

**Sentencing Council meeting:**  
**Paper number:**  
**Lead Council member:**  
**Lead official:**

**16 November 2018**  
**SC(18)NOV03 – Mental Health**  
**Rosa Dean**  
**Mandy Banks**  
**0207 071 5785**

## **1 ISSUE**

1.1 At the last meeting the Council considered a substantially revised version of the draft guideline, and agreed that the draft was now moving in the right direction. The Council asked for some rewording and amendments to be made to the draft, these have been done and can be seen highlighted in red in the attached draft at **Annex A**.

1.2 Given the very specialised nature of this guideline, and so to make it as thoroughly researched as possible ahead of a public consultation, the draft was sent to a small number of experts for comment (independently of one another). The group included four academics, two charities, one specialising in mental health (Rethink) and one in brain injuries (Headway), and a member of the Royal College of Psychiatrists. The Council will be reassured to note that the feedback on the proposed draft was very positive from all the different experts. In addition, they have provided helpful and insightful comments on the draft, with some suggestions for amendments, which will be discussed in the body of the paper.

1.3 There are two further scheduled meetings to discuss this guideline, with consultation scheduled for spring next year. If the work continues to progress well however it may be possible to sign this guideline off for consultation with one further meeting.

## **2 RECOMMENDATION**

2.1 At this meeting the Council are asked to note the revised draft and in particular:

- To note the changes that have been made to the wording following the last Council meeting
- To note the proposed changes to the draft suggested by the group of experts since the last meeting
- To consider whether to include wording to deal with issues around privately funded patients and their treatment

- To note the proposal that the guideline is only for offenders aged 18 and over

### 3 CONSIDERATION

#### *Section 1: General approach*

3.1 Starting at paragraph 1 on page 4 of **Annex A**, at the last meeting the Council asked that the reference to 'defence advocate' at the very end of the paragraph be deleted. This meant that the remaining sentences read: *'The mere fact that an offender has such a condition or disorder does not necessarily mean that it will have an impact on sentencing. Where it does, it is likely that it will have been raised as a significant issue.'* However, this revised wording of the sentence prompted some of the experts who saw the draft to query, *'raised by whom?'*. Professor Jill Peay also commented that even with the new L&D services she remains concerned that many offenders' mental health issues go unnoticed by the courts, particularly when they plead guilty and/or in the magistrates' courts, and for certain types of disorders such as personality disorders where there may have been little previous contact with mental health services. She also noted that this sentence in para 1 contradicts the first bullet point under para 2 *'care should be taken to avoid making assumptions, as unlike some physical conditions, many mental health conditions or learning disabilities are not easily visible.'*

3.2 It is recommended therefore that this last sentence in para 1, *'where it does, it is likely that it will have been raised as a significant issue'* is deleted in its entirety. This allows the point still to be made in para 1 that just because an offender has a mental health condition/disorder, it does not necessarily mean it will have an impact on sentencing, but does not preclude the situation where for the reasons outlined in para 2, a condition may be raised for the first time during court proceedings.

3.3 The new last bullet point in para 2 has been inserted as requested by the Council, following a discussion at the last meeting regarding the basis on which an offender is diagnosed.

3.4 At the last meeting the Council discussed the basis on which reports are sent to the prison, (para 4) the Council having noted the new CrimPR and CrimPD regarding psychiatric and related reports coming in to force. The Council asked that the new Rules and PD be checked to see what the obligation on the sentencer is in this regard. The Rules/PD have been checked and they are silent on this point. This has been raised with the CrimPR Committee secretariat, who suggested that such a requirement for sentencers to ensure that reports are sent with an offender to custody could be made by way of rules, by analogy with rule 28.9. They suggest that if the Council were so minded to, they could recommend this action to the Rule Committee, who would act on the recommendation promptly.

**Question 1: Does the Council wish to make this recommendation to the Rule Committee? Is the Council content with the rest of the changes in section 1?**

3.5 Para 6 is new suggested guidance which has followed on from a letter that was sent to the LCJ by Kingston Local Authority, following a Local Learning Lessons Case Review after the death of two children. The report produced a number of recommendations, some of which pertain to the sentencing of offenders who have private healthcare and select their own treating hospital. The PQBD replied to Kingston saying that he would refer the issues raised to the Council to consider as part of the work on the new mental health guideline, although he stressed that it was entirely up to the Council how to, or whether to, act on the issues raised. He added that if the Council after consideration felt that it was not appropriate to offer guidance, he would refer the matter to Judicial College. The findings of the review that are relevant are:

- 1) The ability of a defendant to select their own private healthcare jeopardises parity of treatment within the criminal system and potentially impacts on the provision of appropriate treatment of offenders and consequently the safeguarding of children
- 2) The terms used to describe the level of security within mental health provision are open to misunderstanding in court, in relation to the meaning of a 'locked', low secure and medium secure ward. This could risk patients being sent to a different hospital setting than that intended by Judges.
- 3) Psychiatric assessment and treatment needs to take account of information from other professionals and agencies in situations where serious crimes have been committed.

3.6 The brief facts of the case that gave rise to this are as follows. The offender killed her two severely disabled children. She has one remaining child. She was found guilty of manslaughter on the grounds of diminished responsibility and was placed on a s.37 hospital order without restrictions. She was described as mildly depressed, with no evidence of severe mental illness, and that it was a 'unique case' as she did not represent a risk to others. After eight days in prison, she was transferred to a private hospital, as recommended by her private psychiatrist, which she then remained at before, and after trial. This was all paid for via her private health insurance. This private hospital was described in court as medium secure. However it later transpired that it was not medium or even low secure, visitors and patients were able to leave without any restriction. She had home leave to visit her remaining child, and to stay over in the family home, 10 months after the offence. She was discharged from the s.37 order 13 months after the offence.

3.7 The hospital did not offer a forensic service (one with specialist staff able both to address an offender's mental health needs as well as the serious or violent nature of offending behaviour), which gave rise to concerns that although she was treated for depression, her offending behaviour was not addressed in any way. The hospital did not generally take NHS patients or transfers from prison, staff evidently were amazed when she arrived in handcuffs. In addition, due to her being in a private rather a forensic setting, which would be more usual following serious offences, there did not appear to be any risk assessments conducted before home leave, to ensure her safety, and the safety of the remaining child.

