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Mental Health Conditions and Disorders: Draft Legal Guidance 2019

Crown Prosecution Service
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Contents

Principles

This guidance identifies the principles relevant to the prosecution of individuals who have:

- A mental disorder, as defined by the Mental Health Act 2007
- A learning disability
- A learning difficulty
- Autism Spectrum Disorder
- An acquired or traumatic brain injury
- Dementia

Further information on these, together with other specific conditions, can be found at Annex A.

This guidance seeks to assist prosecutors in the application of the Full Code Test and the decision to prosecute, in dealing with issues of fitness to plead, in ensuring the effective participation of defendants in the court process and in their duty to assist the court in sentencing or any other disposal.

There are a very wide range of mental health conditions and developmental disorders, and each will impact on individuals in different ways. The fact that someone has a mental health disorder or condition may be relevant to the offence, but it may not. For this reason, the prosecutor should approach each case on its own facts and merits and assess the nature, extent and effect of the condition on an individual, together with the circumstances of the particular offences.

Additionally, while some mental health conditions are distinct and easily defined, there are also crossovers and individuals may suffer with a number of related conditions. For example, autism is often diagnosed alongside other conditions, such as learning disabilities and/or difficulties. Where this is the case, it will be important to understand the combined impact on the behaviour and capabilities of the individual concerned.

The Full Code Test has two stages: the first is the evidential stage. The prosecutor must be satisfied that there is a realistic prospect of conviction given the evidence available. The mental health of a suspect may be relevant to the decision as to whether there is enough evidence to prosecute; prosecutors should refer to guidance on the evidential stage set out below.

If the prosecutor is satisfied that there is sufficient evidence to justify a prosecution, they must then consider whether a prosecution is required in the public interest. Detailed examination of common issues is set out in the public interest stage of this guidance. When considering the public interest stage, the prosecutor should examine all available information including:

- the seriousness of the offence,
- the circumstances of, and the harm caused to, a complainant, and
- the level of culpability of the suspect, including information about their mental health at the time of the offence and when a prosecution is considered, provided by the police, defence or any other source.

The Code for Crown Prosecutors makes clear that there is a balance to be struck between the public interest in diverting a defendant with significant mental illness from the criminal justice system and other public interest factors in favour of prosecution, including the need to safeguard the public.

The decision to prosecute should always be taken with as much relevant information as possible about the offence and the suspect. Many mental health conditions or learning disabilities and difficulties are not always easily recognisable and prosecutors should ensure they are alert to material or evidence that suggests the suspect or defendant may have a mental health issue, requesting clarification from the police where appropriate.

Guidance

Key Documents

The key documents that are relevant to the CPS policy in dealing with cases in which the defendant has a mental disorder are:

1. Code for Crown Prosecutors (the Code);
2. Home Office Circular 66/90 - Provision for Mentally Disordered Offenders; and
3. Diverting offenders with mental health problems and/or learning disabilities within the National Conditional Cautioning Framework;

Definition of Mental Disorder

Section 1(2) Mental Health Act 2007 amended section 1(2) Mental Health Act 1983 and defines mental disorder as “any disorder or disability of the mind”.

Disorders or disabilities of the brain are not mental disorders unless, and only to the extent that, they give rise to a disability or disorder of the mind as well.

Examples of clinically recognised mental disorders include mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities.

“Learning disability” means “a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning” (section 2(3) Mental Health Act 2007 inserts subsection 1(2A) into the Mental Health Act 1983).

Dependence on alcohol or drugs does not come within the meaning of “mental disorder” for the purposes of the Mental Health Act 1983 section 1(3). However, mental disorders which accompany or are associated with the use of or stopping the use of alcohol or drugs, even if they arise from dependence on those substances, may come within the meaning of “mental disorder” for the purposes of the Mental Health Act 1983.

The Civil Framework

Prosecutors should have an awareness of Part II of the Mental Health Act 1983 which covers compulsory civil admission to hospital, guardianship, and community treatment orders. The existence of a “civil section” and compliance with any community treatment orders are factors to be taken into account when considering the decision to prosecute, the continuation of proceedings and may be directly relevant to an offender’s bail status.

Sections 2 - 5 of the Mental Health Act 1983 provide the procedure for compulsory hospital admission. The most common types of compulsory civil detention are:

1. Admission for assessment (section 2). This allows for a person to be admitted and detained in hospital if they are suffering from a mental disorder and they need to be detained for assessment (or for assessment followed by treatment) for their own health and safety or the protection of other people. An application must be supported by the written evidence of two doctors.

An admission under section 2 lasts for up to 28 days and cannot be renewed or extended. Following assessment within the 28 day period, a person can be detained under section 3, or remain as a voluntary patient.

2. Admission for treatment (section 3). This provides that a person can be detained if they are suffering from a mental disorder, and it is necessary for their own health and safety, or the protection of other people, and treatment cannot be provided unless they are detained in hospital, and two doctors agree that appropriate medical treatment is available.

   Initial detention is for up to six months, which can then be renewed by a further six months, followed by annual reviews.

3. Informal admission (section 131). Also known as "voluntary admission", section 131 allows those aged over 16 who require treatment for a mental disorder to either be admitted to, or remain in hospital, on a voluntary basis. People admitted informally are "patients", and in contrast to sections 2 and 3 above, are not "detained".

Discharge

There are a number of possible ways in which a person who has been subject to a section can be discharged. Both the timing of, and trigger for, any discharge depends upon the type of, and age of, detention. Prosecutors should be satisfied that they know the current detention status of any suspect or defendant, and should not make any relevant review or bail decisions without being provided with this information by the police.

Community Treatment Order

Following treatment in hospital, a responsible clinician can order that a person is discharged under a Community Treatment Order (s17A Mental Health Act 1983) if that person is suffering from a mental disorder, which requires medical treatment, and it is necessary for their health or the protection of others that they receive treatment. A person subject to a Community Treatment Order can be recalled (s17E) if, for example, they stop taking required medication or their mental health condition deteriorates.

Guardianship (section 7) enables some patients who have a mental disorder, and who require treatment outside of hospital without having been admitted, to be subject to some supervision or control within the community. Guardians are either a local authority or any other person accepted by the local authority.

The Decision to Prosecute

The following is proposed as a structure for reviewing a case where a suspect's mental health or disability is a live issue, in accordance with the Code for Crown Prosecutors.

Evidential stage: introduction

At the evidential stage, a prosecutor will consider if there is sufficient evidence for a realistic prospect of conviction. This means both whether there is sufficient evidence to prove that the suspect did the act or omission alleged ("actus reus"), and that they had the state of mind required for the offence alleged ("mens rea"). Proof of both or either may rest on confession evidence, and as such a prosecutor should consider its admissibility and the weight to be attached to it. Further, a prosecutor will consider whether a suspect is likely to raise a viable defence and if so what the prospects are of disproving it beyond reasonable doubt.

Actus reus

A prosecutor should begin with an objective assessment of the evidence concerning the act or omission of the offence alleged. Notwithstanding the possibility or likelihood of a mental health disposal, the prosecutor should be satisfied as in any case, either that there is sufficient evidence available which is likely to satisfy a court that the suspect did the act or omission alleged to the criminal standard (as part of the "Full Code Test"), or that there is a reasonable suspicion that the suspect did the act or omission alleged, that further evidence will become available within a reasonable period to enable the Full Code Test to be applied, and that the other conditions for the Threshold Test have been met.

Mens rea

In order to prove that a suspect is guilty of a criminal offence, a prosecutor must often also prove that the suspect had a particular mens rea when committing the offence: for example, intention, or recklessness, as to a consequence of the suspect's action or omission; or knowledge, or belief, or suspicion, of circumstances in which those actions or omissions take place. There are a number of ways in which a suspect's particular and individual mental state may be relevant to whether a prosecutor can prove that they had the mens rea for the offence alleged. This can range from diagnosed mental ill health, to learning difficulties, to evidence that a suspect (without proof of a condition) did not, for instance, appreciate or turn their mind to a risk which was present in a case.

