Mental health and the criminal justice system

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Police responses to allegations of criminal offences by or against vulnerable people should be governed by principles of equal access to justice.

Responding to mentally vulnerable victims

People with mental health issues and learning disabilities, because of their conditions, may be at greater risk of becoming victims of crime, especially those with severe mental illnesses (**Victim support report** 2013).

A victim or witness with mental ill health or learning disabilities should have equal access to justice and be treated with respect and dignity. Their ability to report crime and have that investigation carried out fully must not be prejudiced by their additional needs. Officers and staff should not assume that mental ill health in any way equates to the potential unreliability of that person as a victim or witness. If the police took this approach, it may amount to a violation of the **European Convention on Human Rights** (**B v DPP, 2009**).

Referral

Police forces should ensure that arrangements are in place to refer vulnerable people to appropriate services for assessment and support. They should support vulnerable victims and witnesses in making complaints of criminal offences. They should also consider referral to healthcare and support services whenever mental vulnerability is identified. A referral for an assessment of medical and social care needs may happen irrespective of whether or not a report will lead to a criminal prosecution or any other form of policing outcome (see **Referral for assessment of needs under the Care Act 2014**).

Investigation

Forces must ensure that mechanisms exist for vulnerable people to report crimes. They should also ensure that investigations are as thorough as they would be for others, without assumptions about reliability. Research (**Victim support report** 2013) indicates that offences against people who are mentally disordered are less likely to lead to a criminal justice disposal and the attrition rate is poorer than the norm at both the police and Crown Prosecution stages.

Officers should assess a victim or witness's suitability to give evidence on a case-by-case basis, as with any other potential witness, both in terms of the potential quality of the evidence and the impact on their ongoing health.

The **Youth Justice and Criminal Evidence Act 1999** allows for all vulnerable and intimidated witnesses to be supported through the criminal justice process by accessing special measures when giving evidence. While some aspects of an individual's condition may affect the person's ability as a victim, witness or suspect, officers and staff should recognise and manage this in an informed way.

Participation in the criminal justice system is known to be a stressor that can aggravate mental distress and ill health (**Peay 2010**). When interviewing witnesses and taking statements, officers should seek advice and assistance from carers, appropriate adults and medical professionals as appropriate (see **Special measures for vulnerable and intimidated witnesses**).

Hate crime

When investigating reports of crime against people who are mentally vulnerable, officers should consider the possibility that people have been targeted because of their vulnerability. Where officers suspect this, they should manage the incident according to force procedure for investigating and prosecuting disability hate crime (mental health problems are recognised as a disability). The impact of offences and a victim's perception of their experiences should also be reflected in a victim impact statement.

For further information see:

- **authorised professional practice (APP) on Hate crime** (**College of Policing (2014) Hate Crime Operational Guidance)**
- **APP on Vulnerable adults** (**ACPO (2012) Guidance on Safeguarding and Investigating the Abuse of Vulnerable Adults**)

Witnesses who are mentally vulnerable

The Youth Justice and Criminal Evidence Act 1999 includes some provisions that allow investigators to support witnesses who are vulnerable (or intimidated) in the same way that officers may refer vulnerable victims of hate crime. Support may come from professionals such as NHS community mental health services or from third sector organisations (for example, **Mind**).

Suspects with mental ill health and vulnerabilities

The relationship between mental health and criminal offending is complex. A mental disorder may directly cause someone to offend, or play no significant part in their offending behaviour. In cases of serious illness, patients experiencing delusions or hallucinations may perceive people as posing a serious threat to them, when in fact none exists. This can account for why a vulnerable or distressed person might attack others, believing it to be a form of self-defence.

NICE guidelines on violence and aggression suggest that just 10% of offences are causally connected to a mental disorder. The remainder may be unrelated or at best play a contributory role without negating the potential for someone to be held criminally liable.

