Magistrates Association

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Response to the Sentencing Council Consultation on Draft Overarching Principles: Sentencing Offenders with Mental Health Conditions or Disorders

Introduction

This response was informed by a round table seminar held at the Prison Reform Trust on Thursday 13 June 2019. The following people attended, and we are grateful for their contributions:

- Jo Easton, Hattie Stair, Magistrates Association
- Mark Day, Marc Conway and Jenny Talbot, Prison Reform Trust

We were also joined by Mandy Banks at the Sentencing Council and thank her for her attendance. The following consultation response was informed by our round table seminar. It does not necessarily represent a single view from those present.

Consultation Questions

Question 1: Do you agree with the proposal that the draft guideline only applies to offenders aged over 18? If not, please tell us why.

The Sentencing Children and Young People Overarching Principles set out the need for vulnerabilities, including mental health problems, learning difficulties, learning disabilities, brain injury, trauma or speech and language difficulties to be taken into account. The two overarching principles in dealing with children under the age of 18 are to reduce reoffending and consider the welfare of the young person. Vulnerabilities, such as mental health conditions or disorders, that may impact on participation and culpability should be considered a welfare issue. It would, therefore, be useful to have a similar Annex available in the overarching principles for sentencing children and young people, which describes mental health conditions or disorders as they relate to children.

Question 2: Do you agree with the proposed title of the guideline? If not, please tell us why and suggest any alternatives.

Although technically correct, ‘mental health conditions or disorders’ is likely to be misleading for many sentencers who, in the absence of routine and mandatory training on mental health conditions and disorders, may not appreciate that ‘disorders’ include disabilities such as autism and learning/intellectual disabilities.

The current Equality and Human Rights Commission inquiry into pre-trial processes for people with vulnerabilities refers to ‘cognitive impairments’ – a term that many people may be more familiar with.

Our suggestion is to stick with the title but to add a strap line/short paragraph describing some of the conditions and disabilities that the guide covers, noting that the list is informative rather than comprehensive and referring the reader to Annex A. This will help ensure sentencers appreciate the breadth of guideline.

In order to ensure consistency of approach across the criminal justice pathway, the titles, descriptions and language used in the guideline should be the same as in the Crown

Prosecution Service's Guidance for prosecutors on dealing with defendants with mental health conditions or disorders, upon which the CPS has recently consulted.

Question 3: Do you have any comments on the proposed contents of paragraphs one to six? Do you think the information will be helpful to courts? If not, please tell us why.

Paragraph 2:

Although drug and /or alcohol dependence is highlighted as a factor, the relationship between substance misuse and mental ill health is complex and this should be better reflected. For example, people may self-medicate because they find it hard to access services, and dependence can hide underlying mental health conditions or disorders.

The danger of relying on unqualified or self-diagnosis is highlighted. The guideline should remind the court that if there is any doubt about a person's mental health condition or disorder, they should request an assessment from a health practitioner/liaison and diversion service.

This section should clearly state in a separate bullet point that mental health conditions can fluctuate, and although someone may appear to be well and / or have insight into their condition during the trial , this may not reflect their mental state and its impact on their behaviour at the time the offence was committed – and vice versa.

The role of liaison and diversion could be emphasised here, as an important service to identify people who have mental health conditions or disorders when they first come into contact with the criminal justice system.

In referencing other sources of information about an offender's vulnerability, including "probation, defence representatives, prison, police or court mental health teams, or family members", the offender themselves should also be included.

Paragraph 5:

Although this guideline relates to sentencing, paragraph 5 points out that certain conditions or disorders might affect an offender's ability to understand the process and participate in proceedings. This is a welcome reference. It is important that offenders can provide sentencers with information that may impact their sentence and can understand the sentence ordered by the court. Further guidance on how the court can ensure the offender has fully understood their sentence, and what they need to do to comply with it, would be useful.

There is a helpful reference to the updated Equal Treatment Bench Book, which includes sections on mental disability, as well as specific factors relevant to people from a minority background, or with particular cultural and religious beliefs. However, we note that referring to this is not the same as receiving sufficient training on the relevant issues.