The evidence of mens rea may come from tangible evidence, for instance if the suspect's thoughts are recorded in a document or in electronic communications, or if they provide an account of their thought process in a police interview (see below). Often however it will rest solely or heavily on inference. A suspect who lashes out in a heated confrontation may be deemed to be reckless as to an assault on a person who is struck; a suspect who repeatedly and continuously lashes out may be deemed to intend to assault. Proof of mens rea by inference is proof nonetheless.

Prosecutors should have regard to the evidence in the case, whether that is expert evidence of mental ill health, the suspect's account in interview, or any other direct or inferential evidence of mens rea. Prosecutors should consider first whether it is admissible. The evidence must be scrutinised as to how and why it is said to bear on the suspect's mental state at the time of the alleged offence. See for example ***Henry*** [2005] EWCA 1681 where expert evidence of the defendant's suggestibility that fell short of demonstrating very low IQ or mental illness was not admissible either as to lack of intent or in support of the defendant's credibility in advancing this defence in evidence. It is not generally permissible for an expert witness to give evidence as to the credibility of the defendant or his defence, save in respect of confessions. See also *Chard* (1972) 56 Cr. App. R. 268: absent evidence of insanity or mental illness (or, it is submitted, other recognised condition), expert evidence as to intent was inadmissible.

If the evidence relevant to mens rea is admissible, prosecutors should consider objectively what weight to attach to it.

- When considering the weight to attach to a suspect's account, as in every case, prosecutors will consider carefully the credibility of any explanation, firstly on its own terms and secondly in terms of the other evidence in the case. Prosecutors will consider whether any other material is available or could be available in support of it. This evaluation should come before an assessment of any expert evidence. It may be that this account is a clearer account of the suspect's mental health or disability or mens rea than that provided by expert evidence. It may be that this account identifies other issues in the case, e.g. alibi, or other dispute of fact which the jury will have to determine.

- When considering the weight to attach to expert evidence, prosecutors will consider to what mens rea requirement of the offence alleged it is said to be relevant. Does it take the suspect's account of a mental state of, for instance, anxiety or fear any further? Or will it serve only to confuse the jury with medical terminology which is secondary to the suspect's own explanation? Should the jury first be determining other disputes of fact before considering

the suspect's mental state? Does it relate to the material time (where time has elapsed between offence and expert report)? What opportunity has the expert had to assess the suspect? What other material did the expert have to hand? Has the expert considered other possibilities, such as deception by the suspect, and why have they been discounted? Does the report comply with the Criminal Procedure Rules? Is it appropriate to accept these conclusions or should a second expert be instructed?

Ultimately, prosecutors must apply this assessment to the relevant mens rea for the offence alleged which are not obscure or expert terms; they are concepts which are either ordinary words which do not benefit from elaboration or paraphrase, such as "intent", or words whose definition has been provided for by law, such as "recklessness".

Intent or recklessness may be present and whilst there may be evidence of intoxication, or mental ill health, that must act so as to negate the intent or recklessness to amount to a defence: *Kingston* [1995] 2 A.C. 355. Similarly, the suspect's mental ill health must be shown to have been such that they did not know a fact, or foresee a consequence, or other mental element required for guilt – mental ill health where such elements remain will not provide for acquittal on the basis of an absence of mens rea.

Confession evidence

Part of the evidence against a suspect, in respect of an act or omission and/or the mental element required (for instance, accepting presence at the scene of the crime, or accepting that they intended the outcome which followed), may come from a statement they have made which is wholly or partly adverse to them: "confession evidence". This may come from a suspect's police interview but applies to any statement relied upon wholly or adverse to them, for instance, documents they have written, electronic communications they have sent.

When assessing confession evidence in a case involving a suspect with live mental health issues, prosecutors should consider:

- Whether safeguards have been observed, for instance about questioning provided for by PACE Code B, and if not the likely prospect of evidence being excluded pursuant to section 78 Police and Criminal Evidence Act 1984.
- Whether the confession has been obtained by oppression or in consequence of anything said or done which was likely to render the confession unreliable, and if so, the likely prospect of evidence being excluded pursuant to section 76 Police and Criminal Evidence Act 1984, noting also the need for special caution in section 77.

- At any rate, what weight to attach to the confession taking into account evidence concerning the suspect's mental health.

Defences

Having considered the actus reus and mens rea a prosecutor will consider any likely viable defence. It is not possible to consider every potential defence provided for. In general, where a person's genuine (even if mistaken) belief provides for a defence – for instance, that a person consented to criminal damage pursuant to section 5(2)(a) Criminal Damage Act 1971 – mental ill health leading to that genuine belief will support that defence. Where, however, there is an objective test of reasonableness – for instance, reasonable belief in consent for a sexual offence – mental ill health will not make a non-reasonable state of mind any more reasonable: *M A B v The Queen* [2013] EWCA Crim 3.

Three potential defences available across the criminal law are considered below: self-defence or defence of another, duress and automatism. In each case, once they have properly been raised, the prosecution must disprove them beyond reasonable doubt. Therefore when assessing whether there is a realistic prospect of conviction, prosecutors will need to consider the prospect of disproving these defences beyond reasonable doubt. Thereafter this guidance will address the two defences to murder, loss of self-control and diminished responsibility

Defence of self or another

This defence comprises two limbs:

(i) did the suspect genuinely (even if mistakenly) believe that force was needed in the circumstances as s/he understood them to defend themselves or another?
(ii) If so, did the suspect use reasonable force in so doing?

In assessing the first (subjective) question, a suspect's mental health will be relevant. The suspect may be able to give evidence about their own mental state (their perceptions and how they processed them) and may also explain their own mental ill health at the time of the offence. Expert evidence is also admissible, but only if it assists the jury with the issue of genuine belief once the suspect's account and the other evidence in the case have been considered: *Ibrahim* [2014] EWCA Crim 121; *Martin* [2001] EWCA Crim 2245. However, a mistaken belief in the need to defend oneself or another will not allow for a claim of self-defence where induced by voluntary intoxication, including proximate voluntary intoxication which has induced poor mental health causing the mistaken belief: *Taj* [2018] EWCA Crim 1743.

The second question, however, is an objective one. When deciding whether a defendant has used reasonable force in self-defence, prosecutors should not have regard, and should invite the court to disregard, whether the suspect was suffering from a psychiatric condition and the effect that had on the degree of force used: *Martin* (which suggested that expert evidence might be possible in exceptional circumstances), *Canns* [2005] EWCA Crim 2264 and *Oye* [2013] EWCA Crim 1725 (which could not conceive of such circumstances).

Duress

The question of whether a threat or circumstances compelled a person to act as they did involves the application of an objective test: would the threat or circumstances have had that effect on a person of reasonable firmness? However, one exception to this objective assessment is that a jury is entitled to consider whether a suspect's mental health made them more susceptible to the threat or circumstances causing their will to be wholly over-borne: *Bowen* [1996] 2 Cr App R 157. In accordance with *Bowen*, prosecutors should apply, and invite the court to apply, the reasonable firmness test unless expert evidence, duly scrutinised as to its admissibility (see elsewhere in this guidance), provides evidence of a "recognised condition" (and nothing less than this) relevant to susceptibility to threats or circumstances.

Automatism

Automatism involves a total loss of control such that a suspect acts wholly involuntarily. For instance, violence, medicines or hypnotic influences may affect the mind and/or body in such a way that the suspect cannot be held responsible for the acts or omission which followed because they had no conscious control over them. Automatism is sometimes said to fall into insane automatism and non-insane automatism; the distinction is made between total loss of control such that a suspect acts wholly involuntarily, which provides for a total defence of automatism and acquittal, and insanity (as defined below) which provides for the special verdict of not guilty by reason of insanity.

The areas which a prosecutor may scrutinise will include: was there a total loss of control or was control merely impaired? Could the suspect have reasonably foreseen the condition? Were there any sign of its onset? What could have been done to avoid it?

