Criminal Law

Sentencing mentally disordered offenders: new hybrid orders

by Estella Baker

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The *Crime (Sentences) Act* 1997 ('CSA 1997') is regarded by many as one of the most contentious pieces of criminal justice legislation ever to reach the statute book. Its provisions were subject to widespread criticism from the point when former Home Secretary, Michael Howard, heralded its 'two strike' automatic life sentences, 'three strike' mandatory minimum sentences and restrictive early release scheme in his 1995 Party Conference speech, through to the Bill being rushed through its final parliamentary stages prior to the general election. Moreover much of the most potent criticism emanated from the senior judiciary. Overshadowed by the almost exclusive concentration on these widely publicised measures, the Act has also introduced a new hybrid sentence for mentally disordered offenders. Despite the comparative lack of attention that this development has attracted, it has the potential to be as revolutionary in its impact as those measures that have fuelled the controversial reputation of the legislation.

Certain provisions of the Act were brought into force by statutory instrument on 1 October 1997. As these included the new hybrid order it is particularly important that its existence is brought out of its present obscurity and that the ramifications of its introduction receive wider recognition and discussion. The purpose of this paper is to assist in this process. It will begin by explaining the changes introduced by the legislation, taking a critical look at its provisions; it will then briefly consider the circumstances behind their introduction and will conclude by addressing the present and future implications of the new orders for the development of policy towards mentally disordered offenders.

THE NEW HYBRID ORDER

Section 46 of the CSA 1997 introduces the new orders. Although executed through the insertion of two fresh sections into the *Mental Health Act* 1983 ('MHA 1983'), for clarity of explanation they will be referred to throughout the body of this article as orders under the 1997 Act. The novel departure that they represent arises from their deliberate combination of therapeutic and punitive characteristics which creates a hybrid of objectives that English law has previously attempted to keep separate. In essence, what the Act now permits is for the Crown Court to order that a prison sentence (other than a mandatory life sentence) is served in hospital rather than prison. The conditions for making the new order are that the court is satisfied, on the basis of written or oral medical evidence from at least two doctors, that:

(1) the offender is suffering from 'psychopathic disorder' within the meaning of the MHA 1983;

(2) the disorder is of a nature or degree that makes detention in hospital for treatment appropriate;

(3) that such treatment is likely to alleviate or prevent a deterioration of the offender's condition (the 'treatability criterion').

Where these conditions are met and at least one of the doctors concerned gives oral evidence before the court, a 'hospital direction' and 'limitation direction' may be made in respect of the offender, provided that the court is also satisfied that arrangements have been made for hospital admission to occur within 28 days. Behind this apparently straightforward measure nestles a complex set of questions regarding the interaction of the new power with pre-existing sentencing provisions, not to mention others introduced by the CSA 1997 itself. Partly so as to shed light on these, it is helpful to examine more closely the mental health law features of the new measure, before considering its sentencing aspects.

MENTAL HEALTH LAW

Those familiar with the MHA 1983 will notice a strong resemblance between the terms of the inserted provision and those already contained in that Act. At least one of the doctors giving evidence to the court must be approved under s. 12 of the 1983 Act as having: 'special experience in the diagnosis and treatment of mental disorder'.

Apart from the fact that the new orders apply exclusively to psychopathic disorder, the medical criteria reflect those required under s. 47 of the Act, which empowers the Home Secretary to transfer a sentenced prisoner to hospital for treatment. Consequently, it is no surprise that a 'hospital direction' takes effect as a 'transfer direction' under that section. Similarly, the 'limitation direction' takes effect as a 'restriction direction'. Under s. 49 of the MHA 1983 the minister enjoys the discretion to make the latter direction in addition to a transfer direction. Its significance is that it confers the status of 'restricted patient' upon the prisoner so that decisions regarding discharge from hospital, leave of absence and transfer to another institution, may only be taken with the minister's consent. The intention in placing these procedural restrictions on those charged with the patient's treatment is to ensure that considerations of public safety are given priority when the relevant decisions are made.

Clearly there are some differences between the transfer powers of the minister and the new disposal introduced by the CSA 1997. In the latter the court is obliged to impose restrictions on the patient's management because it is mandatory to add a limitation direction to a hospital direction. In addition the

court must be informed by oral medical evidence in reaching its decision, whereas there is no obligation on the minister to obtain such information before making a restriction direction. This does not mean, however, that the evidential requirements placed upon courts by the new legislation have no precedent; they are based on another provision of the 1983 Act.