Question 4: Do you have any comments on paragraph seven? Do you think the information will be helpful to courts? If not, please tell us why. Is there any further information relating to private treatment that you think should be added?

It is important for the court to be confident that treatment is available if the disposal involves in-patient care at a private facility. Our understanding is that such disposals are rare. The guideline should, therefore, make it clear that points made are specific to this situation. This would ensure that sentencers are not inadvertently discouraged from using other mental health disposals. We do not think disposals involving in-patient care at a private facility should be set out as a principle. Instead, we suggest that it is included when looking specifically as hospital orders, rather than in the main body of the guideline.

We are concerned that reference to the need for a court to consider whether a hospital or treatment centre has the necessary "appropriate level of security" does infer that additional security is likely, although it is not clear why this would be any more relevant for mental health disposals than any other court order.

Similarly, the guidance notes that restraining orders or other ancillary orders might be appropriate; but these should be considered as part of all sentencing decisions, and they are unlikely to be more necessary in addition to a mental health disposal.

In addition, the fact that reference is made to a Mental Health Treatment Requirement (MHTR) being carried out at a hospital or treatment centre and a psychiatrist treating the offender suggests that this is the only way a MHTR can be approached. This is not in line with all the positive work done in relation to the Community Sentence Treatment Requirement (CSTR) protocol, which encourages MHTRs to be offered more flexibly. Roll out of CSTRs to nine additional courts was announced on 20 June 2019.[1]

We suggest that it might be better to have a general paragraph on sentencing, which reminds sentencers of the CSTR protocol, and encourages sentencers to consider whether mental health conditions can be addressed at the lower level of sentencing, and to look at the full range of sentences available.

Question 5: Do you think the guidance within paragraphs eight and nine is helpful? Is there any of the guidance that you disagree with? If so, please tell us why you disagree with it.

The paragraphs clearly explain the complexity of the relationship between mental health conditions or disorders and culpability, and that in some cases, conditions may affect culpability while others may not. However, we are concerned that the guidance does not provide enough practical advice for sentencers, or the importance of referring to independent expert advice.

We appreciate that there may be circumstances where conflicting expert opinions require the court to adjudicate between them, and that it is important sentencers are reminded that any final decision rests with them. However, assessing culpability in response to vulnerabilities is complex, and sentencers should be encouraged to seek advice from medical professionals, including Liaison and Diversion teams.

[1] https://www.gov.uk/government/news/lifeline-community-treatment-pilots-to-steer-offenders-away-from-crime

Question 6: Please tell us your views on the contents of paragraph ten- do you think this will be helpful to courts? If not, please tell us why and suggest any alternative approaches to assessing culpability that you think may be more appropriate.

Paragraph 10 sets out useful questions that will help a court decide whether a specific vulnerability may have impacted on culpability. Although the guideline states that it is not an exhaustive list, there may be additional questions that would be helpful or there may be suggested amendments to the questions as they stand.

We are particularly concerned how sentencers would be expected to interpret the question in relation to whether the offender had insight into their illness. Given that mental health conditions and disorders can fluctuate, individuals may demonstrate a considerable degree of insight into their illness at trial but have had little insight into how it was influencing their behaviour at the time of the offence. Therefore, it would be useful to add reference to the fact that sentencers must focus on the circumstances of the offender at the time of the offence.

The final question is misleading and gives cause for concern. The relationship between substance misuse and mental ill health is more complex than the question suggests. There is clear evidence that misuse of drugs and alcohol is often related to poor mental health. People with mental health conditions or disorders can find it hard to access medical advice and maintain contact with mental health services. NHS England has said that:

> … people with a learning disability and/or autism who come into contact with the criminal justice system, or those at risk of such contact, often 'fall through the gaps' of existing provision; [are] often excluded from mainstream mental health or forensic services because of their learning disability and/or autism, and excluded from learning disability services because they are considered too able or too high risk, or because they have autism but do not have a learning disability.[2]

Access can be particularly problematic for people from black and minority ethnic communities who experience poor mental health, and for women who commonly have histories of abuse and trauma. Consequently, individuals may self-medicate by using drugs and alcohol even when they are aware of the potential consequences of doing so. Many local areas have a reduced availability of and long waiting lists for drug and alcohol services (due to significant public health funding cuts, for which offenders should not be penalised), especially for people with co-occurring mental health conditions or disorders. Unless these social realities are recognised, sentencing decisions are bound to have unintended unfair consequences on vulnerable and disadvantaged individuals.