Partial defences to murder: loss of control

Section 54 of the Coroners and Justice Act 2009 provides that a person is to be convicted of manslaughter, and not murder, if they kill another person but raise sufficient evidence of the following, to be determined by a Judge considering each of

the criteria in turn, and these propositions are not disproved beyond reasonable doubt by the prosecution:

- The person's acts and omissions in killing resulted from a loss of self-control (such loss not being attributable to voluntary intoxication);
- The self-control had a qualifying trigger, defined by section 55 (fear of serious violence, or things said or done which constituted circumstances of an extremely grave character and caused the person to have a justifiable sense of being seriously wronged, or a combination of both)
- A person of the same sex and age, with a normal degree of tolerance and self-restraint and in the circumstances of that person, might have reacted in the same or a similar way. The reference to circumstances is to all circumstances, save to exclude those whose only relevance to the person's conduct is that they bear on the suspect's general capacity for tolerance or self-restraint.

In *Rejmanski [2017]* EWCA Crim 2061, the Court held that the potential relevance of mental ill health is fact-specific to all three questions. Care must be taken to assess, as against each of the criteria for loss of self-control, what the legitimate and non-legitimate relevance of evidence of mental ill health is and, in turn, whether the defence is to be left to the jury. In relation to the third criterion, evidence that the mental disorder acted so as to reduce the person's capacity for tolerance and self-restraint will not be admissible. The suspect may instead raise diminished responsibility. If, however, the mental disorder had other relevance, for instance it was a matter about which the suspect had been taunted, that evidence will be admissible in support of loss of self-control.

Partial defences to murder: diminished responsibility

Section 2 of the Homicide Act 1967, as amended, provides that a person is liable for conviction for manslaughter and not murder if they kill another person but prove, on the balance of probabilities, that:

- They were suffering from such abnormality of mind as substantially impaired their mental responsibility for the acts and omissions involved in the killing; or,
- They were suffering from an abnormality of mental functioning (for guidance, see *Byrne* [1960] 2 Q.B. 396) which provides that this must (i) arise from a recognised medical condition; (ii) substantially impair the suspect's ability to understand the nature of their conduct, form a rational judgment and/or exercise self-control; and (iii) provides an explanation for their acts or omissions in killing. As to voluntary intoxication, diminished responsibility is made out if notwithstanding the fact that voluntary intoxication played a role in the suspect's actions, the mental abnormality substantially impaired mental

responsibility for the fatal acts. Diminished responsibility however is not available where an abnormality of mental function is triggered by voluntary intoxication: *Joyce, Kay* [2017] EWCA Crim 647.

Evidential stage: conclusion

If, at this stage, the prosecutor is satisfied that there is a realistic prospect of conviction, they will proceed to consider the public interest stage. If they are not satisfied that there is a realistic prospect of conviction the case must not be charged.

It is appropriate at this stage – the point at which an evidential stage conclusion has been reached and the public interest stage is to be considered – to address two separate issues which have some areas of overlap: insanity, and fitness to plead. Either or both may occur in a case: a suspect may or may not have been insane at the time of the offence, and may or may not be unfit to plead at the time of the trial.

The Code for Crown Prosecutors provides that a realistic prospect of conviction includes a special verdict of not guilty by reason of insanity: paragraph 4.6. A prosecutor who is satisfied that there is a realistic prospect of conviction shall remain so satisfied notwithstanding a likelihood that the suspect will obtain a special verdict. Further, a prosecutor who is satisfied that there is a realistic prospect of conviction shall remain so satisfied notwithstanding a likelihood that the suspect will be found unfit to plead. However, the likelihood of both or either is bound to be relevant when assessing whether a prosecution is required in the public interest.

The rationale for the relationship between the Code for Crown Prosecutors and the insanity and fitness to plead provisions set out above is as follows:

- If a prosecutor did not authorise a charge in every case in which a likelihood of insanity or the suspect being found unfit to plead was present, because there was no realistic prospect of conviction solely on the basis that the outcome would be a special verdict or a finding that the defendant did the act or omission alleged and thus not a conviction, it would frustrate these provisions. No cases, in fact, would proceed to a special verdict or a hearing at which it is determined that the defendant did the act or omission alleged. Parliament has provided for these procedures and the sentencing disposals available in respect of them.
- If, however, a prosecutor were to authorise charge without being satisfied that there was sufficient evidence for a realistic prospect of conviction then those who were insane at the material time or unfit to plead when the case came to trial would be in a worse position than those not in this position. They would be charged when those who are sane or fit to plead would not be charged.

- As to the actus reus, the prosecution must always be able to satisfy the court of this and no prosecution should proceed without a prosecutor being able to satisfy a court of it.
- As to the mens rea, proof of this may in practice be displaced by consideration of the issue of insanity, and is not required in a fitness to plead hearing, but there must nonetheless be evidence satisfying the mental element alleged. No prosecution should take place on the basis of an accident or mere negligence, for instance, where intent and recklessness are required. Objective evidence is required to raise mistake, accident or self-defence when enquiring as to whether the defendant did the act alleged: *Wells* [2015] EWCA Crim 2.

Insanity

Section 2 of the Trial of Lunatics Act 1883 provides:

"Where in any indictment or information any act or omission is charged against any person as an offence, and it is given in evidence on the trial of such person for that offence that he was insane, so as not to be responsible, according to law, for his action at the time when the act was done or omission made, then, if it appears to the jury before whom such person is tried that he did the act or made the omission charged, but was insane as aforesaid at the time when he did or made the same, the jury shall return a special verdict that the accused is not guilty by reason of insanity."

The following falls to be addressed:

- What does "insane" mean?
- How is the special verdict reached?
- What are the implications of the special verdict?

What does "insane" mean?

To establish the common law defence of "insanity", it must be clearly proved that, at the time of committing the act, the suspect was labouring under such a "defect of reason", from a "disease of the mind", as

(i) not to know the nature and quality of the act being done (a delusion, for instance where a suspect believes they are cutting a slice of bread when in fact they are cutting a throat), or,

(ii) that the suspect did not know what was being done was wrong ("wrong" meaning contrary to the law – *Johnson* [2007] EWCA Crim 1978): *M'Naghten's Case* (1843) 10 Cl & F 200).

“Insanity” thus has a legal definition, to be assessed by a prosecutor and thereafter, if appropriate, by the court applying the *M’Naghten* criteria. It incorporates conditions such as sleepwalking, psychomotor epilepsy, diabetes and arteriosclerosis where the *M’Naghten* criteria are met; but not, conversely, severe mental illness, or expert evidence diagnosing the suspect as “insane”, unless the *M’Naghten* criteria are met. It may be permanent, temporary, organic or functional, but must not come from an extraneous cause (which would amount to non-insane automatism): *Sullivan* [1984] A.C. 156.

Insanity does not mean an absence of mens rea. A suspect who lashes out in a confrontation causing injury is likely to be reckless as to an assault albeit they are insane if they do so labouring under a delusion as to the nature and quality, or wrongness, or what they are doing. A suspect who repeatedly and continuously lashes out in a confrontation causing injury is likely to intend an assault albeit they are insane if they do so labouring under a delusion as to the nature and quality, or wrongness, or what they are doing. Insanity can be a defence to a strict liability offence or an offence with an objective element, if the person comes to be doing what is criminal because of a delusion as to its nature and quality: *Loake v DPP* [2017] EWHC 2855 (Admin).

How is the special verdict reached?

The prosecution cannot accept a plea to the special verdict *R. v. Crown Court at Maidstone, ex p. London Borough of Harrow* [2000] 1 Cr.App.R. 117, DC. It must be reached by the court: by a jury in the Crown Court pronouncing the special verdict or by a finding of not guilty in the youth court or magistrates’ court. The tribunal of fact must be satisfied by the prosecution so that they are sure that the defendant did the act or omission alleged, and must be satisfied by the defendant on the balance of probabilities that the defendant was insane at the time of the offence. Defendants are to be presumed to be sane and should only be held to be otherwise where cogent evidence demonstrates the case to be otherwise (in the Crown Court, the evidence of two or more registered medical practitioners at least one of whom is duly approved is required: section 1 Criminal Procedure (Insanity and Unfitness to Plead) Act 1991).

What are the implications of the special verdict?

Upon the return of the special verdict, the court must make one of the following orders:
(a) a hospital order (with or without a restriction order);
(b) a supervision order; or
(c) an order for his absolute discharge.

Fitness to plead

Insanity concerns a person's mental state at the time of the alleged offence. Fitness to plead concerns whether a person can participate in a criminal trial at the time they come to be prosecuted. See below for the procedure and relevant law.

