Sentencing and Mental Health: the role of psychiatric evidence

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Outline

- Judges face a difficult choice between sentences with a penal element and wholly therapeutic sentences.
- Leading cases and sentencing guideline focus on culpability, treatability, and risk.
- Remit of psychiatrists under MHA 1983 often extended in court.
- Should psychiatrists go beyond their expertise?
- What if their evidence is used in support of outcomes that conflict with medical ethics?

Context

- Prisoner mental health is worsening: Record-breaking rates of self-inflicted death (in 2016) of assaults and self-harm incidents (in 2019) (Ministry of Justice, 2018; 2020).
- 2012 – 2014: 70% of prisoners who died by self-inflicted means had been identified as having mental health needs at the time of their death (PPO 2016).
- Contributing factors to self-inflicted deaths: shortage of community treatment options and secure mental health beds (House of Commons Justice Committee 2021).

Sentencing options

For offenders suffering from mental disorder (MHA 1983, s.1(1)) convicted in the Crown Court:

- Hospital order (with or without restrictions): ss.37 / 41 MHA 1983
- Hospital and limitation direction (s.45A) + prison sentence (determinate or indeterminate) = a hybrid order.
- Prison sentence alone (Justice Secretary can transfer under s.47)
- Community sentence + mental health treatment requirement

Trends in sentencing

- 1986 - 2016, rate of hospital orders (ss.37/41): ⇩ 49%.
- Rate of transfers from prison to hospital: ⇧ 710% (Keown *et al.* 2019).
- 40% of offenders serving community sentences have a diagnosable mental health condition (Judicial College 2021).
- In 2019, MHTRs accounted for just 0.4% of requirements under suspended or community sentences (Ministry of Justice 2020).

➔ Therapeutic sentencing options are underused.

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Role of the psychiatrist

Hospital orders and hybrid orders require evidence from two registered medical practitioners that the offender:

> is suffering from **mental disorder** [...] of a **nature** or **degree** which **makes it appropriate** for him to **be detained in a hospital for medical treatment** and **appropriate medical treatment is available** for him' (MHA 1983, s.37(2) and s.45A(2)).

- Restrictions can be applied by the court under s.41 if necessary to protect the public from serious harm.
- A hybrid order includes a restriction order.

Differences in effect

- **Hospital orders**: the Tribunal must discharge the patient if the detention criteria are no longer met – even if it believes that the person poses a risk to the public (MHA 1983, s.72(1)(b)). Discharge can be absolute or conditional.
- **Hybrid orders**: The Tribunal cannot discharge a patient subject to a prison sentence – it can only inform the Justice Secretary, who may decide to discharge the patient, or return them to prison.
- Prisoners serving indeterminate sentences ➔ **Parole Board.**
- **Conditional discharge**: Conditions set by Tribunal and/or Justice Secretary. Recall to hospital only if detention criteria are met.
- **Licence requirements**: Set by Parole Board. Recall to prison initiated by Probation on risk grounds.

Sentencing guidance / guidelines

- In *R. v. Vowles* [2015] and *R. v. Edwards* [2018], the Court of Appeal emphasized culpability, treatability, and risk.
- 'Sound reasons' are needed to depart from the 'usual course' of a prison sentence.

➔Low/no culpability + treatment likely to reduce risk: ss.37/41

➔Higher culpability + unclear if treatment will reduce risk: s.45A

- Similar approach taken by the Sentencing Council's (2020) Guideline *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments*.
- Some attention paid to impact of sentence, but less regard given to offender welfare or therapeutic interests.

Psychiatric evidence

- Psychiatrists are often asked to comment on culpability, treatability, risk, release provisions, recall powers, and powers to monitor offenders in the community.

  "*it is the duty of the sentencer to make their own decision, and the court is not bound to follow expert opinion if there are* ***compelling reasons*** *to set it aside*." (2020 Sentencing Guideline)

➔Courts will not always follow psychiatric experts' recommendations

➔Psychiatric evidence may be used to support an outcome that the expert disagrees with.

Psychiatric evidence in the case law

- *R. v. Lundy* [2021]: Both psychiatrists recommended ss.37/41. Evidence of high risk was taken by judge to support a life sentence + s.45A. Evidence Lundy could be recalled to prison was dismissed by Court of Appeal.
- *R. v. Reynolds* [2021]: All psychiatrists recommended ss.37/41. Court of Appeal held punishment necessary, and that Reynolds was likely to spend whole sentence in hospital under s.45A.
- R. v. Lall [2021]: Two psychiatrists gave detailed evidence that ss.37/41 regime would be best for managing Lall's condition and that prison posed a risk to his mental health. Court accepted.
- *R. v. Miller* [2021]: All psychiatrists recommended ss.37/41. Court considered that Miller could be returned to prison if recalled from life licence and held that medical supervision and risk monitoring better under ss.37/41.

Ethical and legal problems

- Courts seem underinformed about effects of different sentencing options, and reliant on psychiatric experts.
- Psychiatric evidence can make a significant difference in practice, but at the risk of expert witnesses going beyond their expertise.
- Commenting on culpability poses an ethical dilemma.
- Concept of 'treatability' used by courts more stringent than 'appropriate medical treatment' in legislation.
- Psychiatric evidence may be used to support a hybrid order – RCPsych recommended abolition in 2018.

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