3.8 It could be that this case represents a unique set of circumstances, so the concerns that have followed are perhaps unlikely to happen again. However, in discussion with Rosa on these issues, she noted that in Harrow she is aware of a number of wealthy defendants with their own psychiatrists and treatment plans. Accordingly, in consultation with Rosa some guidance to address these points has been developed at paragraph 6.

***Question 2: Does the Council wish to offer some guidance to address the issues raised? If so, is the Council content with the proposed wording in paragraph 6?***

*Section 2: Assessing culpability*

3.9 There are some minor amendments to wording in para 8, suggested by Headway and Rethink. Rethink suggested the additional wording at the end of para 8, to clarify when expert opinion might be overruled. Professor Ronnie MacKay suggested some minor changes to the wording in bullet points 1 and 3.

***Question 3: Is the Council content with the minor changes within section 2?***

*Section 3: Determining the sentence*

3.10 Professor Jill Peay commented that s.142(2)(d) of the Criminal Justice Act 2003 specifically disapplies s.142(1) the purposes of sentencing, when making a hospital order, a hospital order with restrictions or a hospital and limitation direction under the MHA 1983. Accordingly, new wording has been added at the end of para 10 to clarify this.

3.11 In para 12 the insertion of the words '*length or nature*', as agreed by Council at the last meeting have been added. Professor Peay also suggested adding '*or whether a disposal under the Mental Health Act is appropriate*' in this paragraph.

3.12 Rethink suggested the new second bullet point in this list, to reflect the fact that by the sentencing stage, offenders may have spent substantial time on remand in prison, which can lead to a deterioration in their condition. This can then mean that the offender's mental health may not be the same at trial or sentencing as it was at the time of the offence. They

suggest that the court may then wish to consider whether the offender's mental health appears to fluctuate significantly based on their environment, thus indicating that a custodial sentence may significantly worsen their mental health.

3.13 The fourth bullet point in this list within para 12 has been deleted, as agreed by Council, as it repeats the point in the first bullet point. Paras 13 and 14 have been deleted in their entirety, as agreed by Council at the last meeting. Para 15 contains new wording, to reflect the point that the Council discussed at the last meeting, that the draft should make clear that courts must not assume that one hospital order is better than another, or offers greater public protection than another.

3.14 There is only one minor change to section 4, the addition of the words '*this is not an exhaustive list*' underneath the list of disposals. This is in response to a query from one of the experts that the list does not contain all the disposals available to a court, discharge, fine etc, as the list had been provided of just the pertinent mental health disposals/guidance.

***Question 4: Is the Council content with the proposed changes to section 3 and 4?***

*Annex A*

3.15 Annex A remains broadly unchanged since the Council saw this last time. One of the experts who has seen the draft, Professor Pamela Taylor of the Royal College of Psychiatrists, has offered to review this section in depth, but due to other commitments will need a couple of more weeks in order to do so. Accordingly this should be done by the time the Council next considers the guideline. The one substantive amendment in this annex comes under the learning disability heading on page 12. This wording was suggested by Miranda Bevan (who worked at the Law Commission on the fitness to plead project), who commented that it might be helpful to remind courts that someone with a learning disability would only be eligible for an MHA 1983 disposal if they satisfy s.1(2A) MHA 1983 (that their learning disability is 'associated with abnormally aggressive or seriously irresponsible conduct')

***Question 5: Is the Council content with the new information within Annex A?***

*Annex B - reports*

3.16 The rewording of the start of the first paragraph as suggested by the Council at the last meeting has been done, and can be seen on page 15. There is also a new bullet point (fourth from the bottom of the list) which the Council also requested at the last meeting should be included.

3.17 The section regarding s.38 orders has also been reworded as requested by Council, this is the insertion of the wording '*before ordering a s.38 the court will have to be satisfied a*

*bed is available, and that a s.38 order is necessary in the circumstances of the case*'. Jill Peay queried the last sentence of this paragraph: *'However, although such an order may enable a better assessment to be made than in a prison environment, courts should consider carefully the acute pressure on the availability of secure beds*'. She asked why the courts are being asked to consider the acute pressure on beds, when the offer of a bed has already, of necessity under s.38 (4) been made. She wondered if the Council was encouraging courts to trump a medical assessment of need. The Council was reflecting the reference in *Vowles* in this wording, however it is suggested that the last sentence of this paragraph is removed. The reference to assessments also being conducted in the community, as discussed at the last meeting, has been included.

3.18 Miranda Bevan also suggested that the paragraph should make it clear that s38 MHA orders are available in the summary courts, but only for imprisonable matters. To reflect this point, new wording has been inserted in the first line *'for offences punishable with imprisonment'*.

**Question 6: Is the Council content with the changes to the wording within Annex B?**

*Annex C – sentencing disposals*

3.19 Miranda Bevan suggested that the wording relating to MHTRs be checked within the box at the start of Annex C on page 18, as the defendant need not have a 'medical condition' susceptible to treatment, rather it need only be the case that his or her 'mental condition' is susceptible to treatment. There have been some changes to wording to rectify this. A new bullet point has been added under the box on MHTR's at Annex C, also at the suggestion of Miranda Bevan, who commented that it may be helpful to remind courts that MHTRs offer them an option to require treatment for offenders who fall outside the MHA mental disorder bracket. The fourth bullet point has had the wording added that the Council discussed at the last meeting *'where the offence is not serious enough to cross the custody threshold'*. The fifth bullet point is a new suggestion, and partly echoes wording used in the theft guideline, that MHTRs may be a proper alternative to a short or moderate custodial sentence.

3.20 The text underneath the table on s.37 orders has been revised and made clearer, following the discussion at the last Council meeting.

**Question 7: Is the Council content with the changes made to Annex C?**

*Age applicability of the guideline*

3.21 The Council may recall that in one of the earlier meetings the question of whether the guideline should apply to all offenders, or only those over 18 was discussed. During this

discussion Rob Butler suggested that young offenders may have different, specific needs compared to adult offenders, and that it may be difficult to accommodate these within an all age guideline. He suggested contacting an expert in this area, Professor Dame Sue Bailey, to ask her opinion. Professor Bailey has given some thought to this question and she concurred with Rob, that considerations for adolescent offenders with mental health conditions are different from those for adult offenders, so it would be difficult and probably inappropriate to try to produce a robust guideline that could be applicable for all ages.

