognitive, psychological, emotional and behavioural effects of brain injury can be

difficult to detect by those without specialist training.

Multi-morbidity and comorbidity (dual diagnosis)

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

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

Glossary of most commonly prescribed drugs[3]

Commonly used oral anti-psychotic medicines

- amisulpride
- aripiprazole
- chlorpromazine
- haloperidol
- olanzapine
- quetiapine
- risperidone
- clozapine

Commonly used anti-depressants

- citalopram
- dapoxetine
- escitalopram
- fluoxetine
- fluvoxamine
- paroxetine
- sertraline
- vortioxetine
- duloxetine
- venlafaxine
- mirtazapine

Commonly used medicines to treat bi-polar disorder

- lithium

Commonly used medicines to treat ADHD

- methylphenidate
- dexamphetamine
- lisdexamfetamine

Commonly used medicines to treat PTSD

- paroxetine
- sertraline

Commonly used medicines to treat dementia

- donepezil
- rivastigmine

- galantamine

Commonly used medicines to treat addiction

- naltrexone
- methadone

Annex B – reports

This information provided below is correct as of the date of the guideline coming into force on 01/10/2020. It does not form part of the guideline.

Courts should refer to the form '*Directions for Commissioning a Psychiatric or other medical report for sentencing purposes*', rule 28.8, regarding commissioning a medical report.

Courts may find it helpful to consider including a request for information (via ticking the 'any other matter' box on the form) on the following issues:

- how the condition relates to the offences committed,
- the level of impairment due to the condition at the time of the offence and currently,
- if there has been a failure of compliance (e.g. not attending appointments, failing to take prescribed medication) what is thought to be driving that behaviour,
- if a particular disposal is recommended, the expected length of time that might be required for treatment, and details of the regime on release/post release supervision,
- any communication difficulties and/or requirement for an intermediary.

When requested by clinicians wanting to undertake an inpatient assessment, for offences punishable with imprisonment, courts may wish to consider making an interim hospital order (s.38 MHA). Before making a s.38 order the court should ensure that the statutory requirements are satisfied.

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

Additional requirements in case of offender suffering from mental disorder (s.232 Sentencing Code)

1. This section applies where— a) the offender is or appears to be suffering from a mental disorder, and b) the court passes a custodial sentence other than one fixed by law ("the sentence").

2. Before passing the sentence, the court must obtain and consider a medical report unless, in the circumstances of the case, it considers that it is unnecessary to obtain a medical report.

3. Before passing the sentence, the court must consider— a) any information before it which relates to the offender's mental condition (whether given in a medical report, a pre-sentence report or otherwise), and b) the likely effect of such a sentence on that condition and on any treatment which may be available for it.

4. If the court did not obtain a medical report where required to do so by this section, the sentence is not invalidated by the fact that it did not do so.

5. Any court, on an appeal against the sentence, must— a) obtain a medical report if none was obtained by the court below, and b) consider any such report obtained by it or by that court.

6. In this section— "medical report" means a report as to an offender's mental condition made or submitted orally or in writing by a registered medical practitioner who is approved for the purposes of section 12 of the Mental Health Act 1983— a) by the Secretary of State, or b) by another person by virtue of section 12ZA or 12ZB of that Act, as having special experience in the diagnosis or treatment of mental disorder; "mental disorder" has the same meaning as in the Mental Health Act 1983.

7. Nothing in this section is to be taken to limit— a) the pre-sentence report requirements (see section 30), or b) any requirement for a court to take into account all information that is available to it about the circumstances of any offence, including any aggravating or mitigating factors.

Annex C – Sentencing disposals: criteria and release provisions

This information provided below is correct as of the date of the guideline coming into force on 01/10/2020. It does not form part of the guideline.

Mental Health Treatment Requirement (Schedule 9 part 9 Sentencing Code) (can only be imposed as part of a community order or suspended sentence order)	
May be made by:	A magistrates' court or the Crown Court
In respect of an offender who is:	Convicted of an offence punishable with imprisonment.
If the court is satisfied	That the mental condition of the offender is such as requires and may be susceptible to treatment but does not warrant detention under a hospital order. The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order— (a) in-patient treatment in a care home, an independent hospital or a hospital within the meaning of the Mental Health Act 1983, but not in hospital premises where high security psychiatric services are provided; (b) treatment as a non-resident patient at such institution or place as may be specified in the order; (c) treatment by or under the direction of such registered medical practitioner or registered psychologist (or both); during a particular period or particular periods, but the nature of the treatment is not to be specified in the order.
And the court is satisfied	That arrangements have been or can be made for the treatment to be specified in the order and that the offender has expressed a willingness to comply with the requirement.