Public interest stage

A suspect's mental health is likely to be relevant to the application of the public interest stage of the Code for Crown Prosecutors, in particular the assessment of the suspect's culpability. The Code provides (at paragraph 4.14):

"Prosecutors should also have regard to whether the suspect is, or was at the time of the offence, affected by any significant mental or physical ill health or disability, as in some circumstances this may mean that it is less likely that a prosecution is required. However, prosecutors will also need to consider how serious the offence was, whether the suspect is likely to re-offend and the need to safeguard the public or those providing care to such persons."

Accordingly, decisions to prosecute in cases where mental health or disability is a live issue should firstly consider any evidence concerning the nature and degree of the mental ill health or disability and the relationship between the mental ill health or disability and the conduct of the suspect and reach a preliminary view on the suspect's culpability before turning to consider:

- The seriousness of the offence
- The likelihood of repetition
- The need to safeguard

Seriousness is not made out simply where the outcome of proceedings is likely to result in more than a nominal/minor penalty. It requires an assessment of the overall seriousness of the offence which will depend on the facts and merits of each individual allegation. Offences of violence, sexual offences or weapons offences, save for the most minor, are likely to be serious; dishonesty or public order offences may require more careful assessment. The Code provides at 4.14(b) and (c) for considerations relevant to seriousness, namely an assessment of culpability and harm.

An assessment of the likelihood of repetition should be informed by evidence addressing the following if possible:

- Any history of similar and/or recent behaviour

- Any proposed treatment of the suspect, the aim of that treatment and its potential impact on offending behaviour
- The suspect's history of engagement with, and response to, treatment
- The suspect's current response to treatment

The evidence should also address the risk of causing harm to others. A prosecution is more likely to be in the public interest where the risk of harm to others through reoffending is high.

Prosecutors should consider what weight to attach to seriousness, likelihood of reoffending and the need to safeguard and reach a conclusion considering these in the round.

Prosecutors should also weigh into account any evidence of an adverse impact on the suspect's health or disability of a prosecution. It does not serve public confidence in the administration of justice to pursue proceedings where the circumstances of an accused, in particular evidence of a likely substantial impact on their health, would make such proceedings unseemly or oppressive.

The likelihood of a nominal penalty (in particular, if that is the likely outcome of a not guilty by reason of insanity verdict, or a finding that a defendant who is not fit to plead did the act alleged), or of the court ordering treatment which the defendant is already receiving, will not necessarily be determinative. Prosecutors should have regard to the following:

- Deterrence may legitimately and importantly be achieved by subjecting the suspect's conduct to scrutiny in proceedings conducted in open court and formally recording the outcome;
- Justice may be achieved for victims by the formal finding of a court, following the hearing of evidence in open court, that a defendant has done the acts alleged, even if not guilty by reason of insanity or unfit to plead, and the views of victims must where possible be taken into account;
- Public confidence in the administration of justice may be upheld in finding a defendant did the acts alleged against him through the mechanism provided by Parliament to provide a defence for, or accommodate, accused persons suffering from serious mental disabilities. There may be a wider importance to the community and public at large in hearing the allegations and having them tested; and
- There is a public interest in a judicial determination of allegations and in hearing the evidence of complainants in a case.

Question 1

Do consultees agree or disagree with the proposed factors to be taken into account by prosecutors at the public interest stage? Do consultees propose any further factors to be taken into account at this stage?

Diversion from prosecution

Diversion may mean diversion from prosecution by way of a caution, or conditional caution or diversion from the criminal justice system altogether.

Once a decision is taken that there is enough evidence to justify a prosecution, prosecutors should consider whether there is a suitable out of court disposal, as an alternative to prosecution, which is appropriate to the seriousness and consequences of the offending, and meets the aims of rehabilitation, reparation or punishment.

A caution or conditional caution will not be appropriate if there is any doubt about the reliability of any admissions made or if the suspect's level of understanding prevents him or her from understanding the significance of the caution or conditional caution and giving informed consent.

However, it should not be assumed that all offenders with mental health issues are ineligible for cautioning or conditional cautioning. When such a disposal appears to be in the public interest, information and advice should be sought from the Liaison and Diversion Service liaison or other reliable source, and any suitable steps should be taken to enable an offender with mental health issues to understand the significance of the caution and give informed consent.

See also:
Diverting Offenders with Mental Disorders and/or Learning Disabilities within the National Conditional Cautioning Framework

Where a caution or conditional caution is inappropriate, the only alternative diversion to prosecution is to take no further action.

Liaison and Diversion Service

Prosecutors should be aware of what local Liaison and Diversion (L&D) services are in place so they may advise the court appropriately.

L&D services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they come into contact with the criminal justice

system as suspects, defendants or offenders. The service can then support people through the early stages of the criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

L&D services aim to improve overall health outcomes for people and to support people in the reduction of re-offending. The main services that L&D practitioners offer are:

Identification: Criminal justice agencies working at the police and court stages of the pathway are trained to recognise possible signs of vulnerability in people when they first meet them. They then alert their local L&D service about the person.

Screening: Once someone is identified as having a potential vulnerability, the L&D practitioner can go through screening questions to identify the need, level of risk and urgency presented. It also helps determine whether further assessment is required.

Assessment: Using approved screening and assessment tools an L&D practitioner will undertake a more detailed assessment of the person's vulnerability. This provides more information on a person's needs and also whether they should be referred on for treatment or further support.

Referral: The L&D practitioner may refer someone to appropriate mainstream health and social care services or other relevant interventions and support services that can help. A person is also supported to attend their first appointment with any new services and the outcomes of referrals are recorded. L&D services will also provide a route to treatment for people whose offending behaviour is linked to their illness or vulnerability.

L&D services record all information about a person's health needs and share these with relevant agencies so they can make informed decisions about case management, sentencing and disposal options.

Regional NHS England contacts can be found here and case studies with videos on how the scheme works can be found here.

In Wales, there is no national Liaison and Diversion service but there are local diversion protocols in place, for example in Cardiff where there is a Liaison and Diversion Scheme Protocol between Cardiff and Vale UBH and South Wales Police. Prosecutors should also be aware of the NHS Wales Anti Violence Collaborative.

Question 2

Do consultees agree or disagree that the new section on diversion from prosecution sets out the right factors for prosecutors to consider? Is there anything else that should be taken into account?

Remand for defendants with a mental disorder

Remand for reports

Section 35 Mental Health Act 1983 sets out the provisions for the magistrates' court and the Crown Court to remand a defendant to hospital in order for a mental condition report to be prepared.

A person can be remanded if the court is satisfied, on the written or oral evidence of a registered medical practitioner, that there is reason to suspect that the accused person is suffering from a mental disorder and the court is of the opinion that it would be impracticable for a report on his mental condition to be made if he were remanded on bail.

A court shall not remand an accused person unless it is satisfied that arrangements have been made for the defendant's admission to hospital within seven days of the remand.

The court can direct that the person is conveyed to and detained in a place of safety (as defined by section 135 Mental Health Act 1983) pending admission to hospital provided that arrangements have been made for his admission to hospital within seven days of the remand (section 35(5) Mental Health Act 1983).

If the remand is before a conviction then the Custody Time Limit will continue to run and it may be necessary to apply to extend the Custody Time Limit pending the preparation of a report.

Remand for treatment

Section 36 Mental Health Act 1983 contains the provisions for an accused to be remanded to hospital for treatment, pending trial or sentence. This applies only to defendants appearing in the Crown Court.

If the remand is before conviction or the start of a trial, Custody Time Limits will continue to apply.

This power may be used in cases where the defendant might otherwise be found unfit to plead, to enable a defendant to receive treatment prior to trial, which may then proceed at a later date when the condition of the defendant has improved.

Remand considerations for defendants with a mental disorder

When a defendant appearing before the court is subject to an order or arrangement under Part II of the Mental Health Act 1983, or an existing s37 or 37/41 hospital order, prosecutors should ensure that they are in possession of the following information from the police or L&D services before addressing the court in relation to bail:

- Information as to the type of any current admission to hospital, including when this is due to be reviewed;
- An up-to-date MG7 “Remand in Custody Application” from the police;
- An up-to-date risk assessment, if applicable.