Special provisions for vulnerable suspects can be found within the following sections of the **APP on Detention and Custody APP**:

- **Management and supervision**
- **Monitoring, observing and engaging**
- **Condition of the detainee**
- **Signs indicating increased risk**
- **Medication**
- **Medical emergencies**
- **Appropriate care**
- **Case notes**
- **Supervision and security in hospitals**
- **Police supervision**
- **Increased risk of self-harm post-interview**
- **Detainee risk assessment while outside custody**
- **Welfare and safety**

- Diversion and referral
- Triggers for referral
- Benefits of diversion
- Care pathways out of custody
- Fit to be interviewed

Liaison and diversion services

Liaison and diversion (L and D) is a process whereby people of all ages with mental health problems, a learning disability, substance misuse problems and other vulnerabilities are identified and assessed as early as possible as they pass through the youth and criminal justice systems (**Liaison and Diversion Operating Model**). Individuals can then be diverted towards health and social care services that may support their needs.

Diversion should be interpreted in its wider sense, referring to diversion out of and within the youth and criminal justice systems. Criminal justice system contact points include police custody suites and courts.

L and D services allow for screening of those who are arrested and better information sharing between the police and the NHS. Services encourage early identification of people in police custody who may have unmet needs. L and D also aids the exchange of information between the police and support services and may help reach an appropriate criminal justice disposal decision and provide appropriate health and social care services.

As people may be detained by the police throughout the day and night, it is important to the effectiveness of L and D schemes that out-of-hours provision is available overnight and during the weekends. Police use of timely referral to L and D services at the point of release from custody and case disposal is designed to support vulnerable members of the community and encourage desistance from crime.

Street triage and L and D services

Forces that use a ‘street triage’ service to support their response to mental health-related incidents should consider the way in which any street triage schemes and L and D services operate alongside each other.

There is a natural overlap in their work and such schemes usually operate at different times of the day. It may be possible for both street triage and L and D services to assist investigating officers and local mental health care services through enhanced information exchange.

Investigation

Investigating officers should recognise that the law presumes all suspects to be sane and to be legally accountable for their actions, unless the contrary is proved in court. This is an underlying principle of the criminal justice system (as outlined in the M'Naughten rules on insanity).

M'Naughten rules on insanity

The M'Naughten rule is a test for criminal insanity. It states:

> *'at the time of the committing of the act, the party accused was labouring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.'*
>
> **Queen v M'Naughten, 8 Eng. Rep. 718 (1843)**

The police must record all allegations of crime and incidents in accordance with **Home Office Counting Rules**. They should always investigate suspects for their potential liabilities following allegations against them.

All available information should be considered during any criminal investigation before deciding on the outcome (whether determined by the police or by the Crown Prosecution Service). When deciding on whether or not it may be appropriate to charge a mentally ill or vulnerable person with an offence investigators should consider (as a guide) that the more serious the offence, the more appropriate it is likely to be to consider prosecution for the crime involved. This level of additional consideration is supported by **Home Office circular 66/1990**.

Home Office circular 66/90 Provision for mentally disordered offenders

Home Office circular 66/90 requires that officers and staff consider diversion for offenders who are mentally disordered before making a decision on charging. Offenders who are mentally disordered should, wherever possible, receive health and social care as an alternative to being punished by the criminal justice system.

Diversion of this type requires the police and health and social care agencies to collaborate, and may involve:

- removing the suspect to a health-based place of safety under the **Mental Health Act 1983 (MHA 1983) s 136** for assessment and treatment
- arranging for an assessment of social care needs to be completed (see Care Act 2014)
- referring the suspect to L and D services
- facilitating the person's voluntary admission to hospital

Bail during mental health assessment

It may be appropriate to keep a suspect who has been diverted to hospital for assessment under the MHA 1983 on police bail while in hospital, until the investigating officer is able to access all available information that might support a decision to charge the suspect.

When more information becomes available, bail may then be cancelled for those suspects. This approach means that a charge and prosecution for the offence can be progressed if appropriate (for example, if it later emerges that the suspect's condition was not relevant because the behaviour was solely due to substance abuse).

This approach serves to prevent a situation in which a suspect who has been diverted to a hospital and assessed while detained under the MHA 1983 **s 2** or **s 3** is then released without a criminal justice sanction despite health staff concluding that they do not have a mental health disorder that prevents the criminal justice system holding them to account.