Rather than the powers of transfer given to the Secretary of State, the pivotal sections of the 1983 Act that apply to mentally disordered offenders are the court disposal powers in s. 37 and 41. Under s. 37, which is cast in equivalent terms to s. 47, a magistrates' court or the Crown Court may make a 'hospital order' as an alternative to imposing a custodial sentence. Section 41 then gives the Crown Court (only) the discretion to add a 'restriction order' to the hospital order, thereby turning the offender into a restricted patient and putting in place the restrictions summarised above. However, before it can make the restriction order, the court must hear oral testimony from at least one of the doctors giving evidence for the purposes of s. 37. Thus the origin of the medical evidence requirements attached to limitation directions can be seen. But what is the purpose of the medical evidence?

Although there is no express declaration in s. 41 a court cannot impose a restriction order unless: 'it appears ... necessary for the protection of the public from serious harm' to make the offender subject to the restrictions imposed by the order. It is obvious from this that restriction orders are targeted at offenders who are both disordered and dangerous. Consequently, by implication, the purpose of the medical testimony is to assist the court in assessing the offender's dangerousness. This view was confirmed by the Court of Appeal in *Birch* (1990) 90 Cr App R 78, the guideline case on restriction orders. However it should be noted that the court emphasised that the statutory obligation extended only as far as *hearing* the evidence. Where the doctor recommended a particular course of action, the court did not have to adopt it as the ultimate responsibility for assessing the offender's dangerousness rested with the judge. Given that courts have no choice under the 1997 Act but to superimpose a limitation direction upon a hospital direction, the dangerousness criterion in s. 41 of the MHA 1983 is not reproduced and the requirement of oral testimony looks redundant. Nevertheless, it has been suggested that, in this context too, testimony is likely to centre on the question of risk (Eastman and Peay, *Sentencing Psychopaths: Is the 'Hospital and Limitation Direction' an Ill-Considered Hybrid* [1998] Crim LR 93 at 100).

SENTENCING ASPECTS

On the sentencing side, the observations are more of omission than comparison, since the 1997 Act is silent on most pertinent matters. Considering the hybrid orders in isolation, one of the most fundamental issues that arises is how sentence length is to be fixed. No guidance is provided by the legislation, so the premise must be that the new powers can be used in conjunction with any prison sentence (other than a mandatory life sentence), and that sentence length will be set according to ordinary sentencing principles. Theoretically, then, the statutory sentencing framework of the *Criminal Justice Act* 1991 (CJA) (as amended) will apply. Section 2(2)(a) of the 1991 Act establishes the normal desert-based rule that the length of the sentence must be commensurate with the seriousness of the offence. But this is subject to what the 1997 Act has ensured is an evolving list of exceptions.

The contributions made by the new automatic 'two strikes' life sentences and mandatory minimum sentences for drug trafficking offences, both of which have come into force, have been added to the original exception provided by the 1991 Act itself. Section 2(2)(b) of the latter Act enables a court to pass a longer than commensurate sentence (not exceeding the maximum penalty for the offence) on an offender who has been convicted of an offence defined as 'violent' or 'sexual' where, in the court's opinion, doing so:

'is necessary to protect the public from serious harm from the offender'.

For reasons discussed below, it should be noted that there are strong echoes of s. 41 of the MHA 1983 in this provision.

Length of sentence

At first sight, apart from the fact that the hybrid orders must be implemented in the context of a considerable catalogue of problems associated with general sentencing law, there may not appear to be any intrinsic difficulty in pinning a hospital and limitation direction to a prison sentence, whatever its underlying rationale. But reflection suggests that a number of important questions will arise in relation to the determination of sentence length. First of all, in some instances, courts will be faced with a fundamental contradiction between the criteria by which sentence length is determined and the therapeutic ambition that prompts the direction that the sentence should be served in hospital. This can be illustrated by the principles that have been established for the imposition of restriction orders.

on the internet

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The European Institute of Mental Health Law provides an interface for all those working in the area of mental health law. The site includes recent developments in mental health law and information about forthcoming conferences and training.

Section 41 of the MHA 1983 provides for orders of both fixed and indeterminate duration. However in *Birch* the Court of Appeal reiterated earlier advice that cases in which a determinate order is appropriate are exceptional, since it is highly unusual to be able to predict with any degree of certainty how long an offender will remain a danger to the public. Similarly, it is easy to imagine a parallel conflict arising where the medical evidence suggests that the offender's disorder is of long-term duration but, in sentencing terms, either the offence deserves a comparatively modest sentence and none of the exceptions enabling a longer term to be imposed apply, or the permitted extension is relatively short.