Prosecutors should ensure that the court is in possession of all relevant information at every hearing at which bail is considered and be alert to the possibility that a defendant who would otherwise have been the subject of an application to remand into custody could be released from hospital whilst criminal proceedings are ongoing.

Where a defendant is to be tried in the magistrates’ court and is subject to a Custody Time Limit of 56 days, prosecutors should invite the court to set a date within the CTL for a trial or finding of fact hearing: there may need to be an adjournment or adjournments during which time the defence will seek a medical report but sight must not be lost of the CTL.

Trial Procedure

Fitness to plead in the Crown Court

Fitness to plead concerns whether a person can participate in a criminal trial. In the Crown Court, the approach is set out in s4 and 4A Criminal Procedure (Insanity Act) 1964. The question of fitness to plead shall be determined as soon as it arises, unless the court is of the opinion that it is expedient to do so and it is in the interests of justice to postpone consideration of fitness to be tried until any time up to the opening of the case for the defence (ss 4(4) and (4(2)).

A judge must determine if the defendant is fit to plead and to stand trial. This is a determination on the balance of probabilities if the defendant raises the issue, or if he contests it then it is for the prosecution to satisfy the court beyond a reasonable doubt (*R v Robertson* [1968] 1 WLR 1767). There must be written or oral evidence by two or more registered medical practitioners, at least one of whom is approved by the Home Secretary, that the defendant is incapable of:

1) understanding the charges;
2) deciding whether to plead guilty or not;
3) exercising the right to challenge jurors;
4) instructing solicitors and counsel;
5) following the course of the proceedings;
6) giving evidence: section 4 and 4A Criminal Procedure (Insanity) Act 1964 as amended and *R v John M* [2003] EWCA Crim 3452, following *Pritchard* [1836] EWHC KB 1)

Modifications to the trial process and special measures may be relevant to this assessment (see Effective Participation, below).

If the judge finds the defendant to be fit to plead, then the trial proceeds. Medical evidence is only required for a determination of unfitness. A judge can determine that a defendant is fit to plead without receiving medical evidence on the point (*R v Ghulam (Habib) [2009] EWCA Crim 2285*). If the judge finds the defendant to be unfit to plead, then a jury will determine whether or not the defendant did the act, without consideration of the defendant's mens rea. Defences based on mens rea (lack of intent, diminished responsibility) are therefore not to be left to the jury: *Grant* [2001] EWCA Crim 2611, whereas self-defence, mistake and provocation are: *Antoine* [2001] 1 AC 340. This hearing is not a trial: section 4A(2)A provides that upon a finding of unfitness that a trial should "not proceed or further proceed".

If not satisfied to the criminal standard, the defendant shall be acquitted; otherwise the defendant upon such a finding shall receive one of the disposals outlined above:

(a) a hospital order (with or without a restriction order);
(b) a supervision order; or
(c) an order for his absolute discharge.

The case of *Norman [2008] EWCA Crim 1810* stressed the need for careful case management once fitness to plead has been raised, to ensure that full information is provided to the court and to avoid delay.

Fitness to plead in the magistrates' court and youth court

The Criminal Procedure (Insanity) Act 1964 does not apply in the magistrates' court and youth court.

In *R (P) v Barking Youth Court* [2002] EWHC Admin 734, the High Court said that the statutory framework for dealing with issues of fitness to plead in the magistrates' court is set out by a combination of s37(3) Mental Health Act 1983 and s11(1) Power of Criminal Courts (Sentencing) Act 2000. A youth court is a magistrates' court within the meaning of section 37(3) Mental Health Act 1983 which provides:

"Where a person is charged before a magistrates' court with any act or omission as an offence and the court would have power, on convicting him of that offence to make a Hospital or Guardianship order under subsection (1) above in his case as being a person suffering from mental illness or severe mental impairment, then if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him."

Section 11(1) PCC(S)A 2000 provides:

"If, on the trial by a magistrates' court of an offence punishable on summary conviction with imprisonment, the court—

a) is satisfied that the accused did the act or made the omission charged, but
b) is of the opinion that an inquiry ought to be made into his physical or mental condition before the method of dealing with him is determined, the court shall adjourn the case to enable a medical examination and report to be made, and shall remand him".

A remand is either for three weeks in custody or four weeks if on bail (section 11(2) PCC(S)A 2000.

Section 37(3) applies only to those defendants with a 'mental disorder', and so does not, for example, apply to those defendants with a learning disability whose behaviour is not associated with abnormally aggressive or seriously irresponsible conduct (section 1(2A) and (2B) Mental Health Act 1983). It does not apply to non-imprisonable offences. The only available disposals under section 37(3) are a hospital order or a guardianship order.

In *Barking* the court said that the procedure is first to determine whether P did the acts alleged against him, and if so, then to consider, in the light of such reports as they may think necessary, whether the case is one for an order under section 37(3) of the Mental Health Act 1983. If the court finds that that the defendant did the act then it should consider whether to seek further medical evidence with a view to making an order under the 1983 Act.

It is permissible for a hearing which begins as a criminal trial to switch to a 'fact finding' inquiry (see *Crown Prosecution Service v P* [2007] EWHC 946 (Admin), where the High Court held that where the court decided to switch from a criminal trial into an inquiry as to whether or not the defendant has done the act, it might consider the switch at any stage).

It is likely that the court process will have the following features in common with the procedure in the Crown Court:

1. Issues relating to unfitness to plead raised as an issue before the trial;
2. Defence will provide written or oral evidence of two registered medical practitioners that the defendant has a mental disorder requiring treatment;
3. Prosecution review case and consider whether or not to instruct own expert(s);
4. A criminal trial or 'fact finding' inquiry in court, taking into account all of the evidence before the court;
5. If found to have committed the act, court considers whether or not further medical evidence is required to make an order under s37(3);
6. If found not to have committed the act, then a 'not guilty' verdict is recorded.

Question 3

Do consultees agree or disagree that the guidance clearly and accurately sets out the procedures for fitness to plead?

Prosecutors should be aware of measures to assist vulnerable defendants, including defendants with a mental disorder, in the court process. The primary responsibility lies with the court and the defence but prosecutors should, consistent with their duty to the court, be aware of these measures and ready to draw them to the attention of the court and/or defence if necessary.

Reasonable Adjustments

Under the Equality Act 2010 where defendants meet the definition of disability, as set out in section 6(1) of the Act, prosecutors should be aware that they may be entitled to reasonable adjustments under section 20 of the Act.

Prosecutors should also be aware that reasonable adjustments may need to be made by the court in order to realise the right to access justice under Article 6 of the European Convention on Human Rights, as incorporated by the Human Rights Act 1998, and Article 13 of the United Nations Convention on the Rights of Persons with Disabilities.

Live Links

A live link is defined in section 33B Youth Justice and Criminal Evidence Act 1999 (inserted by section 47 of the Police and Justice Act 2006) as “an arrangement by which the accused, while absent from the place where the proceedings are being held, is able to see and hear a person there, and to be seen and heard by the judge, justices, jury, co accused, legal representatives and interpreters or any other person appointed by the court to assist the accused.”

Section 33A of the Youth Justice and Criminal Evidence Act (also inserted by section 47 of the Police and Justice Act 2006), provides that a defendant aged 18 and over may give evidence in criminal proceedings in the magistrates' court and the Crown Court using a live link if:

- he suffers from a mental disorder (within the meaning of the Mental Health Act 1983) or otherwise has a significant impairment of intelligence and social function; and

- he is for that reason unable to participate effectively in the proceedings as a witness giving oral evidence in court; and

- use of a live link would enable him to participate more effectively in the proceedings as a witness (whether by improving the quality of his evidence or otherwise (s33A (5) Youth Justice and Criminal Evidence Act 1999 as inserted by section 47 of the Police and Justice Act 2006); and

- the court is satisfied that it is in the interests of justice for the defendant to give evidence through a live link.