Evidential considerations

Evidence to prove the mental element of an offence should be gathered in the normal way – see **APP on Investigative strategies**.

As with any criminal offence, guilt is proven by demonstrating the actus reus (**criminal act**) and the associated mens rea (**criminal intent**). Mens rea is a different thing to a presumption of sanity. When investigating offences in which the suspect may be experiencing mental ill health or is mentally disordered, investigators should gather evidence that supports an understanding of the suspect's background and mental health at the time of the incident. This will support decision making around whether it is in the public interest to prosecute.

Background information (for the CPS)

The Director of Public Prosecutions has issued **guidance on Mentally Disordered Offenders** outlining the background information that the Crown Prosecution Service (CPS) require prior to considering prosecution.

In addition to a Police National Computer (PNC) check for convictions, investigating officers may wish to understand:

- any previous diversions from justice following offences that were not prosecuted
- if a patient has disengaged from care after diversion and then offended on a second or subsequent occasion (this may influence whether a diversionary approach is appropriate)
- It is rarely necessary to have expert psychiatric opinion about a suspect prior to making a charging decision, and a written statement from a psychiatrist will not always be required

Mental capacity concerns

The legal concept of 'capacity' is often considered in relation to the prosecution decision. Specifically, does a patient have the capacity to form the mens rea of an offence?

It is not necessary at the investigation stage, however, to pre-empt or predict the question of whether or not a particular suspect would be fit to plead or stand trial at court.

It is appropriate to commence an investigation on the legal presumption that everyone who is accused of an offence is presumed to be sane and able to be held responsible in law for their actions, until this is challenged in court. The evidential test will be applied by the CPS, which will consider questions of intent and recklessness.

Prosecution decisions

Initially, police officers are required to consider whether there is enough evidence to charge the suspect. To the extent that they are able to use discretionary decision making for summary offences, they may also consider out-of-court disposal options such as cautioning. It is also important that L and D services are able to share information to balance the various considerations. The evidential test must then be considered and applied by the CPS, which will be required to consider how a suspect's cognitive state may affect their criminal liability.

Any decision taken by the CPS to prosecute a 'mentally disordered or otherwise mentally vulnerable' (MHA 1983) suspect will be considered in the normal way, against the framework set out in the **CPS Code for Crown Prosecutors**. The CPS code outlines that a suspect's mental health is just one important factor to be considered in a range of issues which must be weighed in each individual case. There may be circumstances, however, in which the purpose or value of prosecuting a vulnerable adult is considered to be low, and not in the interests of the public or justice.

For further information see **Strategic oversight and management**.

Diversion from prosecution

In reaching decisions about whether to institute an out-of-court disposal for an offence, officers should consider the suspect's level of vulnerability. Someone's mental health problems could suggest that prosecution would be inappropriate (for example, when someone is acutely unwell and the offence is trivial).

In such situations, **Home Office circular 66/1990** advocates diverting offenders from the justice system where this is consistent with public safety and where it is more likely to lead to recovery and rehabilitation.

Officers should seek the support of an appropriate adult as necessary to help formalise the outcome of the investigation. They should still consider whether to refer the person (with their consent) to any professionals providing care and support or any third-sector organisation.

In situations where there is a risk to public safety (public protection issues), however, prosecution may still be the most effective way to ensure appropriate management of an individual.

For further information see **Strategic oversight and management**.

When prosecution is appropriate

Police officers and the CPS should be aware that certain powers and protections under MHA 1983 can only be instigated by criminal courts. Prosecution will be appropriate when criminal courts are best placed to weigh the full context and circumstances of a particular case, in the light of full psychiatric reports.

Prosecution may be necessary for more serious offences, even where vulnerable suspects are potentially seriously unwell. A suspect may be likely to succeed in putting forward a defence of insanity or be found unfit to plead. If the offence is one that would require the public to be protected from a serious risk posed by the defendant, however, then the investigating officer should consider the evidence and benefits of a prosecution.