3.22 It is recommended that this guideline only applies to over 18s, and that additional guidance on issues of immaturity relating to young adults is considered as part of the work on providing expanded explanations in offence specific guidelines.

**Question 8: Does the Council agree that this guideline should only apply to the over 18s?**

3.23 At the last meeting the Council agreed on a revised title '*Overarching Principles: Sentencing Offenders with mental health or similar conditions.*' A number of the experts however found the title confusing or unhelpful. Most of the comments suggested that 'similar conditions', as a catch all, doesn't work. Jill Peay queried, '*does it mean similar in effect, as in intoxication? Or similar in origin? Which could include a series of physical conditions....as mental disorder is so widely defined in the MHA one might ask if any further qualification is necessary?*' Others felt that the title needed to list all the conditions the guideline referred to, Miranda Bevan suggested that it should read '*mental health conditions, learning disability and developmental disorders*' and Headway felt that '*neurological impairments*' should be added to the title.

3.24 Sensitivity around language in these areas is something it is suggested the Council should be mindful of. For example, Headway had commented that although brain injury was included within Annex A, and so was covered by the guideline, there was no mention of it within the guidance, only references to mental health. They also added that there is general confusion between mental health and neurological conditions, so it would be helpful for the guidance to specifically refer to mental health and neurological conditions, as well as development disorders such as autism. The text within the guidance has been amended to add references to neurological impairments. And, it is suggested that it may be appropriate to have a fuller title, so '*Overarching Principles: Sentencing Offenders with mental health conditions, learning disability, developmental disorders or neurological impairments*', is proposed.

**Question 9: Does the Council agree to the suggestion regarding the revised title?**

**4 IMPACT/RISK**

4.1 In terms of the impact of the guideline, the CPD data, which we would usually draw upon to help develop guidelines, does not include information about whether the offender had a mental health disorder or learning difficulty. The A&R team is continuing to explore what other data is available in this area, including looking at the CCSS, to see if it contains any data on the volumes and sentences involved and to try and assess what the impact of the guideline might be. A lack of data could make the draft resource assessment problematic, in terms of accurately assessing the impact of the draft guideline.

4.2 Officials are also maintaining close links with officials in the MOJ and other Government departments to keep up to speed with developments on the various related initiatives in this area, the L&D scheme, review of the MHA, and so on.

***Question 10: Is the Council content that the impact/risks have been sufficiently considered at this stage?***



# Sentencing Council

Overarching Principles:

Sentencing offenders with Mental  
Health or similar conditions

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### **Applicability of guidelines**

In accordance with section 120 of the Coroners and Justice Act 2009, the Sentencing Council issues this definitive guideline. It applies to all offenders aged ~~18~~ and older, who are sentenced on or after xxxx, regardless of the date of the offence.

Section 125(1) of the Coroners and Justice Act 2009 provides that when sentencing offences committed after 6 April 2010:

“Every court -

(a) must, in sentencing an offender, follow any sentencing guidelines which are relevant to the offender’s case, and

(b) must, in exercising any other function relating to the sentencing of offenders, follow any sentencing guidelines which are relevant to the exercise of the function,

unless the court is satisfied that it would be contrary to the interests of justice to do so.”

This guideline applies only to the sentencing of convicted offenders: it does not address issues of fitness to plead or disposals for those found unfit to plead.

## **Section one: General approach**

4. The guidance given in this guideline will assist sentencers when sentencing offenders who have any of the conditions or disorders outlined in **Annex A**. The mere fact that an offender has such a condition or disorder does not necessarily mean that it will have an impact on sentencing. Where it does, it is likely that it will have been raised as a significant issue ~~by the defence advocate.~~
  
2. There are a wide range of mental health conditions, neurological impairments and developmental disorders, and the level of any impairment will vary between individuals. Accordingly, in assessing whether the condition or disorder has any impact on sentencing, the approach to sentencing should be individualistic and focused on the particular issues relevant in the case concerned. In particular:
  - care should be taken to avoid making assumptions, as unlike some physical conditions, many mental health conditions, neurological impairments or learning disabilities are not easily visible
  - no inference should necessarily be drawn if an offender had not previously been formally diagnosed, or had not previously declared a condition (possibly due to a fear of stigmatisation or because they are unaware they have a condition)
  - 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, ‘dual diagnosis’<sup>1</sup>
  - difficulties of definition and classification in this field are common, there may be differences of expert opinion and diagnosis in relation to the offender, or it may be that no specific condition can be identified
  - sentencing should be conducted on the basis on which a condition or disorder has been diagnosed by an expert (as opposed to self-diagnosis by an offender)
  
3. In any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law, unless, in the circumstances of the case, the court is of the opinion that it is

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<sup>1</sup> There is more information on co-morbidity and dual diagnosis in Annex A

unnecessary (s.157 Criminal Justice Act 2003)<sup>2</sup>. It may be unnecessary if existing sources of information can be used, such as from probation, defence representatives, prison, police or court mental health teams, or family members. In addition, s.39 of the Mental Health Act (MHA)1983 provides that a court may request information about a patient from local health services if considering making a hospital or interim hospital order. Further information about requests for reports can be found at **Annex B** of this document.

