Sentencing Council consultation on Sentencing Offenders with Mental Health Conditions or Disorders Guideline

JUSTICE consultation response

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Introduction

1. JUSTICE is an all-party law reform and human rights organisation working to strengthen the justice system – administrative, civil and criminal – in the United Kingdom. It is the UK section of the International Commission of Jurists.

2. In 2017 we published our *Mental Health and Fair Trial* Report, chaired by Sir David Latham.[1] In the Report we recommended that a sentencing guideline on mental health and vulnerability should be created. We considered that such a guideline would be immensely helpful to courts, prosecution and defence advocates, and other practitioners (such as probation and liaison and diversion), in determining the appropriate outcome for vulnerable defendants.

3. In submitting this response, JUSTICE reconvened members of the Working Party to consider the draft Guideline.

4. JUSTICE welcomes the Sentencing Council Guideline, which is a direct response to our recommendation. We believe the Guideline will be useful in ensuring that sufficient regard is paid to mental health disorders at the sentencing stage and in providing a structured approach to sentence in these cases. Overall, we are impressed with the Guideline's contents; in our view, the document is thorough and well-considered. We nevertheless have some observations that we hope will improve the Guideline, in response to question 1 and questions 3-15 in the consultation, as outlined below.

Question 1: Do you agree with the proposal that the draft guideline only applies to offenders aged over 18?

5. We agree that the Guideline should only apply to defendants aged over 18.

6. However, we suggest that the Youth Sentencing Guideline should be amended and fully updated.[2] In its current form, that Guideline simply alerts judges to the possibility that a

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[1] Available online at https://2bquk8cdew6192tsu41lay8t-wpengine.netdna-ssl.com/wp-content/uploads/2017/11/JUSTICE-Mental-Health-and-Fair-Trial-Report-2.pdf.

[2] The Sentencing Council, Sentencing Children and Young People: Definitive guideline, (1 June 2017), available at https://www.sentencingcouncil.org.uk/wp-content/uploads/Sentencing-Children-and-Young-People-definitive-guideline-Web.pdf.

child or young person may have a mental health problem or learning difficulty, without advising on how the court should deal with such cases. We therefore propose that the Youth Guideline refers sentencers to the Guideline on Sentencing Offenders with Mental Health Conditions or Disorders, where they can access information on particular conditions and disorders as well as information on the mental health sentencing disposals that are available for defendants depending on their age. This will assist sentencers in approaching cases involving young defendants who are mentally unwell.

7. The Youth Sentencing Guideline should also be amended and fully updated to include clear reference to the needs of children and young people who may have a mental health problem or a learning difficulty. We propose that this updated Youth Guideline should include more detailed information about the referral of young people who may have mental health conditions or developmental disorders to a psychiatrist to determine whether or not any such disorders are present.

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?

8. We consider that paragraphs one to six are very appropriate and provide useful, on point guidance for non-mental health professionals. However, in our view, certain aspects of these paragraphs require further attention.

9. In our Report we stated that "the appropriate sentence will depend upon the crime, but certain sentences can reflect the need to address the vulnerability that the individual may have."[3] We consider that this point should be reiterated for sentencers to consider in paragraph one of the Guideline.

10. We are impressed by the list of points in paragraph two, which remind sentencers that sentencing should be "individualistic" and "focused on the particular issues relevant in the case concerned".[4]

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[3] Page 92 of our report.

[4] Paragraph 2 of the proposed Guideline.

11. In our view the term 'developmental disorders'[5] is the correct term to use, as recommended in DSM-5 which has recently been updated both for neurodevelopmental disorders and for other psychiatric disorders.[6] Other concepts and terms such as 'wellness' are not included in the psychiatric classification systems, nor in the MHA 1983. We believe it is important that psychiatric terminology is evidence based, and that psychiatrists creating reports for the court can reference the texts from which they drew the terms they are using. For that reason, 'neurodevelopmental disorders' is the appropriate term for psychiatrists to use, since it takes into account the lifespan developmental nature of these disorders – such as ADHA and Autistic Spectrum Disorder (ASD). Any such psychiatric report should include references to DSM-5 and the MHA 1983 (as amended in 2007).