_ Hospital order (s. 37 MHA 1983)		
May be made by:	A magistrates' court or the Crown Court	
In respect of a person who is:	*Where made by a magistrates' court:*	*Where made by the Crown Court:*
	Convicted by that court of an offence punishable on summary conviction with imprisonment, or *Charged before that court with such an offence but who has not been convicted or whose case has not proceeded to trial, if the court is satisfied that the person did the act or made the omission charged.	Convicted before that court for an offence punishable with imprisonment (other than murder).
If the court is satisfied	On the written or oral evidence of two doctors, at least one of whom must be approved under section 12, that • the offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment, and • appropriate medical treatment is available.	

And the court is of the opinion	Having regard to all the circumstances, including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with the offender, that a hospital order is the most suitable method of dealing with the case.
And it is also satisfied	On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case, or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the period of 28 days starting with the day of the order.

*This guideline does not deal with orders other than on conviction.

- These orders are an alternative to punishment. Under s.57(3) of the Sentencing Code, the five statutory purposes of sentencing in s.57(2) do not apply when making a hospital order (with or without restriction), an interim hospital order or a limitation direction,
- A hospital order or guardianship order can only be made where the criteria are met **at the time of sentence**, irrespective of the condition at the date of the offence,
- Hospital orders and guardianship orders are not available to treat substance use disorders and addictions, s.1(3) MHA,
- When making a hospital order, the court will need to consider if a restriction order is necessary. The magistrates' court does not have the power to make a restriction order but, if it considers it is appropriate to make a s.37 order upon conviction (but not where there has been a finding of having done the act or omission) and a s.41 restriction order may be appropriate, it can commit to the Crown court, even for a summary only offence, s.43 (see below),
- When making a hospital order, the court cannot pass a sentence of imprisonment, a community order, a youth rehabilitation order or a referral order or impose a fine. The court may make any other order which it has the power to make, such as a compensation order.

Restriction Order (s.41 MHA 1983)

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

- A restriction order should not be passed simply to mark the seriousness of the offence,
- Where the court is considering if it is necessary to make a restriction order to protect the public from serious harm, the harm need not be limited to personal injury nor need it relate to the public in general, but it does not include harm to the offender. The risk need not be linked only to the offence for which the offender is being sentenced. A comparatively minor offence, where other factors are present, may lead the court to conclude that there is a risk of serious harm,
- The parties must be given an opportunity to address the court before making a restriction order,
- A restriction order can be passed where neither psychiatrist recommends such an order, as the court is not bound by expert evidence, though it will wish to have careful regard to it,
- In some cases the treating psychiatrist may prefer not to give evidence or provide a report in case it compromises treatment.

Imprisonment with Hospital Direction and Limitation Direction (s.45A MHA 1983)	
May be given by:	The Crown Court

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

- If a penal element is appropriate, taking account of the level of culpability and the seriousness of the offence, and the mental disorder can be dealt with by directions under s.45A, then the judge should make such directions,
- The court will need to hear evidence about the different release regimes under s. 37/s.41 orders and a s. 45A order from the medical witness. Once the order is made the release provision cannot be altered. There will be cases where the protection of the public via a restriction order will outweigh the importance of a penal element and other cases where greater public protection is provided by a hybrid order.

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

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

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

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

Guardianship order (s. 37 MHA 1983)	
May be made by	a magistrates' court or the Crown Court

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

*This guideline does not deal with orders other than on conviction

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

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

Effect of hospital orders, restriction orders and 'hybrid orders' and their release provisions:

1. References to 'the tribunal' are references to the First Tier Tribunal (Mental Health) for England, and the Mental Health Review Tribunal for Wales.

2. **Hospital Orders**

a. A hospital order initially lasts for six months, but can be renewed for a further six months, and then a for a year at a time, s. 20,

b. A hospital order can be discharged by the responsible clinician or manager of the responsible hospital or the patient's nearest relative (subject to certain safeguards in s.25), s. 23,

c. The responsible clinician can discharge the patient under a community treatment order, which makes the patient liable to recall to hospital, s. 17A-17E,

d. After six months, the patient, or their nearest relative, can apply to the tribunal for discharge, s.69. If no application has been made by the patient, or their nearest relative, then the hospital managers must refer the case to the tribunal, and must also refer the case to the tribunal if it has been more than three years

since the case was last considered by the tribunal, s.68. The SoS can refer the patient to the tribunal at any time, s. 67,

e. Powers of the Tribunal:
    i. The tribunal shall direct the release of the patient, immediately or on a future date, if it is not satisfied that, s. 72(1)(b)(i)&(ii):
        1. the criteria for a hospital order are met; or
        2. it is necessary for the health or safety of the patient or for the protection of other persons that he should receive treatment or that appropriate medical treatment is available for him,
    ii. The tribunal has powers to discharge a community patient, s. 72(1)(c),
    iii. The tribunal may recommend that the responsible clinician consider whether to make a community treatment order, but cannot make any such order itself, and may further consider the case if the responsible clinician does not make such an order, s. 72(3A).