4. Where a custodial sentence is passed the court should forward psychiatric, [medical](#) and pre-sentence reports to the prison, to ensure that the prison has appropriate information about the offender's condition and can ensure their welfare.
5. Courts should always be alive to the impact of a condition on an offender's ability to understand and participate in proceedings. To avoid misunderstandings, which could lead to further offences, it is important to ensure that offenders understand their sentence and what will happen if they reoffend and or breach the terms of their licence or supervision. Courts should therefore consider putting the key points in an accessible way. Further information can be found at Chapter Four of the Equal Treatment Bench Book:

<https://www.judiciary.uk/publications/new-edition-of-the-equal-treatment-bench-book-launched/>

6. [Where a defendant is proposing to commission or has had commissioned on their behalf a privately funded report with a view to a bed at a private hospital, or to a privately managed Mental Health Treatment Disposal, the court should require additional information to ensure that the proposals are rigorous and that the level of security or treatment is suitable. Courts should also consider whether a restraining order or any other ancillary order would be appropriate.](#)

### **Section two: assessing culpability**

7. Courts should refer to offence specific guidelines to assess culpability, in conjunction with this guideline. If an offender has any of the conditions or disorders listed in **Annex A**, it is possible that it may affect their level of responsibility for an offence. The relevance of any condition will depend on the nature, extent and effect of the condition on an individual and whether there is a causal connection between the condition and the offence. It is for sentencers

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<sup>2</sup> There is more information on s.157 of the Criminal Justice Act in Annex B.

to decide how much responsibility the offender retains for the offence, given the particular disorder or condition and the specific facts of the case at hand.

8. In some cases the condition may mean that culpability is significantly reduced, in others, the condition may have no relevance to culpability. Assessments of culpability will vary between cases due to the differences in the nature and severity of conditions, [and the fluctuation of some conditions](#); it is not possible to be prescriptive in this regard. Careful analysis of the evidence is required to make this assessment, which the sentencer, who will be in possession of all the relevant information, is best placed to make. Expert evidence, where offered and relevant, should be taken into account, but sentencers must make their own decisions and should not feel bound to follow [expert psychiatric opinion](#). [This may be appropriate if there is conflicting expert advice or](#) where [experts suggest a diagnosis without a clear indication of how it impacts culpability](#).

9. Courts may find the following list of questions to consider helpful, to assist in deciding the level of culpability:

- Did the offender's condition mean [it impaired their ability to](#)~~they were unable to~~ exercise appropriate judgement?
- Did the offender's condition impair their ability to make rational choices, or to think clearly?
- Did the offender's condition impair their ability to understand the [nature and](#) consequences of their actions?
- Did the offender's condition have the effect of making them disinhibited?
- Were there any elements of premeditation or pre-planning in the offence, that might indicate a higher degree of culpability?
- Were there attempts to minimise their wrongdoing or to conceal their actions, that might indicate a higher degree of culpability?
- Did the offender have any insight into their illness, or did they lack insight?
- Did the offender seek help, but failed to receive appropriate treatment or care?
- If there was a lack of compliance in taking medication or following medical advice, was this influenced by the condition or not?
- If the offender exacerbated their condition by drinking/taking drugs, were they aware of the potential effects of doing so?

**This is not an exhaustive list.**

### **Section three: determining the sentence**

10. Courts should consider all the purposes of sentencing during the sentencing exercise: the punishment of offenders, reduction of crime, rehabilitation of offenders, protection of the public, and reparation. Just because an offender has a mental health condition, neurological impairment or disability, it does not mean they should not be punished, and in the case of serious offences protection of the public may be paramount. For offenders whose condition has contributed to their offending the effective treatment of their condition should in turn reduce further offending and protect the public. [However, in relation to the making of a hospital order, a hospital order with restrictions or a hospital and limitation direction, the statutory requirement to have regard to the purposes of sentencing does not apply.](#)
11. Decisions will need to be made on a case by case basis. For example, in a case where an offender's culpability was high, the sentence **may** be more weighted to punishment. In a case where an offender's culpability was low, the sentence **may** be more weighted to rehabilitation.
12. An offender's condition at the point of sentence could have a bearing on the type, [length or nature](#) of sentence that is imposed, [or whether a disposal under the Mental Health Act is appropriate](#). Some points to consider are:
- [The existence of a condition at the date of sentencing, or its foreseeable recurrence, could mean that a given sentence could weigh more heavily on the offender than it would on an offender without that particular condition](#)
  - [By the time of sentence, some offenders may have spent substantial time on remand, which may have led to a deterioration in their condition. If this is the case, in deciding sentence the court may wish to consider whether imprisonment may significantly worsen an offender's condition](#)
  - Imprisonment can exacerbate poor mental health and in some cases increase the risk of self-harm
  - ~~[For some prisoners their condition may mean a custodial sentence may have a greater punitive effect than it would for a prisoner without the condition](#)~~
  - Some requirements of community orders may be impractical, consideration should be given to tailoring the requirements of orders, as necessary in individual cases. An offender should not receive a more severe sentence, such as custody, because they would be unable to do unpaid work as part of a community order, for example

~~13. If there is a serious risk of imprisonment having a gravely adverse effect on the offender's condition, courts will need to consider this risk very carefully, in exceptional cases looking at alternatives to custody, and potentially sentencing outside the range indicated by the offence guideline. Where the offence is very serious and retained culpability high, custody may be inevitable but the condition may still properly impact on sentence length. Courts should refer to any medical evidence or expert reports on this point to assist them.~~

~~14. However, although consideration of the impact of imprisonment on an offender is a legitimate one, any consideration should be balanced against the gravity of the offending, including the harm done to the victim(s), and the public interest in appropriate sentences being set.~~

15. In deciding on a sentence, courts should also carefully consider the criteria for, and regime on release. It should not be assumed that one order is better than another, or that one order offers greater protection to the public than another, careful analysis of all the facts is required in each case, including what is practically available, before deciding on the appropriate disposal.

The graver the offence and the greater risk to the public on release of the offender, the greater emphasis the court must place upon the protection of the public and the release regime.

Further details are given at **Annex C**, but in summary:

- A **s37 hospital order** lasts initially for six months but can be renewed for a further six months and then for a year at a time. Discharge from a hospital order can be made by the responsible clinician (RC) or the hospital at any time. The RC can also make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. The patient can apply to the tribunal<sup>3</sup> for discharge after six months and annually thereafter.
- A **restriction order under s41** lasts indefinitely and does not need to be renewed. The Secretary of State for Justice (SoS) can lift the restriction order at any time if satisfied that it is no longer necessary to protect the public from serious harm. A patient who is still in hospital when the restriction order is lifted is treated as if admitted under a hospital order on the day the restriction order ended.
- A **limitation direction under s45A** ends automatically on the patient's 'release date'. The effect of this is that the limitation direction will end at the halfway point of a determinate sentence. If the patient is serving a life sentence, or an indeterminate sentence, the release date is the date (if any) on which the person's release is ordered by the parole board. Although the limitation direction ends on the release date, the hospital direction does not. So a patient who is still detained in hospital on the basis of the hospital direction on their release date, remains liable to be detained in hospital from then on as an unrestricted hospital order patient. While the limitation direction remains in effect, if the patient no longer requires treatment in hospital for a mental disorder, the SoS

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<sup>3</sup> First Tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal in Wales



may direct that the patient be removed to prison (or equivalent) to serve the remainder of their sentence, or else release them on licence.