12. The Youth Sentencing Guideline has been adopted in recognition of the complexity of sentencing for children. As stated in our Report, some of the principles in that Guideline[7] should also be considered in relation to the approach to sentencing individuals with mental health difficulties.[8]

13. In particular, sentencers should consider:
    i. The welfare of the individual and which disposal will best support them and/or exacerbate any underlying issues;
    ii. The ability of the individual to fully appreciate their actions;
    iii. The seriousness of the offence;
    iv. The likelihood of further offences being committed; and
    v. The extent of harm likely to result from those further offences.

14. We recommend that the Guideline on Sentencing Offenders with Mental Health Conditions or Disorders set out certain similar principles which sentencers ought to take into account.

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[5] Paragraph 2 of the proposed Guideline.

[6] See 'DSM-5 Provides New Take on Neurodevelopment Disorders,' available online at https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2013.1b11.

[7] Pages 4-5 of the Sentencing Council, Sentencing Children and Young People: Definitive guideline, (1 June 2017), available at https://www.sentencingcouncil.org.uk/wp-content/uploads/Sentencing-Children-and-Young-People-definitive-guideline-Web.pdf.

[8] Page 92 of our report.

15. We are impressed with how the Guideline approaches co-morbidity – for example, the third point in paragraph two states that "it is not uncommon for people to have a number of different conditions, 'co-morbidity' and for drug and/or alcohol dependence to be a factor". The Guideline also addresses co-morbidity under the 'Multi-morbidity and comorbidity (dual diagnosis)' heading in Annex A.

16. The final point in paragraph two alludes to the fact that self-diagnosis or diagnosis from unqualified persons "will rarely be sufficient." However, we consider that it needs to be reiterated here that diagnosis is the role of suitably qualified medical professionals and that proper assessments can more accurately determine whether the person has the capacity to follow the process and whether they have any vulnerabilities that need to be addressed.[9] In our Report we expressed concern that police officers and legal professionals are not capable of assessing vulnerability, and we recommend that this point should be reiterated in paragraph two of the Guideline.

17. With regards to paragraph three, there needs to be an explicit warning about accepting information from 'probation, defence representatives, prison, police or court mental health teams, or family members', as a substitute for a medical report. While this may help to flag up a mental health concern, we do not consider such reports to be sufficiently comprehensive as to the nature of the person's condition. We have experience of receiving reports from court mental health teams that claim to have been prepared by mental health practitioners but which are wholly inadequate. We are particularly concerned about the use of 'apparent' mental health reports provided by third sector organisations.[10] Such a caution would alert sentencers to the fact that alternative information can be of varying quality.

18. Additionally, we are concerned that the statement in paragraph three (reminding sentencers that a report may be unnecessary if existing information can be used) might encourage magistrates not to order a report or allow an application for a report.

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[9] Pages 97-98 of our report.

[10] We are aware that certain third sector organisations employ graduates who do not operate under the umbrella of any clinical professional body.

19. We are impressed by the effort to signpost sentencers to practical guidance. In particular, where the Guideline refers to "Chapter Eight of the Equal Treatment Bench Book" we are pleased that a link to this document is provided.[11]

Question 4: Do you have any comments on paragraph seven? Do you think the information will be helpful to courts? Is there any further information relating to private treatment that you think should be added?

20. The Guideline states that "if the treatment proposed is not within an NHS hospital, courts should take particular care to confirm the proposed hospital/treatment centre has the appropriate level of security and specialist staff able to address the offending behaviour in addition to treating the mental health condition."[12] We believe that this standard should apply regardless of whether or not the hospital is independent. It should not necessarily be presumed that all NHS hospitals always have an appropriate level of security and specialist staff. We understand that there are detailed standards accepted by the Ministry of Justice that ensure equivalence for both independent and NHS care and security standards – at medium and low security.[13] Nonetheless, we are concerned that the statement may suggest that approved treatment programmes can always be guaranteed in NHS hospitals, which may not be the case.