Defendants who are charged but subsequently found insane or unfit to plead or stand trial may leave the criminal justice system without being convicted of offences. They may still be subject to the range of restriction and hospital orders available under the **MHA 1983 Part III**.

Prosecution might enable services to deal effectively with the risk posed by a violent or sexual offender, and ensure that they can be better managed following discharge than would otherwise be the case.

Hospital orders

A hospital order is a court order made under **MHA 1983 s 37**, generally after conviction in the criminal courts. The conviction would ordinarily result in sentencing under the following.

- **Section 1(2B)** or 1A(5) of the Prevention of Crime Act 1953.
- Section 51A(2) of the **Firearms Act 1968**.
- **Section 139(6B)**, **139A(5B)** or **139AA(7)** of the Criminal Justice Act 1988.
- Section 110(2) or **111(2)** of the **Powers of Criminal Courts (Sentencing) Act 2000**.
- **Section 224A** of the **Criminal Justice Act 2003**.
- **Section 225(2)** or **226(2)** of the Criminal Justice Act 2003.
- **Section 29(4)** or **(6)** of the Violent Crime Reduction Act 2006 (minimum sentences in certain cases of using someone to mind a weapon).

The court may by order authorise admission to, and detention in, a specified hospital. The court may also place the subject under the guardianship of a local social services authority or another person approved by a local social services authority.

Restriction orders

The crown court can impose a **restriction order** under the **MHA 1983 s 41**. Patients subject to a restriction order are known as **restricted patients**. The restrictions set out in this section can be applied to the following patients.

- **Section 37** (**hospital order**) patients – only the crown court can impose a restriction order for these patients. In deciding whether to impose a restriction order, the judge will consider the nature of the offence, the offender's criminal record and the risk of further offences being committed if they are released (see **s 41**(1)).
- **Section 47** prison transfer patients (the restrictions are imposed via section 49) – in this case the restrictions (on a determinate sentence only) end on the prisoner's non-parole date. The Home Office almost always imposes the restrictions, unless the patient is near the end of their sentence (and therefore would soon cease to be subject to the conditions anyway).
- **Section 45A** hospital direction patients – in these cases the restrictions are always imposed via a limitation direction.
- Patients sectioned under the **Criminal Procedure (Insanity) Act 1964.**

Part III of the MHA 1983

- **Section 35** allows for a defendant to be remanded to hospital for psychiatric reports and treatment. A court may impose more than one period of detention under the section. An accused person cannot be remanded under this section for more than 28 days at a time or for more than 12 weeks in all (s 35(7)). This may be imposed by a magistrates' court after a trial or a crown court after first appearance.
- **Section 36** allows for a hospital remand for treatment only – there may be more than one period of detention. This may be imposed by a magistrates' court after a trial or a crown court after first appearance. An accused person cannot be remanded or further remanded under this section for more than 28 days at a time or for more than 12 weeks in all (s 36(6)).
- **Section 37** allows a magistrates' court or crown court to impose a hospital order (see Hospital orders).

- **Section 38** allows for an interim-hospital order – this allows a 12 week period to determine whether or not it would be appropriate for the court to impose a hospital order as the appropriate sentence in a particular case. This may be renewed for further periods of not more than 28 days at a time (if it appears to the court, on the written or oral evidence of the responsible clinician, that the continuation of the order is warranted).
- **Section 41** allows a crown court to 'restrict' a hospital order – this means the court has determined that the defendant poses a risk of serious harm to the public, and the psychiatrist in charge of the restricted patient's care is prevented from taking decisions about transfer, leave or discharge. Such decisions must first be approved by the Ministry of Justice.
- **Section 42** (conditional discharge) allows for a restricted patient to be discharged into community mental health care services, subject to certain conditions. The subject remains liable to be recalled to hospital if it is deemed necessary because of concerns about public safety.
- **Section 45A** (known as a 'hybrid' order) – this criminal sentence imposes a period of hospitalisation in the first instance with an overall sentence timescale. If the person's treatment in hospital concludes prior to the sentence expiring, any remaining part of the sentence is served in prison.
- **Section 47** (a transfer direction) – this allows for convicted prisoners to be moved from prison to hospital if their mental health deteriorates while in prison or if the person is unwell when they arrive at prison.
- **Section 48** (a transfer direction) – this allows for non-convicted prisoners and others such as immigration detainees to be transferred to hospital.
- **Section 49** (a restriction direction) – this allows for those transferred under the MHA 1983 s 47 or s 48, which has the same effect as a restriction order under s 41.
- **Section 50** provides the power to remit a transferred prisoner back to the prison estate if their period of treatment in hospital has concluded before their sentence or their time in detention expires.
- **Section 55** provides a definition of a 'place of safety' in the context of managing patients concerned in criminal proceedings and allows the courts to remand a defendant in a 'place of safety' pending their admission to hospital under s 35-38. In this context, 'place of safety' has a different definition to that contained in MHA 1983 s 135(6) and includes a prison, a police station or any hospital where the manager is willing.