#### **Section four: sentencing disposals**

16. The following is a list of available mental health disposals/orders and relevant guidance (further details on each are at **Annex C**).

#### **Magistrates' courts**

- Community Order with a Mental Health Treatment Requirement (MHTR)
- Section 37 Hospital order
- Section 37 Guardianship order
- Section 43 Committal to the Crown Court (with a view to a restriction order)

#### **Crown Court**

- Community Order with a Mental Health Treatment Requirement (MHTR)
- Section 37 Hospital order
- Section 37 Guardianship order
- Section 41 Restriction order
- Section 45A Hospital and limitation direction

**[This is not an exhaustive list](#)**

**The following guidance applies in the Crown Court only:**

Where:

- (i) the evidence of medical practitioners suggests that the offender is currently suffering from a mental disorder,
- (ii) treatment is available, and
- (iii) the court considers that a hospital order (with or without a restriction) may be an appropriate way of dealing with the case,

the court should consider **all sentencing options** including a section 45A direction and consider the importance of a penal element in the sentence taking into account the level of culpability assessed at section two above.

### **Section 45A hospital and limitation direction**

- a. Before a hospital order is made under s.37 MHA (with or without a restriction order under s.41), consider whether the mental disorder can appropriately be dealt with by custody with a hospital and limitation direction under s.45A MHA. In deciding whether a s.45A direction is appropriate the court should bear in mind that the limitation direction will cease to have effect at the automatic release date of a determinate sentence.
- b. If a penal element is appropriate and the mental disorder can appropriately be dealt with by a direction under s.45A MHA, then the judge should make such a direction. (Not available for a person under the age of 21 at the time of conviction).

### **Section 37 hospital order and s41 restriction order**

If a s.45A direction is not appropriate the court must then consider whether, (assuming the conditions in s.37(2) (a) are satisfied), the matters referred to in s. 37(2)(b) would make a hospital order (with or without a restriction order under s.41) the most suitable disposal. The court should explain why a penal element is not appropriate.

### **Annex A**

The following information provides brief detail on common mental health disorders, [neurological impairments](#) and developmental conditions, listing the main features that may be relevant in understanding how the condition may affect people ~~with the condition~~.

**Mental disorders** – such as (but not limited to) depression, anxiety, schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), or personality disorders (particularly associated within the criminal context are anti- social, borderline, narcissistic and paranoid personality disorders). These conditions can affect thought, feelings and behaviour, [including the capacity to make decisions, or make them consistently](#). Conditions can be short or long term, some conditions can fluctuate, and a range of symptoms can be experienced. The main features that may be relevant for each of the conditions are:

#### **Depression/Anxiety**

- difficulties in concentrating and making decisions
- poor memory

- irritability, anger, anxiety, agitation, restlessness, being distressed
- avoiding/leaving situations in order to relieve uncomfortable feelings
- on occasions depression may be accompanied by delusions and hallucinations

### **Schizophrenia**

- hallucinations-experiencing something that isn't really there- most commonly hearing voices
- delusions-strongly holding beliefs that others do not share and have no basis in reality and which may exhibit paranoid thinking
- acting strangely or dangerously as a result of delusional beliefs or ideas
- muddled thinking and speech
- difficulty in relating to others
- apathy, disorganised thinking, difficulty in concentration and following instructions

### **Bi-polar disorder ('manic depression')**

- extreme changes of mood, from severe lows (depression) to highs (mania)
- acting irrationally, unpredictable or unexpected behaviour
- overactive/excitable, excessive energy, become angry quickly or irritable
- unusual beliefs/delusions not based in reality
- spend excessive amounts of money/end up with debts

### **PTSD**

- irritability/aggressive behaviour
- intense distress/panic in response to real or symbolic reminders of the trauma
- involuntary re-experiencing of the trauma with flashbacks, intrusive thoughts, nightmare, and images
- difficulty concentrating

### **Personality disorders**

- reckless/impulsive behaviour
- not trusting others/feeling threatened
- irresponsible and anti-social behaviour
- disregards/violates the rights of others
- easily frustrated/angered
- unable to feel guilt

- emotionally unstable
- grandiose sense of self importance
- temporary psychotic states
- unfounded suspicion of others and bearing grudges

**Psychosis-** also called a psychotic experience or psychotic episode, is when people perceive or interpret reality in a very different way from others. Psychosis is a symptom of some mental health problems, and not a diagnosis in itself. Most common types of psychosis are hallucinations and delusions, some may also experience disorganised thinking and speech. The word is usually used to refer to an experience. Psychosis affects people in different ways, with some having only one experience, some having short episodes, and other people living with it most of the time.

**Learning disabilities** – a life-long condition which includes significant impairment of intelligence (an IQ of less than 70) and social functioning (a reduced ability to cope independently and adapt to the daily demands of a normal social environment). A learning disability can range from mild, moderate to severe. The main features that may be relevant are:

- limited comprehension and communication skills
- being acquiescent and suggestible
- having difficulty understanding social norms.

[\\*In general a learning disability is a mental disorder but for the purposes of detention in hospital by the courts and transfer to hospital from prison it can only be considered a mental disorder if associated with abnormally aggressive or seriously irresponsible conduct \(Mental Health Act 1983 s1\(2A\)\).](#)

**Learning difficulties** – such as dyslexia, Attention Deficit Hyperactivity Disorder (ADHD), or Attention Deficit Disorder (ADD). A learning difficulty is different to a learning disability as it is unrelated to intelligence. The main features that may be relevant for **ADHD/ADD** are:

- impulsiveness
- inattentiveness
- extreme impatience
- inability to relate to others in socially acceptable ways
- inability to express feelings and emotions in an appropriate way
- inability to deal with stress or to be able to think clearly.