21. Where paragraph seven refers to noncompliance with a mental health treatment requirement ("MHTR"), the document refers to the duty of the 'proposed treating psychiatrist' to report such a breach. Here, we would like to point out that the supervising professional can also be psychologist or another registered medical practitioner (such as a GP) who presumably has the same duty. The Guideline should be amended to clarify this.

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[11] Paragraph 6 of the proposed Guideline.

[12] Paragraph 7 of the proposed Guideline.

[13] Quality Network for Forensic Mental Health Services, Standards for Forensic Mental Health Services: Low and Medium Secure Care – Third Edition (May 2019), available at https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-standards-qnfmhs/standards-for-forensic-mental-health-services-fourth-edition.pdf?sfvrsn=2d2daabf_6.

Question 5: Do you think the guidance within paragraphs eight and nine is helpful? Is there any of the guidance that you disagree with?

22. JUSTICE considers that paragraphs eight and nine offer helpful guidance for non-mental health professionals.

23. However, we would query the use of the word 'responsibility' in paragraph eight, where the Guideline states "it is possible that it may affect their level of responsibility for an offence". In particular, we question why the word 'responsibility' has been used as opposed to 'culpability'. It is not clear whether this is an intentional use of a different term to make a distinction, in which case the Guideline should clarify the difference between the two words.

24. Additionally, we propose that the assessment of causation should explicitly involve three stages, addressing firstly (1) the condition or disorder *per se*; secondly (2) the condition or disorder in the defendant; and finally (3) the condition or disorder in the defendant in relation to the offence. This approach recognises that a given mental condition or disorder in an individual may, but not necessarily will, be relevant to judicial consideration of 'responsibility', and that certain conditions *per se* may, by their symptoms, at least raise the likelihood of its relevance.

25. Regarding paragraph nine, we recommend that the phrase "where experts suggest a diagnosis without a clear indication of how it affects culpability" be amended to read "where experts suggest a diagnosis without a clear indication of how it gives rise to medical factors relevant to culpability". There is a distinction between assessing 'medical factors relevant to culpability' and 'culpability *per* se'. We are concerned that psychiatrists should not opine on 'culpability' or 'responsibility' since these are not medical constructs. Rather, experts should only give clinical opinion on the role of any mental condition in the causation of the offence. This distinction needs to be made clearer in the Guideline.

26. Finally, we would like to point out that there is increasing evidence that the development of a young person's brain (aged 18 to 25) is relevant to the assessment of culpability and responsibility. We propose that this be recognised in the Guideline, with respect to the Youth Sentencing Guideline, as indicated above at paragraph 12.

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.

27. We consider that the 'list of questions' in paragraph 10 is relevant and helpful. Whilst we are impressed by this list, we are concerned about it effectively developing into a template – which may be potentially invalid in any individual case. This is especially considering that the questions are derived from certain Court of Appeal cases, which risks excluding some questions that may be relevant to the expert in particular future cases. The list can only be illustrative of potentially relevant questions in an individual case; certain questions may be irrelevant to culpability in a given case.[14]

28. We suggest that the 'questions' for judges to address regarding culpability should instead be 'example questions' – and make clear that the list is non-exhaustive and case specific. We propose that paragraph ten should begin with a general statement indicating "There will likely be questions relevant in an individual case to judicial consideration of culpability that can properly be put to a medical expert, but these may well vary with the case." This would helpfully emphasise that certain questions in particular types of cases may be irrelevant.

29. We consider that training is required to make proper use of the questions in paragraph ten, especially given that the sentencing exercise might be conducted without the benefit of a medical report. We are concerned that magistrates do not have sufficient knowledge to undertake the evaluative exercises that these questions entail, or to formulate other relevant questions based on these examples. It is not sufficient to say that sentencers are capable of assessing such issues without any specific additional training.

30. We further propose that this list should be preceded by a general statement on multiple causation.

Question 7: Please tell us your views on the contents of section three – do you agree with the guidance in this section?