Insanity and fitness to plead

Considerations of whether a defendant could be found legally insane or would be found unfit to plead are for the courts and not necessarily relevant to police prosecution decisions where offences are serious. Where less serious offences are committed, diversion from justice should be considered, as outlined above.

It can be lawful and necessary to prosecute a vulnerable suspect in the criminal courts to allow the courts to reach fully informed conclusions about context, background and risks to individual incidents. Where a defendant has been prosecuted, any suggestion of insanity or unfitness to plead can be determined by the courts in front of a jury.

A defendant will be considered unfit if they cannot:

- understand legal proceedings
- instruct their legal representatives
- challenge a jury

A finding of unfitness can then lead to a so-called ‘trial of the facts’ under the **Criminal Procedure (Insanity) Act 1964**. The defendant can be found legally insane if they demonstrate to the court that they did not know what they were doing or did not know what they were doing was wrong (as set out in the M’Naughten Rules in 1843). If a court is satisfied that a defendant did the acts or omissions they are accused of, then they have powers to impose a (restricted) hospital order, a supervision order or an absolute discharge.

As part of a community sentence, courts may also impose a ‘mental health treatment requirement’. Consideration by investigating officers in partnership with health services may identify some suspects who could benefit from such orders. Officers may mention this on the MG6 in the event that a court is required to take a sentencing decision.

Offences within psychiatric inpatient units

Nothing in law prevents the criminal prosecution of someone who is an inpatient in a mental health hospital where there is evidence of an offence and where it is in the public interest to charge the suspect.

In responding to allegations made by staff in a psychiatric inpatient unit, officers should consider the following principles:

- Officers should not presume that a mental health problem or even the fact of someone's detention in hospital under MHA 1983 will mean that a suspect did not understand their actions or that what they were doing was wrong.
- Officers should secure evidence in the normal way and seek as much background information and professional opinion as possible on the patient and their relevant history (see **Evidential considerations**).
- NHS staff may have experienced violence from a particular patient on a number of occasions before deciding to report it to the police and any escalating pattern of behaviour may help the investigating officer or inform the CPS public interest decision.

Arrest decisions in psychiatric inpatient wards

As a general rule, it is not appropriate to arrest mental health inpatients and remove them to custody. Where this action is considered to be justified under the **Police and Criminal Evidence Act (PACE) s 24**, the same caution should be applied to the decision to arrest any hospital inpatient who is receiving ongoing treatment and care.

Any decision to arrest a hospital inpatient should be taken in conjunction with health staff and, in particular, the responsible doctor for the patient concerned. NHS organisations will continue to bear a duty of care to the patient who remains liable for detention under MHA 1983 while they are also under arrest.

Mental health staff often seek police support in connection with safety, as opposed to making an allegation of crime.

Practical considerations

- Officers lawfully on hospital premises still have the power (under **PACE s 19**) to seize evidence in connection with offences.
- Forces should consider making interview equipment available so that patients accused of offending can be interviewed in hospital. This makes it easier to coordinate the availability of an appropriate adult and for solicitors representing suspects to discuss things with those clinicians providing care.

Tags

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