At least three responses to the occurrence of such a case can be anticipated. One possibility is that the doctors would be unwilling to declare the offender 'treatable', taking the matter out of the court's hands. Alternatively, a court might decline to direct the offender to hospital on the grounds that it would be pointless to do so. Thirdly, the court might make the necessary directions in

reliance on the fact that, should the disorder outlast the sentence, the offender could be detained at its conclusion through the use of the civil powers of the MHA 1983. Whatever the result the outcome is an unhappy one. Responses one and two would help to perpetuate the current situation in which it is not only known that significant numbers of offenders are improperly detained in prison (Gunn et al, *Mentally Disordered Prisoners* (1991), Home Office, London), but that they are detained in conditions that are neither designed nor expected to cater for their needs (*Knight v Home Office* [1990] 3 All ER 237). On the other hand, response three threatens to undermine the credibility of any claim that the length of an order has been fixed as a proportionate response to the offence, reproducing a well-rehearsed criticism of the injustice that can result from 'ordinary' hospital orders.

What of the converse situation where a longer than commensurate sentence under s. 2(2)(b) of the 1991 Act is an issue? It has been suggested that it is here that the role of the oral medical evidence may assume critical importance. Like s. 41 of the MHA 1983, s. 2(2)(b) is a dangerousness assessment provision. There is no statutory requirement in the CJA that the court should obtain medical evidence before passing a longer sentence. But the Court of Appeal has indicated that it is good practice to do so (*Fawcett* (1995) 16 Cr App R (S) 55), repeating the established position in relation to the imposition of discretionary life sentences (*Virgo* (1988) 10 Cr App R (S) 427), which are themselves defined by the CJA as s. 2(2)(b) sentences.

It has already been seen that, under the 1997 Act, the court must hear oral medical evidence before imposing a limitation direction. If it is right that this evidence will focus on the question of risk then it has been pointed out that it may be used for a double purpose as simultaneously justifying the imposition of a longer than commensurate (or discretionary life) sentence (Eastman and Peay). From a civil libertarian viewpoint, this is a matter of some concern. If the guidance in *Birch* is applied to limitation directions, which is likely since the wording of the legislation is identical to that in s. 41 of the MHA 1983, then the courts will not regard themselves as obliged to follow medical recommendations to send offenders to hospital to serve their sentences. Nevertheless the effect of exposure to the medical evidence may be to draw certain matters to the sentencer's attention that would not otherwise have been considered. As a result, one effect of the new statutory provisions may be to encourage the elongation of sentences for potentially eligible offenders, regardless of where they are to be served.

Dangerousness prediction is notoriously inaccurate. Therefore any expansion of its use as a basis for decision-making is objectionable in principle and should be resisted. Secondly, as already noted, prison is not, and is not intended to be, a suitable environment for detaining individuals with mental health problems. Consequently, given that the population under discussion is, by definition, on the threshold of compulsory hospitalisation, the propriety must be questioned of introducing a measure which has the capacity to increase the likelihood that such individuals will be imprisoned for longer than would otherwise have been the case.

RELATIONSHIP OF HYBRID ORDERS

Having considered the new orders in their own terms, it is now appropriate to examine their relationship with other forms of sentence and disposal. The first point to clarify is that the hospital and limitation directions constitute an addition to the courts' armoury. Therefore their introduction must be reconciled with those measures that were previously available. The legislation provides some indication as to how this should be done, since it specifies that the power to impose the new orders only arises when the court has already considered the possibility of making a hospital order, and has dismissed it in favour of passing a prison sentence. There is one exception to this rule, however. Where the offender is subject to an automatic life sentence under the 1997 Act, the court must proceed directly to consider whether the conditions for a hospital and limitation direction are satisfied, since s. 37 of the MHA 1983 has been amended to deny this group of offenders eligibility for a hospital order. Leaving aside this atypical group, some observations can be made about the sequence of decisions that must now be followed in 'ordinary' cases.

As mentioned earlier, allowing for the fact that the new orders are applicable only to offenders suffering from psychopathic disorder, the medical criteria that support the making of a hospital direction match those found in s. 37 of the MHA 1983. Logically, this implies that where a court eventually makes a hospital direction, its reasons for rejecting a hospital order cannot arise from lack of satisfaction of the medical conditions but must be dependent on a criterion that the two disposals do not share. In practice, however, this is only partially true, since *Birch* suggests one circumstance in which offenders might now end up serving a prison sentence in hospital, despite qualifying for a hospital order. Therefore there are two situations in which a court might be inclined towards imposing the new orders.

The first is generated by the further condition in s. 37 that, before a court can make a hospital order, it must be:

> *'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 disposing of the case.'*

As the Court of Appeal confirmed in *Birch*, the effect of this provision is to preserve the court's discretion to pass a prison sentence, even where the medical criteria to support a hospital order are satisfied. But the guidance in *Birch* went further giving rise to a second possibility. As has been seen, in a case where the court reaches an initial conclusion that a hospital order is appropriate, it must then consider whether to exercise its discretion under s. 41 of the MHA 1983

to conjoin a restriction order. According to the Court of Appeal, part of the sentencer's deliberations at this stage, should include a reconsideration of whether to send the offender to prison (*Birch* (1990) 90 Cr App R 78 at p. 87). Some such offenders might eventually end up in the hospital and limitation direction pool by this route.