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[14] For example, the question in point five regarding "premeditation or pre-planning" may in some cases be irrelevant when considering the culpability of a mentally ill perpetrator.

31. JUSTICE considers that the Guideline does not go far enough to require sentencers to consider a defendant's ongoing need for treatment as part of the sentencing exercise. The requirement for this to be considered ought to be set out in section three.

32. It would also be helpful if this section made clear that the proper approach regarding expert evidence on risk is through the application of an accepted and widely used risk assessment tool – for example, HCR-20 Version 3. The Guideline needs to stress that sentencing for a serious offence should not proceed on any lesser risk assessment.

Question 8: Do you think the list of different disposals and Crown Court guidance is helpful?

33. In terms of the different disposals, we stated in our Report that "we agree with the Law Commission that the range of disposals available where a defendant lacks capacity must be broadened, and largely available in magistrates' courts and the Crown Court."[15] Whilst we understand that this requires legislation and is out of the Sentencing Council's remit, we maintain that the current options for disposal are limited and need to be expanded.

34. Where section four refers to 'penal' and 'hospital' disposals by the court, the Guideline should also instruct the court to receive expert medical evidence relevant to whether (a) the safest eventual route to community rehabilitation will likely be by way of a health disposal,[16] because the causal link between the condition/disorder and risk of reoffending is high; or whether (b) the risk is more closely related to non-condition/disorder related factors, and risk minimisation will more likely be achieved via parole release and subsequent probation supervision. We believe it may assist to observe that, where there is a close causal connection between the condition/disorder and the offence, safest rehabilitation is often achieved via a health, not penal, disposal.

35. Additionally, the Guideline should caution that the court needs to exercise care when receiving evidence from experts arising from the different regimes. We understand that probation experts might be inexperienced in the hospital order system and, similarly, medical experts may lack experience in relation to the probation system.

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[15] Page 9 of our report.

[16] Whereby risk minimisation is achieved by way or specialist mental health care and community supervision.

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?

36. We are impressed by the efforts being made to simplify complex information so that it can be understood by non-mental health professionals. Overall, we consider that this section is helpful. We nevertheless propose a few amendments below.

37. In revising the Guideline, we consider that further attention should be given to the following sections:
    i. **Mental disorder:** Where the Guideline states "Broadly the concept of illness is used for disorders which start after a sustained period – often a lifetime – of health or average/normal psychological function e.g. schizophrenia, depression", we consider that this sentence should be deleted. The sentence does not add anything useful to the Guideline – it is arguable and risks being misinterpreted by readers. Within the MHA 1983 (as amended in 2007), the definition of mental disorder is described as meaning "any disorder or disability of the mind". The Act further states that "'mentally disordered' shall be construed accordingly."[17] This definition should be referenced and set out in the Guideline.
    ii. **Delirium:** We would like to point out that delirium is not a subtype of psychosis, rather it is a confusional state borne secondarily to often an acute, treatable physical condition such as an infection, poisoning or metabolic disturbance.[18] This section needs to be separated and made distinct from the section on 'psychotic illnesses'. Schizophrenia and Bipolar Affective Disorder offer examples of psychotic mental illnesses.
    iii. **Schizophrenia**: The Guideline states that "Hallucinations most commonly take the form of 'third person hallucinations' when the person hears others talking about them, but when no-one is doing so." We recommend that this sentence should be reviewed by a senior general psychiatrist. As an alternative, we propose the following wording: 'Hallucinations may be of any sensory type, and are commonly

[17] Mental Health Act 1983 (as amended in 2007) s 1, available online at http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf.