Question 7: Please tell us your views on the contents of section three - do you agree with the guidance in this section? If not, please tell us why.

Again we welcome the fact that the importance of taking an individualistic approach to sentencing is noted, as is the need for sentencers to consider the impact of a particular sentence on an offender. These are critical points, but it may be that there are additional points that may assist sentencers in actually making decisions, beyond the need to consider each situation on a case by case basis.

First, in helping sentencers to decide on an appropriate level of seriousness, when considering the type of offence and circumstances of the specific case, there should be a

[2] NHS England (2017) Transforming Care: Model Service Specifications. Leeds: NHS England

reminder of the importance of taking into account the impact of the mental health of an individual. For instance, there may be certain offences or circumstances where a particular vulnerability is more relevant than others. So, for example, if someone has a diagnosis of bipolar, and there is evidence they were in a manic phrase at the time of an offence – if the offence itself was an unplanned, acquisitive crime, then it might be more closely linked to the condition and therefore result in a lower level of seriousness.

Second, in helping sentencers decide on an appropriate form of disposal once the level of seriousness is determined, there should be a reminder to get input from experts on not just what requirements might be suitable but also what support is most appropriate to assist the offender in addressing needs.

The second bullet point under paragraph 13 should be amended as follows: "Custody can exacerbate poor mental health and the impact of other conditions and disorders …."

In the third bullet point under paragraph 13, it should be noted that reasonable adjustments should be made to sentencing disposals to ensure they are compliant with equalities legislation. It would be discriminatory in law for an individual to receive a more serious sentence as a result of a failure to make reasonable adjustments to disposals and this should be made clear in the guideline.

Question 8: Do you think the list of different disposals and Crown Court guidance is helpful? If not, please tell us why.

Section 4 sets out the different disposals available to different jurisdiction but does not set out all the options available to magistrates court for this cohort. We would suggest that Alcohol Treatment Requirements, Drug Rehabilitation Requirements and Rehabilitation Activity Requirements should be included, with explanations of why they may be useful and a reminder that flexible sentencing could use more than one requirement to deal with dual diagnosis or complex needs.

We note that most of the disposals mentioned focus on the Crown Court, and are rarely used by magistrates. We suggest that it would be helpful to have more detailed information in this section for magistrates

It might be helpful if there was specific mention of the CSTR protocol, and how different court orders may be needed.

Reasonable adjustments should be made to disposals in line with equalities legislation. Therefore, we recommend amending this section to make clear that the offer of a community order without reasonable adjustments, where necessary, is not an option. All community sentencing options available to magistrates should set out with reference to specific questions that should be asked for vulnerable people. For example, if giving an exclusion order for someone with a learning disability, it is important to make the order very clear, and easy to understand.

Question 9: What are your views on the information on common mental disorders? Do you think it is helpful? Is there information missing that you would like to see included?

Although Annex A provides very detailed information in relation to some conditions, and clearly references the dangers of relying on diagnoses, which may be limited in nature, which is helpful, we do have some concerns:

- Under delusional disorders, there is reference to the fact that vexatious litigants sometimes have a delusional disorder without providing context;
- Under non-psychotic illnesses, there is reference to 'simple' depression which may be seen as minimising the condition, even though the intention is to infer something different;
- The information relating to PTSD may be misleading: for example, the reference to the fact that the condition must emerge within 6 months of this event does not seem to reflect current understandings of the condition. See https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml
- In relation to a diagnosis of personality disorder, it states "there must be evidence of continuity with problems such as conduct disorder throughout childhood and adolescence" for there to be a diagnosis of personality disorder which could be misleading.
- Reference to 'sufferers' is made multiple times, which may be seen as an assumption that a person with a disability or disorder is experiencing discomfort, pain or hopelessness, and does not seem to reflect current language guidelines on writing about disability https://www.gov.uk/government/publications/inclusive-communication/inclusive-language-words-to-use-and-avoid-when-writing-about-disability
- We note that it would be beneficial for those with patient user experience to be involved in contributing to or reviewing the definitions. We also note that as definitions are constantly changing, it may be helpful putting reference to the Equal Treatment Bench Book to check the most up to date use of language, as this is frequently updated.
- We reiterate the point we made earlier that the definitions should mirror those used by the Crown Prosecution Service, for reasons of consistency. We also reiterate that there should be reminders of fluctuating conditions and dual diagnosis in the Annex.