A youth defendant may give evidence in criminal proceedings in the youth court, magistrates' court and the Crown Court using a live link if:

- his ability to participate effectively in the proceedings as a witness giving oral evidence is compromised by his level of intellectual ability or social functioning; and

- his ability to participate effectively would be improved by giving evidence over a live link (section 33A(4) Youth Justice and Criminal Evidence Act 1999 as inserted by section 47 of the Police and Justice Act 2006); and

- the court is satisfied that it is in the interests of justice for the youth to give evidence through a live link.

The defence must apply for a live link direction, which prevents the defendant from giving oral evidence in the proceedings in any manner other than through a live link

(section 33A(6)). The court may discharge a live link direction at any time if it appears in the interests of justice to do so of its own motion or on application by any party (section 33A(7)). The court must give reasons in open court for giving or discharging a live link direction or for refusing an application for or the discharge of a live link direction. Those reasons must be recorded on the register of proceedings where the decision was made in the magistrates' court (section 33A(8)).

Prosecutors should be aware that when suspects appear for the first time by a video live link it may be harder at arrange for early identification of mental health issues. Prosecutors should take a proactive role in proceedings, raising any concerns about the video link, particularly if it would hinder rather than assist the case management of mental health issues or the Liaison and Diversion Service process.

Intermediaries

Legislation providing for the use of an intermediary by the accused is not yet in force (section 33BA YCJEA 1999 inserted by section 104 of the Coroners and Justice Act 2009), however the Criminal Practice Direction 2015 Division 1, General Matters sets out key principles for dealing with vulnerable people in court (3D – 3G).

Criminal Practice Direction 3.D2 states, “many other people giving evidence in a criminal case, whether as a witness or defendant may require assistance: the court is required take every reasonable step to facilitate the attendance of witnesses and to facilitate the participation of any person, including the defendant… This includes enabling a witness or defendant to comprehend the proceedings and engage fully with his or her defence…and the pre-trial, and trial process should be adapted as necessary to meet those needs”

In *C v Sevenoaks Youth Court* [2009] EWHC 3088 (Admin) it was held that the court has an inherent power to appoint an intermediary to assist a defendant to prepare for the trial in advance of the hearing and during the trial so that s/he can participate effectively in the trial process. However there is no presumption that defendant will be so assisted, and even where an intermediary would improve the trial process, appointment is not mandatory, and judges are expected to deal with specific communication problems faced by any defendant or any individual witness (whether a witness for the prosecution or the defence) as part and parcel of their ordinary control of the judicial process (*R v Cox* [2012] EWCA Crim 549).

There is also merit in an application to appoint a support worker or other companion who can provide assistance when it has not been necessary to appoint an intermediary, as a defendant may still benefit from some additional support to understand proceedings (CPD I General matters 3F.12 and 3F.13)

The Advocate's Gateway has produced a toolkit on the effective participation of young defendants.

Criminal Practice Direction 3E.3 further states that whilst discussion of ground rules is required in all intermediary trials, in cases without an intermediary ground rules hearings are good practice in all young witness cases and in other cases where a witness or defendant has communication needs.

Discontinuance

Where a decision is taken to terminate all proceedings in the magistrates' court against such a defendant, a notice of discontinuance should be issued rather than the charges being withdrawn at court in the absence of the defendant.

When a remand prisoner is transferred to hospital by way of an order under section 48 of the Mental Health Act 1983, the Safer Custody and Public Protection Group at HMPPS will inform by letter the local Chief Crown Prosecutor, the hospital manager receiving the prisoner and the Clerk to the Justices for the court where the defendant's case is being heard.

If it is subsequently decided to discontinue all the proceedings against the defendant, the Medical Records Office of the hospital where the defendant is detained should be immediately informed by telephone.

A copy of the discontinuance notice should then be sent to the hospital concerned, and to the HMPPS Mental Health Casework Section who are responsible for the administration of Section 48 orders. Prosecutors should note that when corresponding with HMPPS, patients are no longer assigned a named case manager according to the patient’s surname. All casework related e-mails (including to a named member of staff) should be sent to: mhcsmailbox@hmps.gsi.gov.uk

Where the procedure under Section 23 of the Prosecution of Offences Act 1985 is used to discontinue some but not all charges, a copy of the Notice of Discontinuance should be sent to the hospital concerned, making it clear that the proceedings are continuing.

In cases where a defendant is remanded in custody to the Crown Court awaiting trial and a section 48 order is made a letter will be sent to the Chief Clerk of the court where the defendant's case is to be heard. This will be copied to the local Chief Crown Prosecutor.

The precise way in which a case may be disposed of in the Crown Court may vary according to circumstances, and be subject to discussions between the relevant

parties. Any action taken which results in the disposal of the case against the defendant should be addressed to the Mental Health Casework Section and a named casework manager if possible by emailing mhcsmailbox@hmps.gsi.gov.uk.

Named casework managers should be your first point of contact for all casework enquires using the email address above. For all general casework queries please contact one of the numbers listed below:

- 07812 760 274
- 07812 760 582
- 07812 760 523
- 07812 760 356
- 07812 760 230

To urgently request recall please contact: 07812 760 248.

These six numbers will be covered at all times between 9am and 5pm, Monday to Friday.

If you have difficulty, please ring the Ministry of Justice switchboard on 020 3334 3555 and ask for the Mental Health Casework Section.

In cases of emergency outside normal office hours (9:00am – 5.30pm, Monday – Friday please call 0300 303 2079, followed by written confirmation sent by email.

Sentencing

Sentencing Principles

The role of the prosecutor at sentence is to assist the court to reach its decision as to the appropriate sentence. This will include drawing the court's attention to:

- the relevant sentencing guidelines or guideline cases;
- the aggravating and mitigating features of the offence under consideration;
- any victim personal statement or other information available as to the impact of the offence on the victim;
- any statutory provisions relevant to the offender and the offences.

In sentencing offenders with mental health issues, the prosecutor should bring to the court's attention any evidence as to the nature, extent and effect of any mental impairment experienced by the offender at the relevant time.

The prosecutor should ensure that the effect of a sentence is explained in open court by the Judge and assist where an explanation is to be given to a victim of the effect of a sentence passed. The table below should assist.

Before passing a custodial sentence other than one fixed by law on an offender who has, or appears to have a mental disorder, a court must obtain and consider a medical report (section 157 Criminal Justice Act 2003 – unless the court is of the opinion that it is unnecessary to obtain a report in the circumstances of the case). The court must also consider any other information before it which relates to the medical condition and the likely effect of such a sentence on that condition and on any treatment which may be available for it.

For these purposes, a 'medical report' is a report as to the offender's condition made or submitted orally or in writing by a registered medical practitioner who is approved for the purposes of 12 MHA 1983 as having special experience in the diagnosis or treatment of mental disorder.

The Court of Appeal in *Vowles (Lucinda)* [2015] EWCA Crim 45 gave guidance on the need to strike a balance between ensuring hospital treatment where appropriate and protecting the public. Thomas CJ stated "It is important to emphasise that the judge must carefully consider all the evidence in each case and not, as some of the early cases have suggested, feel circumscribed by the psychiatric opinions. A judge must therefore consider, where the conditions in s.37(2)(a) are met (to make a Hospital Order), what is the appropriate disposal. In considering that wider question the matters to which a judge will invariably have to have regard to include (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".

This approach was considered further in *R v Edwards [2018]* EWCA Crim 595 in which the Court summarised the principles to be followed;

(i) First, consider whether a hospital order may be appropriate;
(ii) If so, the judge should then consider all sentencing options including a section 45A order;
(iii) In deciding on the most suitable disposal the judge should remind himself or herself of the importance of the penal element in a sentence;
(iv) To decide whether a penal element to the sentence is necessary the judge should assess (as best he or she can) the offender's culpability and the harm caused by the offence. The fact that an offender would not have committed the offence but for their mental illness does not necessarily relieve them of all responsibility for their actions;

(v) A failure to take prescribed medication is not necessarily a culpable omission; it may be attributable in whole or in part to the offender's mental illness;
(vi) If the judge decides to impose a hospital order under section 37/41, he or she must explain why a penal element is not appropriate.

Commissioning of reports

The commissioning of psychiatric reports is governed by the Criminal Procedure Rules and the Criminal Practice Directions.