[18] See https://www.rcpsych.ac.uk/mental-health/problems-disorders/delirium.

auditory and visual in nature. Other examples include tactile hallucinations.'[19] In our view, this wording will be more informative for readers.

iv. **Substance misuse**: Where the Guideline states that "Substance misuse per se is widespread – although evidence on safe drinking limits is not finite", we suggest that this should be split into two sentences, the first being 'Substance misuse is widespread'. We believe the second part ("although evidence on safe drinking limits is not finite") requires clarification. It is not clear what the intended meaning and aim of this sentence is, and we therefore recommend this section be reviewed and amended. It is important to note that current practice with adults and young people who have dependency or addiction problems will usually link drug and alcohol problems since they are very commonly found together. The need for services for these individuals who are co-dependant on drugs and alcohol has been borne out by the positive experience of the Family, Drugs and Alcohol Courts (FDAC),[20] which is a recognised model of good cross-disciplinary practice with adults, children and whole families.

v. **Personality disorders**: The Guideline states that "Risk of harm to self is very high among people with personality disorder". We consider that this ought to be replaced by the following sentence: 'Risk of harm to self is very high among people with certain personality disorders, particularly the emotionally unstable type.' This type of personality disorder is often known as Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorder (EUPD).

vi. **The dementias:** Current research suggests that dementia falls into a number of different categories, many of which relate to the aging process, some to lifestyle and the origins of others are not known but may have a genetic component.[21] The most common causes of dementia may include degenerative neurological diseases – such as Alzheimer's disease, Parkinson's disease, Huntington's disease, Arteriosclerotic disease and some types of multiple sclerosis – traumatic brain injuries (TBI), central nervous system infections including meningitis, HIV and other diseases, long-time alcohol or drug use, and certain types of hydrocephalus.[22] Given the complexities of the origins of dementia it would be

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[19] See M. Gelder, P. Harrison and P. Cowen, 'Shorter Oxford Textbook of Psychiatry' (OUP Oxford, 5th Ed, 2006).

[20] See Family Drug and Alcohol Court (FDAC), available online at https://www.coram.org.uk/supporting-parents/family-drug-and-alcohol-court.

[21] P Whitehouse, 'Classification of the dementias' [2003] 361 Lancet, 1227, available online at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)12937-6/fulltext.

[22] What is Dementia, available online at https://www.webmd.com/alzheimers/types-dementia#1-2.

necessary for doctors to assess and treat the underlying causes of that particular type of dementia.

vii. **Acquired brain injury, often known as Traumatic Brain Injury (TBI):** Similarly, the Guideline lacks clarity where it states "The effects may vary widely, but the more severe the brain injury, the more likely long term effects are likely to be." We presume that this means 'the more severe the brain injury, the more likely it is that there will be long term effects.' However, this section should be amended to make this clear.

viii. **Learning difficulty:** This section appears too far down in Annex A – in our view it needs to be placed higher up, so that it is nearer to the 'Developmental disorders' in order to make the links between the two clearer – i.e. the fact that learning difficulties are all developmental disorders.

38. We also suggest that the Guideline makes reference to the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) and the World Health Organisation International Statistical Classification of Diseases and Related Health Problems (ICD-11),[23] as both are internationally accepted sources of a complete list of conditions and disorders. We understand that it is agreed good practice for courts to be referred to either source in criminal cases and links to the two should be provided.

39. As a more general remark, we consider that the layout of Annex A is not clear. We believe that the inclusion of better headings and signposting would help to make the document more user friendly for sentencers.

40. We believe that the section on 'Multi-morbidity and comorbidity (dual diagnosis)' is particularly helpful and provides very appropriate information. We are pleased that this section features in the Guideline.

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?

41. We consider that it is helpful to include examples of information that might be requested from a report writer; this is pertinent to adding nuance to the condition, and the impact of the condition upon the defendant to be sentenced. We also appreciate the difficulty in

[23] World Health Organisation International Statistical Classification of Diseases and Related Health Problems (ICD-11), available online at https://www.who.int/classifications/icd/en/.

compiling a comprehensive list of factors indicating which expert medical information may be relevant across a wide range of cases and which should therefore be requested by a sentencing judge. We note that the proposed list includes some, but not all, aspects that should appear in many expert medical reports directed at sentencing. To this end, the list of factors provided in Annex B is limited to being only illustrative of potentially relevant information in a given case.