Acquired brain injury

- In relation to acquired brain injury, we endorse and support the Headway submission to the consultation. The definition of acquired brain injuries included in Annex A is very brief in comparison to other definitions. Acquired brain injury is a complex condition which can have a variety of different impacts on an individual's cognitive abilities, personality and behaviour, depending on the position, extent and severity of the injury. This can have important implications for culpability and appropriate sentencing and requires a much fuller explanation than is currently provided in the draft guideline. Furthermore, as we highlight below, there is compelling evidence of a very high prevalence rate of traumatic brain injury (TBI) in offenders in custody relative to the general population.
- We recommend that the Sentencing Council consults closely with expert individuals and organisations including Professor Huw Williams at Exeter University, Headway and the Disabilities Trust in order to ensure that the potential impact of brain injury on offending behaviour is adequately reflected in the guideline. Furthermore, as part of comprehensive health assessments, there should be standardised screening of people for brain injury when they come into contact with criminal justice process, particularly pre-sentence and in custody. There should be increased awareness for criminal justice professionals about the prevalence of brain injury among offender populations, and an understanding of the need for assessment and management within the justice system, in both community (e.g. Youth Offending and Probation

Teams) and custodial settings – and vitally within the Police. For sentencers, there should be reference to brain injury history in pre-sentence reports, which should be considered as a factor in decision-making in the same way that maturity and mental health are considered.

Evidence for the prevalence of brain injury and its impact on offending behaviour

- About 8 in 100 people have had a Mild TBI, and 2 in 100 a moderate to severe TBI. Studies of TBIs amongst offenders in custody show a much high prevalence. A study of young people in a Young Offender Institution in England found that 60% reported some kind of 'head injury', with 46% of the sample reporting loss of consciousness.[3] These findings are consistent with other studies undertaken in Europe[4] and the United States.[5] Often their injuries are due to falls, violence and motor vehicle accidents.
- There is growing evidence of the links between an TBI and subsequent offending. Research has also shown that there are certain factors that make brain injury and offending more likely, such as social deprivation, risk-taking behaviour and addictions.[67] Studies have shown that the risk of offending is much higher in people after TBI compared to society as a whole. A Swedish study found that 8.8% of people with a TBI later committed a violent crime, compared with 3% of the general population.[8] Siblings of the offenders were also at higher risk compared to general population, but not as high as those with TBI. Which means TBI increases risk of crime in those with or without pre-existing conditions (family, genetics) that may be associated with crime. Young offenders with a history of TBI were 2.37 times more likely to commit a serious violent crime. This further increased if the young person had lost consciousness.
- Injury in childhood and young adulthood may be particularly associated with offending behaviour, and a drift "from classroom to courtroom". Behavioural problems due to TBI are present in nearly 60% of children and young people with moderate to severe TBI, and around 20% of those with mild injuries.[9] These may be associated with school exclusion. With a New Zealand study showing that even a Mild TBI at age 5 was linked to nearly doubling the risk of school exclusion later on, and then to criminal behaviour.[10] Offenders who acquired a head injury younger than age 12 were found to have committed crimes significantly earlier than those who acquired a head injury later in their lives. TBI in adult offenders seems to be associated with