People with **dyslexia** may have difficulties with reading, spelling, personal organisation and sequencing, getting dates, times or events in the wrong order.

**Autism Spectrum Disorder** – (including Asperger’s syndrome) a lifelong developmental disability that affects how people communicate and relate to others, and make sense of the world. The main features that may be relevant are:

- social naivety, potentially leading to being unknowingly being involved in crimes
- may develop highly specific interests in a subject or activity
- difficulty with change or unexpected events
- rigid adherence to rules
- being unaware of the consequences of their actions, due to an inability to link cause and effect
- lack of insight into behaviour
- lack of empathy or a limited ability to express emotion.

**Acquired brain injury** – an injury caused to the brain since birth. Injuries can range from mild to severe and may cause complex long-term problems. The effects may vary widely, are often hidden, and often fluctuate, but may include:

- impaired reasoning, affecting the ability to understand rules
- impaired insight into own behaviour and that of others
- loss of control over behaviour and inappropriate behaviour
- rapid mood changes, aggression, impulsivity, irritability and egocentricity
- changes in personality
- memory loss
- disinhibition
- reduced capacity to concentrate, reduced capacity to process information

**Dementia** – a syndrome associated with an ongoing decline of brain functioning, such as Alzheimer’s disease or vascular dementia. The main features that may be relevant are:

- difficulty in controlling emotions, mood swings, aggression
- loss of empathy with others
- difficulty with social interaction

- problems with memory
- in some cases, experiencing hallucinations.
- problems with concentration and reduced ability to focus and pay attention
- reduced ability to reason and make judgements
- problems with speech and language

**Dependence syndrome** – a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance abuse and that typically includes a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences, and a higher priority given to using it than to other activities and obligations. The dependence syndrome may be present for a specific substance e.g alcohol, for a class of substances, e.g opioid drugs, or for a wider range of different psychoactive substances. The main features that may be relevant are:

- violent or anti-social behaviour
- reckless behaviour
- chaotic lifestyle
- strong desire or compulsion to consume the substance above all else
- psychotic states
- disinhibition

### **Co-morbidity**

This is the term used to describe people who experience more than one condition, which is common amongst offenders, for example someone may have a mental health condition and a learning disability. Some people with mental health conditions or learning disabilities also may have communication difficulties.

### **Dual diagnosis**

This is the term used to describe people with mental health and substance abuse problems. Many people with mental health conditions use drugs or alcohol to help them deal with their conditions.

## **Annex B**

Where the court regards a report as necessary it should make the request specific. Requests for psychiatric reports should only be necessary in a limited amount of cases, as outlined in paragraph three. If asking for a report courts should make the request sufficiently specific so that the report writer is clear as to **what** is required, and **when** the report is required by.

Examples of information that might be requested are:

- background/history of the condition
- diagnosis, symptoms, treatment of the condition
- the level of impairment due to the condition
- how the condition relates to the offences committed
- dangerousness
- risk to self and others
- if there has been a failure of compliance (e.g not attending appointments, failing to take prescribed medication) what is thought to be driving that behaviour
- the suitability of the available disposals in a case
- if a particular disposal is recommended, the expected length of time that might be required for treatment, and details of the regime on release/post release supervision
- the impact of any such disposals on the offender
- any communication difficulties and/or requirement for an intermediary
- and any other information the court considers relevant.

Further information on requests for reports can be found within the Criminal Procedure Rules, which can be found here:

[https://www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015#Anchor8.](https://www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015#Anchor8)

When requested by clinicians wanting to undertake an inpatient assessment, for offences punishable with imprisonment, courts may wish to consider making an interim hospital order (s.38 MHA). Before ordering a s.38 order the court will have to be satisfied a bed is available, and that a s.38 order is necessary in the circumstances of the case. ~~However, although such an order may enable a better assessment to be made than in a prison environment, courts should consider carefully the acute pressure on the availability of secure beds.~~

Where appropriate, assessments can also be made in the community.

### **Power to order reports- magistrates courts**

There are limited powers to order reports in the magistrates' courts. s.11 Powers of Criminal Courts (Sentencing) Act 2000<sup>4</sup> provides for the ordering a report, but it is only post- conviction or a finding under s.37 (3) Mental Health Act 1983 that the defendant did the act or made the omission charged. However, the court can request a report and a duly qualified medical practitioner who provides such a report can be paid out of central funds, using s.19 Prosecution of Offences Act 1985<sup>5</sup> plus Regulation 25(1) Costs in Criminal Cases (General) Regulations 1986<sup>6</sup>.

### **Additional requirements in case of mentally disordered offender (s.157 Criminal Justice Act 2003)**

(1) Subject to subsection (2), in any case where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law.

(2) Subsection (1) does not apply if, in the circumstances of the case, the court is of the opinion that it is unnecessary to obtain a medical report.

(3) Before passing a custodial sentence other than one fixed by law on an offender who is or appears to be mentally disordered, a court must consider—

(a) any information before it which relates to his mental condition (whether given in a medical report, a pre-sentence report or otherwise), and

(b) the likely effect of such a sentence on that condition and on any treatment which may be available for it.

(4) No custodial sentence which is passed in a case to which subsection (1) applies is invalidated by the failure of a court to comply with that subsection, but any court on an appeal against such a sentence—

(a) must obtain a medical report if none was obtained by the court below, and

(b) must consider any such report obtained by it or by that court.

(5) In this section “mentally disordered”, in relation to any person, means suffering from a mental disorder within the meaning of the [Mental Health Act 1983 \(c. 20\)](#).

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<sup>4</sup> <https://www.legislation.gov.uk/ukpga/2000/6/section/11>

<sup>5</sup> <https://www.legislation.gov.uk/ukpga/1985/23/section/19>

<sup>6</sup> <https://www.legislation.gov.uk/uksi/1986/1335/regulation/25/made>



(6) In this section “medical report” means a report as to an offender's mental condition made or submitted orally or in writing by a registered medical practitioner who is approved for the purposes of [section 12](#) of the [Mental Health Act 1983](#) by the Secretary of State [ or by another person by virtue of [section 12ZA or 12ZB](#) of that Act] <sup>1</sup> as having special experience in the diagnosis or treatment of mental disorder.