When the proposal to introduce a hybrid order was first mooted, however, it was not primarily intended to cater for either of these types of cases, but rather to overcome difficulties associated with the concept of psychopathic disorder and applicability of the treatability criterion.

TREATABILITY OF DISORDER

Psychopathic disorder is a highly controversial concept. Clinicians disagree about how such disorders should be classified and whether and how they are treatable. Inevitably this has knock-on consequences for the operation of the MHA 1983. Under the scheme of the legislation, psychopathic disorder is classified as a minor disorder, meaning that sufferers are not regarded as hospitalisable per se because they are not so disordered that they are unable to fend for themselves in the community. Consequently, the treatability criterion was included in the admission criteria in order to provide a safeguard against compulsory detention in circumstances where hospital treatment was unlikely to do any tangible good. In practice, however, it has long been alleged that doctors have fostered it in such a way as to protect them from patients that they do not wish to treat. This is not to suggest, however, that their reticence in accepting responsibility for relevant individuals is unfounded. It is clear that such patients do present exceptionally demanding challenges and that some are genuinely untreatable.

Viewed specifically in the context of s. 37, the clinical uncertainties present two inter-related difficulties. First, they cause a reluctance to declare psychopathically disordered offenders 'treatable' within the meaning of the Act, potentially denying beneficial therapy. But this basic reluctance is then exacerbated by a second, practical consideration. Where offenders are declared treatable but, subsequently, the assessment turns out to be erroneous, compulsory hospitalisation has proved to be a dead end. The patient cannot be transferred to prison because a hospital order is not a sentence and, very often, they cannot be discharged because the relevant criteria are not met, or they are thought unsuitable for return to the community because of anxieties about dangerousness.

PRISON IS UNSUITABLE

Prison is not, and is not intended to be, a suitable environment for detaining individuals with mental health problems. Consequently, given that the population under discussion is, by definition, on the threshold of compulsory hospitalisation, the propriety must be questioned of introducing a measure which has the capacity to increase the likelihood that such individuals will be imprisoned for longer than would otherwise have been the case.

The measures introduced by the CSA 1997 are apt to deal with the transferability issue. Although serving sentence in hospital, the offender is nevertheless a prisoner and so legitimately liable to punishment in prison if found to be untreatable (or treatment proves successful prior to sentence expiry). However, it is worth noting that the reforms made by the legislation are not as far reaching as those proposed by the initiators of the hybrid orders. The original proposal was made by a joint Department of Health and Home Office Working Group on Psychopathic Disorder (the Reed Committee) that reported in 1994. While the committee had suggested that the duration of the order would be set by the court according to desert criteria and that it would be classified as a punitive sentence, they had envisaged that the question of where the order would be served would then be determined on purely clinical grounds. This does not entirely tally with the model established by the 1997 Act.

WIDER IMPLICATIONS

This paper has concentrated on drawing attention to some specific problems with the provisions introduced by the 1997 Act. However, in conclusion, it is important to complement these detailed observations by highlighting the wider significance that the new orders may have for policy towards mentally disordered offenders.

Official policy towards the mentally disordered who come into contact with the criminal justice process was summarised in Home Office circular No. 66/90. It provides that such individuals should be diverted into mental health care at as early a stage as possible, reinforcing its message with a comprehensive set of appendices that are designed to remind all relevant agencies of their powers pursuant to putting the policy into effect. It cannot be denied that there is telling evidence that implementation of the policy is far from perfect since criminal justice populations include a significant cohort that is mentally disordered (see, for example, Gunn et al). Nevertheless, the existence of what accumulates to a rich array of formal and informal diversionary mechanisms provides tacit evidence of a genuine and long-standing commitment to this particular policy approach.

Viewed in these terms, it is all the more apparent that the introduction by the CSA 1997 of an order that intertwines punitive and therapeutic goals constitutes a significant re-orientation of policy. Those who regard this as an undesirable development may comfort themselves that the scope of the new provisions is limited to offenders suffering from psychopathic disorder. Given that many of the difficulties associated with this condition stem from its ambiguity as a form of mental disorder and/or criminality, it may not be inappropriate to respond by tailoring an equally ambiguous form of disposal to match. However, while it may be tempting to take refuge in this rationalisation, the reassurance it provides may be short-lived. The legislation vests the Secretary of State with the power to extend the application of hospital and limitation directions to include 'mental disorder of such other description as may be specified in the order'. Therefore the issues raised by the CSA 1997 may acquire far wider relevance than might initially appear. This is a further reason why these novel forms of sentence deserve wider debate.

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