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[3] Williams, W.H., et al., Traumatic brain injury in a prison population: Prevalence and risk for re-offending. Brain Injury, 2010. 24(10): p. 1184-1188.
[4] Timonen, M., et al., The association of preceding traumatic brain injury with mental disorders, alcoholism and criminality: the Northern Finland 1966 Birth Cohort Study. Psychiatry Research, 2002. 113(3): p. 217-226
[5] Blake, P.Y., J.H. Pincus, and C. Buckner, Neurologic abnormalities in murderers. Neurology, 1995. 45(9): p. 1641-1647
[6] Williams, W.H. and J.J. Evans, Brain injury and emotion: An overview to a special issue on biopsychosocial approaches in neurorehabilitation. Neuropsychological Rehabilitation, 2003. 13(1-2): p. 1-11.
[7] Walker, R., et al., Head Injury Among Drug Abusers: An Indicator of Co-Occurring Problems. Journal of Psychoactive Drugs, 2003. 35(3): p. 343-353.
[8] Fazel, S., et al., Risk of Violent Crime in Individuals with Epilepsy and Traumatic Brain Injury: A 35-Year Swedish Population Study. PLoS Med, 2011. 8(12): p. e1001150.
[9] W Huw Williams, Prathiba Chitsabesan, Seena Fazel, Tom McMillan, Nathan Hughes, Michael Parsonage, James Tonks. Traumatic brain injury: a potential cause of violent crime? The Lancet Psychiatry, 2018; DOI: 10.1016/S2215-0366(18)30062-2
[10] McKinlay A, Corrigan J, Horwood LJ, Fergusson DM. Substance abuse and criminal activities following traumatic brain injury in childhood, adolescence, and early adulthood. J Head Trauma Rehabil 2014; 29: 498–506.

younger age of first imprisonment.[11] There is a trend for TBI to be linked with greater violence, and persistence of offending from adolescence to adulthood.[12]

- People with an TBI are at risk of greater mental health problems and adults who were younger when the acquired their head injury had higher rates of depression or mood disorder and /or childhood developmental disorders including secondary Attention Deficit Hyperactivity Disorder (ADHD) or disruptive behaviour difficulties. Research in Finland found that a brain injury acquired during childhood or adolescence was associated with a fourfold increased risk of developing later mental health problems in adult male offenders.[13]
- TBI increases the risk of offending in women. Studies suggest that the prevalence of TBI may be as high, and even higher, in female prisoners than in males. Many having suffered domestic violence.[14] An analysis of women offenders found that 42% who had committed violent offences had suffered an average of two TBIs. Further analysis revealed that three factors were significantly associated with current violent convictions: the number of years since their last episode of receiving domestic violence, the number of prior suicide attempts, and traumatic brain injuries with loss of consciousness.[15]

Question 10: What are your views on the information on reports within Annex B? Is it helpful? Is there information missing that you would like to see included?

We reiterate our earlier point that the opportunity for a liaison and diversion assessment could be emphasised here. This assessment would highlight any previous diagnoses, and liaison and diversion would also be able to give an oral update on court day.

Question 11: What are your views on the information on disposals within Annex C? Is it helpful? Is there information missing that you would like to see included?

In relation to MHTRs, there is helpful reference to remind the court that they may wish to consider ordering a Drug Rehabilitation Requirement and/or an Alcohol Treatment Requirement in addition to a MHTR. However, it also states that a MHTR is not suitable for those with chaotic lifestyles. We believe this reference is unhelpful and should be removed.

We suggest that it may be useful to also include the CSTR protocol, to highlight where sentencers can look for appropriate sentencing disposals, and highlighting the aim of flexible and appropriate use of orders. We note that it might also be beneficial to include tables for Drug Rehabilitation Requirements and other sentencing disposals in the Annex.

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[11] Perron, B.E. and M.O. Howard, Prevalence and correlates of traumatic brain injury among delinquent youths. Criminal Behaviour and Mental Health, 2008. 18(4): p. 243-255.
[12] W Huw Williams, Prathiba Chitsabesan, Seena Fazel, Tom McMillan, Nathan Hughes, Michael Parsonage, James Tonks. Traumatic brain injury: a potential cause of violent crime? The Lancet Psychiatry, 2018; DOI: 10.1016/S2215-0366(18)30062-2
[13] Timonen, M., et al., The association of preceding traumatic brain injury with mental disorders, alcoholism and criminality: the Northern Finland 1966 Birth Cohort Study. Psychiatry Research, 2002. 113(3): p. 217-226.
[14] W Huw Williams, Prathiba Chitsabesan, Seena Fazel, Tom McMillan, Nathan Hughes, Michael Parsonage, James Tonks. Traumatic brain injury: a potential cause of violent crime? The Lancet Psychiatry, 2018; DOI: 10.1016/S2215-0366(18)30062-2
[15] Brewer-Smyth, K., A.W. Burgess, and J. Shults, Physical and sexual abuse, salivary cortisol, and neurologic correlates of violent criminal behavior in female prison inmates. Biological Psychiatry, 2004. 55(1): p. 21-31.