(7) Nothing in this section is to be taken to limit the generality of [section 156](#).

## Annex C

<b>Mental Health Treatment Requirement (section 207 CJA 2003)</b>	
<b>May be made by:</b>	A magistrates' court or Crown Court
<b>In respect of an offender who is:</b>	Convicted of an offence punishable with imprisonment
<b>If the court is of the opinion</b>	<p><u>That the mental condition of the offender is such that it requires and offender suffers from a medical</u> is susceptible to treatment but does not warrant detention under a hospital order.</p> <p>The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order—</p> <p>(a) treatment as a resident patient in a care home an independent hospital or a hospital within the meaning of the Mental Health Act 1983, but not in hospital premises where high security psychiatric services within the meaning of that Act are provided;</p> <p>(b) treatment as a non-resident patient at such institution or place as may be specified in the order;</p> <p>(c) treatment by or under the direction of such registered medical practitioner or registered psychologist (or both) as may be so specified;</p> <p>but the nature of the treatment is not to be specified in the order except as mentioned in paragraph (a), (b) or (c).</p>
<b>And the court is satisfied</b>	That arrangements have been or can be made for the treatment to be specified in the order and that the offender has expressed a willingness to comply with the requirement.

- MHTRs provide a useful option for offenders to receive treatment who would otherwise not qualify for treatment under the Mental Health Act 1983
- 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.
- Courts may also wish to consider a drug rehabilitation requirement and/or an alcohol treatment requirement in appropriate cases.
- A community order with a MHTR may be appropriate where the offence is not serious enough to cross the custody threshold, and the defendant's culpability is substantially reduced by their mental state at the time of the commission of the offence, and where the public interest is served by ensuring they continue to receive treatment.
- Even when the custody threshold is crossed, a community order with a MHTR may be a proper alternative to a short or moderate custodial sentence
- A MHTR is not usually suitable for an offender who is unlikely to comply with the treatment or who has a chaotic lifestyle.

<b>Hospital order (section 37 Mental Health Act 1983)</b>		
<b>May be made by:</b>	A magistrates' court or Crown Court	
<b>In respect of a defendant who is:</b>	<i>Where made by a magistrates' court:</i>	<i>Where made by the Crown Court:</i>
	Convicted by that court of an offence punishable on summary conviction with imprisonment, or Charged before that court with such an offence but who has not been convicted or whose case has not proceeded to trial, if the court is satisfied that the person did the act or made the omission charged	Convicted before that court for an offence punishable with imprisonment (other than murder)
<b>If the court is satisfied</b>	On the written or oral evidence of two doctors, at least one of whom must be approved under section 12, that <ul style="list-style-type: none"> <li>• the offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment, and</li> <li>• appropriate medical treatment is available.</li> </ul>	
<b>And the court is of the opinion</b>	Having regard to all the circumstances, including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with the offender, that a hospital order is the most suitable method of dealing with the case	
<b>And it is also satisfied</b>	On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case, or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the period of 28 days starting with the day of the order.	

A hospital order is, [essentially](#), an alternative to punishment. The court may not, at the same time as making a hospital order in respect of an offender, pass a sentence of imprisonment, impose a fine or make a community order, a youth rehabilitation order, or a referral order. Nor can the court make an order for a young offender's parent or guardian to enter into a recognizance to take proper care of and exercise proper control over the offender. The court may make any other order which it has the power to make, eg a compensation order.

A hospital order made **under s37** (without a restriction order) [authorises the detention of the patient in hospital for medical treatment](#)

- Discharge from the order can be made by the responsible clinician (RC) or the hospital at any time. [The order initially lasts for six months but can be renewed by the hospital for a further six months and then for a year at a time if the conditions for making the order are still satisfied. There is no limit to the number of times that the order can be renewed.](#)
- The patient can apply to the tribunal<sup>7</sup> for discharge after six months and annually thereafter.

<sup>7</sup> First Tier Tribunal (Mental Health) in England and the Mental Health Review Tribunal in Wales

- The RC can authorise a leave of absence for a limited period or indefinitely; such leave can be subject to conditions and the patient can be recalled at any time if the RC considers it necessary in the interests of the patient's health or safety or for the protection of other people (the order can be renewed during a period of absence if hospital treatment remains necessary).
- The RC can make a Community Treatment Order (CTO) which allows for the patient to be treated in the community but provides for recall to hospital if needed to ensure that the patient receives the treatment needed. ~~The hospital order is in effect suspended while the CTO is in force so it does not need to be renewed.~~ The CTO lasts for an initial six months and can be extended for a further six months and annually thereafter.

<b>Restriction Order (section 41 Mental Health Act 1983)</b>	
<b>A restriction order (section 41) may be imposed by the Crown Court where a hospital order has been made and:</b>	
<b>If</b>	At least one of the doctors whose evidence is taken into account by the Court before deciding to give the hospital order has given evidence orally
<b>And, having regard to</b>	<ul style="list-style-type: none"> <li>• the nature of the offence</li> <li>• the antecedents of the offender, and</li> <li>• the risk of the offender committing further offences if set at large</li> </ul>
<b>The Court thinks</b>	It necessary for the protection of the public from serious harm for the person to be subject to the special restrictions which flow from a restriction order

A restriction order lasts until it is lifted by the Secretary of State under section 42, or the patient is absolutely discharged from detention by the responsible clinician or hospital managers with the Secretary of State's consent under section 23 or by the Tribunal under section 73.

While the restriction order remains in force, the hospital order also remains in force and does not have to be renewed.

- The Secretary of State for Justice (SoS) can lift the restriction order at any time if satisfied that it is no longer necessary to protect the public from serious harm. A patient who is still in hospital when the restriction order is lifted is treated as if admitted under a hospital order on the day the restriction order ended. A patient who has been conditionally discharged from hospital will be automatically discharged absolutely on that date.
- A restricted patient may not be discharged, transferred to another hospital or given leave of absence by the responsible clinician (RC) or hospital without the SoS's consent. Either the RC or the SoS can recall a patient from leave.
- The SoS has the power to discharge the patient conditionally or absolutely.
- The Tribunal has no general discretion to discharge restricted patients but must discharge patients who are subject to a restriction order (other than patients who have been conditionally discharged and not recalled to hospital) if it is not satisfied that the criteria for continued detention for treatment under a hospital order are met.