42. We propose that sentencers should be aware of standard forensic psychiatric texts that describe high quality psychiatric reports, including reports directed at sentencing.[24] This would assist in determining the suitability of a particular report in respect of a particular case. We believe that simply providing a list of factors may potentially be unhelpful, or even misleading, when applied to a particular case.

43. We welcome the reference to the "Criminal Procedure Rules (part 28.8 Sentencing Procedures in Special Cases)" and "the Criminal Practice Directions (I General Matters 3P Commissioning Medical Reports and VII Medical Reports for Sentencing Purposes R)", which provide guidance on what a report should look like, and we are pleased that direct links to both documents have been provided.

44. Regarding point five in the list, we believe that the use of the term "dangerousness" needs to be clarified – it is not clear whether this term is to be understood in the context of the CJA 2003, in which case this needs to be explicitly stated. We further recommend clarification on the difference between the 'dangerous assessment' and 'risk assessment'. We note that in the 'Directions for commissioning medical report for sentencing purposes, CrimPR 28.8' form, these issues are dealt with in one combined factor, namely "the degree of risk or danger to the defendant or others posed by the defendant's mental disorder."[25]

45. As a separate observation, we note that the list in Annex B differs to that contained in the Criminal Procedure Rules form under part 28.8.[26] We consider that the two lists ought to

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[24] One example is *K. Rix*, Expert Psychiatric Evidence? (RCPsych Publications, 2011).

[25] Page 3 of the form.

[26] See https://www.justice.gov.uk/courts/procedure-rules/criminal/forms#Anchor5. In particular, we refer to the list under the heading "Particular matters on which expert opinion is sought", found at page 3 of the 'Directions for commissioning medical report for sentencing purposes, CrimPR 28.8' form.

align, and we recommend that the Sentencing Council reviews the identified issues with the Procedure Rule Committee.

46. We are concerned about imposing sentences in the absence of access to a report adhering to current expected standards of risk assessment. For this reason, we recommend that the Guideline indicates that, when sentencing for any serious offence, the expert evidence should necessarily include a reliable and valid risk assessment, based upon a widely used and accepted risk assessment tool.[27] Such a requirement will ensure there is consideration of a range of both individual and contextual risk factors. Proper clinical risk assessment addresses factors intrinsic to the offender; contextual factors that might arise; and interaction between the two; as well as addressing the extent to which the individual and interactive aspects may be subject to amelioration. In our view, including 'formulation', or narrative, of the offender's disorder and their offence propensity alongside the risk assessment is to be preferred over presenting a list of judicial questions.

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?

47. We consider the information set out in Annex C is coherent and particularly useful for sentencers.

48. We support the reminder that "Use of MHTRs attached to court orders for those offenders with identified mental health issues may result in reductions in reoffending, compared to the use of short term custodial sentences."[28]

49. In our report we recommended that "clinical commissioning groups (CCGs) must accept responsibility for treatment of offenders with vulnerabilities in the community."[29] We note that at present, CCGs are reluctant to accept responsibility for people leaving police custody or prison, or who are diverted from the criminal justice system. We maintain that such groups have a vital role in the provision of mental health services in the community, and we propose that there needs to be more liaising with these – and equivalent – services.

[27] We note that HCR-20 Version 3 is most commonly used.

[28] Annex C of the draft Guideline, under the 'Mental Health Treatment Requirement (section 207 CJA 2003)' heading.

[29] Page 93 of our report.

The Guideline should provide information on these services and the practical realities of accessing them.

50. Our Report indicated that “a community order may be appropriate where the defendant’s culpability is substantially mitigated by his mental state at the time of the commission of the offence, and where the public interest is served by ensuring he continues to receive treatment for his mental disorder.”[30] We recommend the inclusion of a similar statement in Annex C under the ‘Mental Health Treatment Requirement (section 207 CJA 2003)’ table.

51. Additionally, in our Report we emphasised that “the conditions of any community order must be achievable, fully comprehended by the individual and supported”.[31] We consider this to be an important recommendation; to ensure engagement with community orders it is imperative that the offender consents to and has expressed a willingness to comply with the conditions. We therefore urge the Sentencing Council to consider our proposal.