3. **Restriction Orders**

a. When a restriction order is made, both the restriction order and the hospital order last indefinitely and do not need to be renewed,

b. The patient cannot be granted leave of absence or transferred to another hospital or discharged without the consent of the SoS, s. 41(3)(c),

c. If the restriction order ceases, the hospital order can still remain in force, s. 42(5),

d. **Powers of the SoS:**

i. If satisfied that a restriction order is no longer required for the protection of the public from serious harm, the SoS can direct the restriction order ceases to have effect and the patient is held as if subject to a hospital order, s. 42(1),

ii. The SoS can discharge the patient from hospital absolutely or subject to conditions. If the patient is discharged absolutely, he ceases to be detained under the hospital order, s. 42(2),

iii. If the patient has been conditionally discharged, the SoS may recall the patient at any time, s. 42(3),

iv. If a patient has been conditionally discharged, and the restriction order ceases to have effect, the patient is deemed to have been absolutely discharged, s. 42(4),

e. Restricted patients can make applications to the relevant tribunals, s. 70,

f. The SoS may refer a restricted patient to the relevant tribunal at any time, s. 71(1). Such a referral shall be made if the patient's case has not been considered within the last three years, s. 71(2),

g. In any tribunal proceedings, the SoS becomes a party,

h. Powers of the Tribunal:
    i. If the tribunal is not satisfied that the criteria for a hospital order are still met, and is satisfied that it is not appropriate for the patient to remain liable to recall for further treatment, the tribunal shall direct the absolute discharge of the patient, and the hospital order and the restriction order cease, s. 73(1) & (3),
    ii. If the tribunal is not satisfied that the criteria for a hospital order are still met but considers that it is appropriate for the patient to remain liable to recall to hospital for further treatment, the tribunal shall direct the conditional discharge of the patient, s. 73(2). If the patient is conditionally discharged, they must comply with any conditions imposed by the tribunal or the SoS and are liable to recall by the SoS,

s. 73(4). If the patient has not been recalled and the restriction order ceases, the patient is deemed to have been absolutely discharged from both the restriction order and the hospital order, s. 73(6).

4. **Hybrid Orders**

a. Hybrid Orders are generally made in cases where a long determinate or indeterminate sentence is being imposed,

b. Under s. 45A, where the period of imprisonment is determinate, if the defendant's health improves so that his responsible clinician or the Tribunal notifies the Secretary of State (SoS) that he no longer requires treatment in hospital under the MHA, the SoS will generally remit the patient to prison under s. 50(1) of the MHA to serve the rest of his sentence. On arrival in prison, the s. 45A order would cease to have effect: the offender would continue to serve his prison sentence and his release from that sentence would be in accordance with the usual provisions. However, if there has been no improvement at the automatic release date, the limitation direction aspect of s. 45A falls away. At that point, the patient remains in hospital but is treated as though they are subject to an unrestricted hospital order so that the point at which he is discharged from hospital is a matter for the clinicians, with no input from the SoS,

c. Where the period of imprisonment is indeterminate, if a s. 45A patient's health improves such that his responsible clinician or the Tribunal notifies the SoS that he no longer requires treatment in hospital under the MHA, the SoS will generally remit the patient to prison under s. 50(1) MHA. On arrival in prison, the s.45A order would cease to have any effect whatsoever. Release would be considered by the Parole Board in the usual way. If a s.45A patient has passed their tariff date and the Tribunal then notified the SoS that he is ready for conditional discharge, the SoS could notify the Tribunal that he should be so discharged (s. 74(2)). In that case, the offender would be subject to mental health supervision and recall in the usual way. However, the SoS would, in practice, refer the offender to the Parole Board.

Footnotes

[1] For ease, the guideline does not necessarily list all impairments and disorders each time in the guidance, but refers to 'impairments or disorders', but this should be taken to include all relevant impairments and disorders including those listed in Annex A.

[2] Diagnostic and Statistical Manual of Mental Disorders (DSM) International Classification of Diseases (ICD)

[3] Note that some drugs can be prescribed for a number of different conditions, e.g paroxetine and sertraline can be used to treat both PTSD and depression

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