- The discharge must be conditional, unless the Tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment, i.e. to be made subject to conditional discharge.
- Where the Tribunal is required to discharge a restricted patient conditionally it may, but does not have to, impose conditions with which the patient is to comply. The SoS may impose conditions and vary those imposed by the Tribunal.

<b>Hospital and limitation directions (section 45A Mental Health Act 1983)</b>	
<b>May be given by:</b>	Crown Court
<b>In respect of a person who is</b>	Aged 21 or over and convicted before that court of an offence punishable with imprisonment (other than murder)
<b>If the court is satisfied</b>	On the written or oral evidence of two doctors, at least one of whom must be approved under section 12, and at least one of whom must have given evidence orally, that: <ul style="list-style-type: none"> <li>• the offender is suffering from mental disorder of a nature or degree which makes it appropriate for the offender to be detained in a hospital for medical treatment, and</li> <li>• appropriate medical treatment is available</li> </ul>
<b>And the Court</b>	Has first considered making a hospital order under section 37, but has decided instead to impose a sentence of imprisonment
<b>And it is also satisfied</b>	On the written or oral evidence of the approved clinician who would have overall responsibility for the offender's case or of some other person representing the managers of the relevant hospital, that arrangements have been made for the offender to be admitted to that hospital within the 28 days starting with the day of the order.

This so-called 'hybrid order' enables the court to combine a hospital order with restrictions with a prison sentence. A hospital direction is a direction for a person's detention in hospital. A limitation direction is a direction that they be subject to the special restrictions in section 41 of the Act which also apply to people given restriction orders. A hospital direction may not be given without an accompanying limitation direction (although, as described below, a hospital direction may remain in force after the limitation direction has expired).

- A limitation direction ends automatically on the patient's 'release date'. The patient's release date is the day that the patient would have been entitled to be released from custody had the patient not been detained in hospital. Discretionary early release such as home detention curfew is not taken into account. For these purposes, any prison sentence which the patient was already serving when the hospital direction was given is taken into account as well as the sentence(s) passed at the same time as the direction was given. The effect of this is that the limitation direction will end at the halfway point of a determinate sentence.
- If the patient is serving a life sentence, or an indeterminate sentence, the release date is the date (if any) on which the person's release is ordered by the parole board.
- Although the limitation direction ends on the release date, the hospital direction does not. So if patients are still detained in hospital on the basis of the hospital direction on their release date, they remain liable to be detained in hospital from then on like unrestricted hospital order patients. This includes patients who are on leave of absence from hospital on their release date, but not those who have been conditionally discharged and who have not been recalled to hospital.
- Unlike hospital order patients, hospital and limitation direction patients are detained primarily on the basis of a prison sentence. While the limitation direction remains in

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

- the offender no longer requires treatment in hospital for mental disorder, or
- no effective treatment for the disorder can be given in the hospital in which the offender is detained.
- When notified in this way by the responsible clinician, or any other approved clinician, the SoS may:
  - direct the offender's removal to a prison (or another penal institution) where the offender could have been detained if not in hospital, or
  - discharge the offender from the hospital on the same terms on which the offender could be released from prison.
- If the Tribunal thinks that a patient subject to a restriction order would be entitled to be discharged, but the SoS does not consent, the patient will be removed to prison. That is because the Tribunal has decided that the patient should not be detained in hospital, but the prison sentence remains in force until the patient's release date.

<b>Committal to the Crown court (section 43 Mental Health Act 1983)</b>	
<b>A magistrates' court may commit a person to the Crown Court with a view to a restriction order if (s43(1))</b>	
<b>The person</b>	Is aged 14 or over, and
	Has been <b>convicted*</b> by the court of an offence punishable on summary conviction by imprisonment
<b>And</b>	The court could make a hospital order under section 37
<b>But having regard to</b>	The nature of the offence The antecedents of the offender, and The risk of the offender committing further offences if set at large
<b>The court thinks</b>	That if a hospital order is made, a restriction order should also be made.

\*Note: there is no power to commit to the Crown Court for a restriction order where a magistrates' court has made a finding that a defendant has done the act/made the omission charged under s 37(3) MHA.

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

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

<b>Guardianship order (section 37 Mental Health Act 1983)</b>		
<b>May be made by</b>	a magistrates' court or the Crown Court	
	where made by a magistrates' court	where made by the Crown Court

<b>In respect of a person who is aged 16 or over and who is</b>	convicted by that court of an offence punishable (in the case of an adult) on summary conviction with custody or charged before (but not convicted by) that court with such an offence, if the court is satisfied that the person did the act or made the omission charged	convicted before that court for an offence punishable with imprisonment (other than murder)
<b>if the court is satisfied</b>	on the written or oral evidence of two doctors, at least one of whom must be approved under section 12, that the offender is 16 or over, and is suffering from mental disorder of a nature or degree which warrants the offender's reception into guardianship under the Act	
<b>and the court is of the opinion</b>	having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with the offender, that a guardianship order is the most suitable method of dealing with the case	
<b>and it is also satisfied</b>	that the local authority or proposed private guardian is willing to receive the offender into guardianship	

Guardianship enables patients to receive care outside hospital where it cannot be provided without the use of compulsory powers. The Act allows for people ('patients') to be placed under the guardianship of a guardian. The guardian may be a local authority, or an individual ('a private guardian'), such as a relative of the patient, who is approved by a local authority. Guardians have three specific powers: residence, attendance and access.

- The *residence power* allows guardians to require patients to live at a specified place.
- The *attendance power* lets guardians require the patient to attend specified places at specified times for medical treatment, occupation, education or training. This might include a day centre, or a hospital, surgery or clinic.
- The *access power* means guardians may require access to the patient to be given at the place where the patient is living, to any doctor, approved mental health professional, or other specified person. This power could be used, for example, to ensure that patients do not neglect themselves.

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