52. We further recommended that “judges should be able to keep sentences under review to ensure that the person is both receiving appropriate assistance and treatment and engaging in the programme.”[32] We consider that the court needs to continue to have oversight of how an order is progressing to ensure that offenders receive the necessary help and treatment and are benefiting from the programme. Additionally, we believe this will enable courts “to understand how treatment requirements and other elements of community orders can work effectively to prevent further offending and direct vulnerable people into treatment.”[33] Whilst this requires a different model to how cases are disposed of at present, and is not necessarily a model which the Sentencing Council can provide, we believe that further, detailed consideration should be given to this proposition.

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

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[30] Page 92 of our report.

[31] Page 103 of our report.

[32] Page 103 of our report.

[33] Page 95 of our report.

53. As stated in paragraph 19 above, JUSTICE is delighted that the Guideline directs sentencers towards and provides a link to "Chapter Eight of the Equal Treatment Bench Book".[34]

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?

54. We consider the Guideline is an appropriate length.

55. However, we note that there is no reference to liaison and diversion ("L&D") services in the Guideline, especially since these services aim to prevent the risk of re-offending and improve the effectiveness of orders, for example by including support for people to attend their appointments.[35] As such, there is a lack of practical guidance for sentencers on how they could benefit from L&D services. As recommended in our report, "L&D practitioners have a key role in preparing recommendations for the court on appropriate sentences and what treatment provision is realistic and available in the person's local area." [36] We strongly feel that the guideline should be amended to include reference to L&D.

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

56. In our Report, we recommend that decisions on disposal and sentence of vulnerable people should be reserved to a dedicated judge, or at a minimum to judges that have undertaken appropriate mental health training.[37] Unfortunately, the Guideline does not allude to a dedicated judge conducting the sentencing exercise nor does it indicate any expectation that mental health awareness training should have been undertaken by sentencers. Whilst we appreciate that currently such a course or module is not available (and therefore the Guideline cannot require judges to undertake training), we stress that it will be crucial to ensure that there is appropriate training in the future to support the delivery of the Guideline's contents.

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[34] Paragraph 6 of the proposed Guideline.

[35] See NHS England, 'Liaison and Diversion', https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/.

[36] Page 103 of our report.

[37] Page 91 of our report.

57. The Guideline does not address how sentencers should approach an individual who was sectioned immediately or shortly after committing an offence, and who now appears for sentence when they are in better mental health. We understand that this occurs regularly, and we recommend that the Guideline alerts sentencers to the exacerbated impact of delaying sentence and makes provision for this.

58. The Guideline further lacks consideration of the relevance of any hospital admission under the MHA 1983 or as an informal patient. There is no reference to credit for time spent on remand (detained in a psychiatric unit or hospital) after the offence has taken place but before a charging decision has been made. We consider that this should be set out as a significant mitigating feature, for which a reduction in sentence – to reflect the time spent not at liberty – may be suitable.

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

59. In our report we expressed concern about lack of appropriate guidance for judges and magistrates who are sentencing individuals with mental health conditions or disorders. We consider that the creation of a sentencing guideline on mental health and vulnerability will go some way to help sentencers – both judges and magistrates – determine the appropriate outcome for vulnerable defendants.

60. We hope the Guideline will increase awareness among actors in the criminal justice system ("CJS") about mental health concerns and their impact on defendants. We are hopeful that it will ultimately lead to more nuanced sentencing and to integration of the approach taken by the CJS and its partners – for example, health carers.

61. Finally, we are alert to the fact that time pressures and a lack of funding and resources in the CJS currently have a negative impact on sentencing and can make it difficult to obtain the right pre-sentence reports in a timely manner. Whilst we believe that the Guideline will assist in ensuring careful consideration is given to the impact of mental health on offending, in our view its effectiveness will be limited by the numerous pressures on the system and the ability to acquire the relevant medical information on time.

62. We are happy to discuss our concerns and recommendations with the Sentencing Council.

JUSTICE

9 July 2019