We emphasise that a previous lack of compliance, which is not the same as breach, should not prevent an offender from having the opportunity to be given support via a Treatment Requirement in the community. It is important that previous engagement with treatment that has not been successful does not exclude a person from being offered the opportunity again. There are many reasons that may affect a person's engagement and response to mental health treatment, including stigma, the quality of the service provided, the age and maturity of the person, and other factors that may impact a person's condition. For example, a recent report by the Prison Reform Trust found that the distance a person had to travel to access services, the number of buses involved, cost of public transport, and whether childcare was available directly affected their ability to engage with services.[16]

We note that it may also be worth including a section on cultural differences, to raise awareness of disparities in presentation and diagnosis between different groups. It may also be helpful to include a reference to disproportionality and the Lammy Review, as a reminder for sentencers that there is disproportionality for some groups in relation to the diagnoses they receive.

Question 12: Are there any other equality and diversity issues that you think should be addressed?

There are issues relating to diversity that could be referenced in the guideline, especially in relation to any disparity in relation to diagnosis of people from minority ethnic communities that sentencers should be aware of. Where appropriate, links and reference to the Equal Treatment Benchbook should be made prominently throughout the guidance.

Question 13: Do you think the length of the guideline is about right or not? Is there information missing that you would like to see included?

The guideline (along with the Annexes) provides useful information, although we are concerned there is insufficient reference to low level mental health conditions or disorders that may not be diagnosed, but could still affect offending behaviour. We note that it may be worth adding some additional information to the guidelines about these conditions and vulnerabilities.

Question 14: Do you have any further comments on the draft guideline not covered elsewhere?

It is unclear when sentencers should refer to this guideline. The danger is that it will only be used when sentencers are informed that the offender has a diagnosis. However, the absence of such information cannot be taken as proof that the offender does not have a mental health condition or disorder. The roll out of liaison and diversion services means that sentencers can request an assessment if they are in any doubt concerning the mental health of an offender and/or the possibility that they might have a mental disorder – and this should be made clear in the guidelines. An assessment confirming the presence or absence of a mental health condition or disorder will inform sentencing decisions and greater confidence in health and justice outcomes.

Although outside the remit of the Sentencing Council, the aim of producing this draft guideline is to improve consistency in sentencing practice, but it is likely that without

[16] Hammond, T., Talbot, J. et al (2019) Out of the Shadows: Women with learning disabilities in contact with or on the edges of the criminal justice system, London: Prison Reform Trust

ensuring availability of CSTRs in every area, sentencers will not have appropriate options to sentence to. If a disposal is available to sentencers as a matter of law, then sentencers should be able to sentence to it. Data should be collected on the availability of statutory disposals at a local level to find out where provision is lacking.

Question 15: What, if any, do you think the impact of the guideline might be on sentencing practice?

We recognise that the guideline explains how different vulnerabilities can affect culpability and the appropriateness of sentences. However, we would welcome the addition of practical guidance to indicate the impact that particular conditions may have on moving between different ranges for each offence category and on the appropriateness of a particular sentence, such as is provided by the Sentencing Council domestic abuse sentencing guidelines. We do recognise however that the individualistic nature of these decisions may make this difficult.

We note that while the guidelines provide detailed information about how particular conditions may impact culpability, we would welcome more information about how these vulnerabilities may also affect mitigation.

We note that it may be useful to collect data on what sentences magistrates would have chosen if they were available, similar to the 'pink slips' system.[17]

[17] As part of the Community Sentence Treatment Requirement (CSTR) pilots, magistrates were asked to fill out 'pink slips' for each case where they ordered a CSTR, indicating what sentence they would have given if a CSTR had not been available.