Court ordered reports for Sentence – Criminal Procedure Rule 28.8

Criminal Procedure Rule 28.8 applies when a medical report, or information about a hospital or guardianship order, is required by the court for sentencing. In such an instance the court must address a number of points including requesting confirmation that the commission is accepted and the expert will adhere to the timetable. This is catered for in the new standard forms which are available from the Ministry of Justice forms site.

Criminal Practice Direction VII emphasises the importance of the court monitoring progress towards compliance. The relevant rules include:

- R.10 which provides further guidance on the commissioning of the report;
- R.16 which states that where a defendant is in custody then the prison (custodian) must also be notified that a report has been ordered to ensure that the preparation can be facilitated;
- R.6 which suggests that the court should set a hearing to consider the report no more than 6-8 weeks after the request and should not be adjourned before it takes place save in exceptional circumstances (and then only by judicial order with recorded reasons); and
- R.7 which provides guidance as to what to do if the report is not provided in time.

Court ordered reports other than for sentence

Criminal Procedure Rule 3.28 will apply where, exceptionally, the court chooses to seek a report on a suspected issue of mental ill health other than for sentence rather than depending on the defence to seek such reports as they consider necessary.

This will most commonly arise on a question whether defendant is fit to participate in the trial process under section 4 Criminal Procedure Insanity Act 1964.

Sentencing Disposals

Hospital Order – section 37 Mental Health Act 1983 (the court may not, at the same time as making a hospital order, impose a sentence of imprisonment, impose a fine or make a community order, a youth rehabilitation order, or a referral order. The court may make any other order which it has the power to make, e.g. a compensation order)

Availability

Magistrates' Court including youth court

- On conviction of any imprisonable offence; or
- A case in which the defendant is not convicted but otherwise found to have done the act or made the omission charged.

Crown Court

- On conviction for any imprisonable offence, other than for an offence where the sentence is fixed by law; or
- Where a special verdict is returned that the accused is not guilty by reason of insanity or a finding that the defendant is under a disability and that he did the act or made the omission charged against him (Section 5 Criminal Procedure (Insanity) Act 1964.

Conditions

- The court must be satisfied on the written or oral evidence of two registered medical practitioners that the defendant is suffering from a mental disorder the nature or degree of which makes it appropriate for the defendant to be detained in 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 him, that it is the most suitable method of disposal for the case (section 37(2)).

- A hospital order can only be made if the court is satisfied that arrangements have been made for the defendant to be admitted to a hospital within 28 days of the making of the order (section 37(4)).

Effect

A hospital order authorises the detention of a patient in hospital for medical treatment. The order initially lasts for 6 months but can be renewed by the hospital for a further 6 months at a time if the conditions for making the order are still satisfied.

Interim Hospital Orders (section 38 MHA 1983)

Availability

Magistrates' court and Crown Court

Conditions

- Section 38 Mental Health Act 1983 contains the provisions enabling the Crown Court and Magistrates' courts to make an interim hospital order following conviction for an offence punishable with imprisonment (other than an offence the sentence for which is fixed by law). An interim hospital order is a form of sentence.

- The court must be satisfied on written or oral evidence of two registered medical practitioners that the defendant is suffering from a mental disorder and that there is reason to suppose that it may be appropriate to make a hospital order.

Effect

The interim order should be for a period not exceeding twelve weeks. It may be further renewed thereafter for 28-day periods, subject to an overall maximum period of twelve months

If an offender is already the subject of a hospital order, or an interim hospital order, a prosecutor should ascertain whether or not a restriction order has been made and when the next review of that order is due to take place, in order to ascertain how long the offender is likely to be subject to that order. This will be particularly relevant in reviewing a case in which an offender if alleged to have committed offences against hospital staff.

Restriction Order (section 41 Mental Health Act 1983)

Availability
Crown Court only
Conditions
• A hospital order has been made; and • at least one of the doctors whose evidence is taken into account by the court has given evidence orally; and • Having regard to: (i) The nature of the offence (ii) The antecedents of the offender, and (iii) The risk of the offender committing further offences • It is necessary for the protection of the public from serious harm for the person to be subject to restrictions on discharge, transfer or leave of absence from of the offender from hospital, without the consent of the Secretary of State A restriction must also be made where the Crown Court makes a hospital order under section 5(2)(a) Criminal Procedure (Insanity) Act 1964 in respect of an offender found to have committed the actus reus for murder.
Effect
The effect of the restriction means that any decision as to discharge is not taken by the responsible clinician or hospital managers, as it would be for an unrestricted patient under s37, but by the Secretary of State. As with a hospital order without restriction, a detained patient may apply for discharge thorough a mental health tribunal, but such an application cannot be made within the first six months of an order.

Committal to the Crown Court (section 43 Mental Health Act 1983)
Availability
Magistrates' court and youth court may commit a person to the Crown Court with a view to a restriction order being imposed.
Conditions

- The offender is aged 14 or over, and

- Has been convicted (this does not include a finding that the defendant has done the act/made the omission) 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
  i) The nature of the offence
  ii) The antecedents of the offender, and
  iii) The risk of the offender committing further offences if set at large

  The court thinks that if a hospital order is made, a restriction order should also be made.

Effect

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

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

Hospital and Limitation Directions (Section 45A of the Mental Health Act 1983

Availability

Crown Court
(if offender aged 21 or over and convicted before that court of an offence punishable with imprisonment (other than murder))

Conditions

- 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.

- The court should consider making a hospital order under section 37,but has decided instead to impose a sentence of imprisonment.

- The court must be 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.

Effect

Hospital and limitation direction patients are detained primarily on the basis of a prison sentence. A limitation direction ends automatically on the patient's 'release date'. The patient's release date is the day that the patient would have been entitled to be released from custody had the patient not been detained in hospital (the halfway point of a determinate sentence).

If patients are still detained in hospital on the basis of the hospital direction on their release date, they remain liable to be detained in hospital from then on, like unrestricted hospital order patients.

While the limitation direction remains in effect, the Secretary of State may direct that they be removed to prison (or equivalent) to serve the remainder of their sentence, or else release them on licence. This is only possible where the SoS is notified by the offender's responsible clinician, any other approved clinician, or by the Tribunal, that:

- the offender no longer requires treatment in hospital for mental disorder, or
- no effective treatment for the disorder can be given in the hospital in which the offender is detained.

When notified in this way by the responsible clinician, or any other approved clinician, the Secretary of State may:

- direct the offender's removal to a prison (or another penal institution) where the offender could have been detained if not in hospital, or
- discharge the offender from the hospital on the same terms on which the offender could be released from prison.

If the Tribunal thinks that a patient subject to a restriction order would be entitled to be discharged, but the Secretary of State does not consent, the patient will be

removed to prison

This “hybrid order” can be made when sentencing an offender with a mental disorder convicted of an offence (other than one of which the sentence is fixed by law) and the court wishes to combine a hospital order with restrictions with a prison sentence.

In such a case, the Crown Court can give a direction for immediate admission to and detention in a specified hospital “hospital direction” for treatment together with a direction that the offender be subject to the special restrictions set out in a section 41 “limitation direction”.

Mental Health Treatment Requirement (section 207 CJA 2003) **As part of a Community Order or Suspended Sentence Order, a Mental Health Treatment requirement means an offender must submit, during a period specified in the order, to treatment by or under the direction of a registered medical practitioner or psychologist with a view to improvement of the offender’s mental condition (s207 Criminal Justice Act 2003).**
Availability
Magistrates’ court and Crown Court
Conditions
• The offender is convicted of an imprisonable offence; • The mental health condition requires and is susceptible to treatment but does not necessitate a treatment under a hospital order;
Effect
The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order— (a) treatment as a resident patient in a care home an independent hospital or a hospital within the meaning of the Mental Health Act 1983, but not in hospital premises where high security psychiatric services within the meaning of that Act are provided; (b) treatment as a non- resident patient at such institution or place as may be

specified in the order;

(c) treatment by or under the direction of such registered medical practitioner or registered psychologist (or both) as may be so specified;

but the nature of the treatment is not to be specified in the order except as mentioned in paragraph (a), (b) or (c).

And the court is satisfied that arrangements have been or can be made for the treatment to be specified in the order and that the offender has expressed a willingness to comply with the requirement

Supervision Order
Availability
Crown Court
Conditions
A supervision order enables treatment to be given to the defendant. It is non-punitive and intended to provide a framework for treatment, and is supervised by either a social worker or probation officer in the area where the defendant lives. An order last no more than two years and can include a requirement to be treated by or under a registered medical practitioner. See Section 5(1) and Schedule 1A Criminal Procedure (Insanity) Act 1964

Guardianship order (section 37 Mental Health Act 1983)
Availability
Magistrates' Court • Offender aged 16 or over and; • convicted by the 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

Crown Court

- Offender aged 16 or over and convicted before that court of an
- offence punishable with imprisonment (other than murder)

Conditions

The court must be 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 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 authority or proposed private guardian is willing to receive the offender into guardianship

Effect

The guardian may be a local authority, or an individual such as a relative of the patient, who is approved by a local authority

Guardians have three specific powers:

- 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.
- 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.

Absolute discharge

Section 5 of the Criminal Procedure (Insanity) Act 1964 enables a person who is either insane or unfit to plead to be made subject to a hospital order, supervision

order or absolute discharge, which is ordinarily a disposal following conviction: Section 12 Power of Criminal Courts (Sentencing) Act 2000.

Annex A

Information about specific conditions can be accessed at the following sites:

- Mind;
- Mencap;
- Scope;
- National Autistic Society;
  - Autism: a guide for police officers and staff
  - Criminal Justice guidance
  - Autism Checklist for prosecutors
- Dementia UK;
- Alzheimer's Society and Dementia friends programme
- Headway, the brain injury association;
- Personality Disorder
- Rethink - Personality Disorders; and
- NHS Health A-Z: Conditions and treatments
  - Alzheimer's Disease
  - Antidepressants
  - Attention deficit hyperactivity disorder (ADHD)
  - Autism spectrum disorder (ASD including Asperger syndrome)
  - Bipolar disorder
  - Clinical depression

- Dementia guide
- Dementia with Lewy bodies
- Down's syndrome
- Dyslexia
- Dyspraxia (development co-ordination disorder) in adults and children
- Generalised anxiety disorder in adults
- Learning disabilities
- Personality Disorder
- Post-traumatic stress disorder
- Schizophrenia
- Vascular dementia

Basic definitions

Mental illnesses are mental health conditions involving changes in thinking, emotion or behaviour, or a combination of these. Mental health is just like physical health, everybody has it and needs to take care of it. Mental health problems can affect anyone at any time, currently around one in four people in any given year, and may be overcome with treatment. They range from common problems, such as depression and anxiety, to rarer conditions such as schizophrenia and bipolar disorder.

Learning disabilities are permanent and affect the way a person learns new things, understands information and communicates. Learning disabilities occur when the brain is still developing (before, during or soon after birth). A learning disability is a reduced intellectual ability with everyday activities, such as household tasks, socialising or managing money. The level of support someone requires depends on the individual. For example, someone with a mild learning disability may require help in getting a job, while someone with a severe learning disability may need fulltime care and support, and may also suffer with a physical disability. Around 1.5 million people in the UK have a learning disability. It's thought up to 350,000 people have a severe learning disability. This figure is increasing. People with certain specific conditions can have a learning disability too. For example, people with Down's syndrome and some people with autism have a learning disability.

The World Health Organisation (WHO) defines learning disabilities as 'a state of arrested or incomplete development of mind'. Someone with a learning disability also has 'significant impairment of intellectual functioning' and 'significant impairment of adaptive/social functioning'. This means that the person will have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations. Because of these difficulties with learning, the person may

also have difficulties with a number of social tasks, for example communication, self-support, awareness of health and safety.

A final dimension to the definition, of a learning disability, is that these impairments are present from childhood, not acquired as a result of accident or following the onset of adult illness or accident. There is still a good deal of debate about the best way to measure ‘significant’ impairment, and the impact of impairments of social functioning.

Learning difficulties are neurological (rather than psychological) and affect the way information is learned and processed, but do not affect intellect. For example, dyslexia is a learning difficulty as opposed to a learning disability. Another learning difficulty example is attention deficit hyperactivity disorder (ADHD), which is also neither a mental disorder nor a learning disability as it does not necessarily affect intellect. It is however more common in people with learning disabilities and studies have shown however that those who suffer with ADHD are more likely to commit crime rather than those without it.

Autism (also known as Autism spectrum disorder) is not a mental health condition, it is a lifelong developmental disability that affects how people perceive and experience the world and how they interact with others. Autism is not an illness or disease and cannot be 'cured'. It is a spectrum condition. All autistic people share certain difficulties, but being autistic will affect them in different ways. Some autistic people also have learning disabilities, mental health issues or other conditions, meaning people need different levels of support. All people on the autism spectrum learn and develop. There are currently 700,000 autistic people in the UK, that’s more than 1 in 100.

Asperger’s Syndrome is on the autism spectrum disorder, but has less severe symptoms and is generally considered to be on the “high functioning” end of the spectrum. There is often not a significant delay in language development as there is with a general ASD diagnosis. People with Asperger’s syndrome are of average or above average intelligence. They do not have the learning disabilities that many autistic people have, but they may have specific learning difficulties. They have fewer problems with speech but may still have difficulties with understanding and processing language. Prosecutors should note that while ‘Asperger’s Syndrome’ is not a term used by the medical profession anymore, that people may still refer to themselves as having Asperger’s and older medical records and reports may also use that term.

Dementia is caused by diseases of the brain that damage brain cells and cause them to die. Dementia is progressive and irreversible, which means the symptoms gradually get worse over time. How quickly this happens varies from person to

person. The symptoms of dementia are a decline in mental ability, usually with age, which affects memory, thinking, problem-solving, concentration, communication and perception. Although dementia mainly affects people over the age of 65, younger people can also develop the condition known as early onset dementia. There are more than 40,000 people in the UK with dementia under the age of 65.

There are several types of dementia, and sufferers can have a combination of more than one type, such as:

- **Alzheimer's disease** is the most common form of dementia (around 60% of diagnoses), although comparatively rare for under-65s. It's thought to be caused by abnormal amounts of proteins in the brain that create plaques and tangles that interfere with and damage nerve cells.

- **Vascular dementia** is the second most common form of dementia in the over-65 age group. It's an umbrella term for a group of conditions caused by problems with blood circulation to the brain. Causes can range from small blood clots, to blocked arteries, to burst blood vessels.

- **Frontotemporal dementia** is the second most common form of dementia for under-65s. It is a group of conditions caused by the death of nerve cells and pathways in the frontal and temporal lobes of the brain.

- **Dementia with Lewy bodies (DLB**), also known as Lewy body dementia, is a common type of dementia estimated to affect more than 100,000 people in the UK.

An **acquired brain injury (ABI)** is an injury caused to the brain since birth. There are many possible causes, including a fall, a road accident, tumour and stroke. Even after a minor head injury, brain function can be temporarily impaired and this is sometimes referred to as concussion. This can lead to difficulties such as headaches, dizziness, fatigue, depression, irritability and memory problems. While most people are symptom-free within two weeks, some can experience problems for months or even years after a minor head injury. The more severe the brain injury, the more pronounced the long-term effects are likely to be. Survivors of more severe brain injury are likely to have complex long-term problems affecting their personality, their relationships and their ability to lead an independent life. Even with good rehabilitation, support and help in the community, survivors and their families are likely to face uncertain and challenging futures.

Personality disorders are increasingly recognised as major mental health issues. They make people think, feel, behave and relate to others very differently from the average person. Symptoms vary depending on the type of personality disorder. A

person with borderline personality disorder (one of the most common types) tends to have disturbed ways of thinking, impulsive behaviour and problems controlling their emotions. They may have intense but unstable relationships and worry about people abandoning them. A person with antisocial personality disorder will typically get easily frustrated and have difficulty controlling their anger. They may blame other people for problems in their life, and be aggressive and violent, upsetting others with their behaviour.

Question 4

Do consultees agree or disagree that the information in Annex A covers the main features of conditions which prosecutors should be aware of when dealing with these cases? Is there anything else that should be taken into account?

Question 5

Do you have any further comments on the revised mental health conditions and disorders legal guidance?