Hybrid justice: proposals for the mentally disordered in the Crime (Sentences) Bill

The ethical, legal and health service cost implications

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The Government's Crime (Sentences) Bill, which is currently passing through Parliament, is highly controversial. One important reason is that it restricts Judges' freedom to dispense justice by taking account adequately of the individual circumstances of an offence and of the offender. There is particular judicial opposition to application of the mandatory life sentence on conviction of a second 'serious offence' ('two strikes and out'). This provision is directly relevant to mentally disordered offenders (MDOs). Also, embedded within the Bill, are new sentencing provisions specifically for MDOs which, together with the effect on MDOs of extension of the application of the mandatory life sentence, should be seen by clinicians and NHS managers as equally highly controversial.

The Bill introduces a new sentencing instrument for MDOs, a 'hospital direction', which will be applicable whether or not the defendant is liable for the new mandatory life sentence. This was initially proposed specifically and solely for psychopaths by the Reed Committee (Department of Health/Home Office, 1994), the recent important joint Department of Health and Home Office investigation into services for MDOs. It was intended to allow Courts who were faced with the uncertain treatability of any such defendants to make a prison sentence but coincidentally to make an immediate 'hospital direction', jointly called a 'hybrid order' by Reed. The MDO would go straight to hospital but, should he prove untreatable, or successfully finish treatment, he would then be remitted to prison for the rest of his sentence. The Home Secretary has adopted and substantially modified this sensible proposal, which was aimed at encouraging psychiatric services to 'have a therapeutic go' with psychopaths. In the Government's recent White Paper on Sentencing (Home Office, 1996), he announced his intention to introduce the hybrid order but said that it would be available to the Courts for *all* MDOs (including those with mental illness and mental impairment). Although the Crime (Sentences) Bill introduces the new 'hospital direction' (the hospital aspect of an effective hybrid order) initially only for psychopaths, it can be extended by Ministerial order to all MDOs once the cost to the NHS is better known, and this is clearly intended. Indeed in Scotland the 'hospital direction' will apply to all MDOs from the outset. Further, the main criteria on which Courts would decide to make hybrid orders would be 'punishment' and 'public protection' rather than 'uncertain treatability'. This apparently arose from Government concern that Mental Health Review Tribunals had the power, in the face of Home Office opposition, to discharge patients on (ordinary) hospital orders made by the Courts, this provision having been included in the Mental Health Act 1983 because of an earlier ruling of the European Court of Human Rights (1981). Clearly, the approach is also driven by publicity over homicides by psychiatric patients (Royal College of Psychiatrists, 1996), most notably Clunis (Ritchie *et al*, 1994), which have spawned the Government's provisions for supervised discharge (DoH, 1996), the Mental Health (Patients in the Community) Act 1995 and guidance on discharge (DoH, 1994). This is in spite of the great majority of psychiatric homicide cases having *not* been perpetrated by patients on hospital orders or by patients discharged by Tribunals (RCPsych, 1996).

The original proposal to introduce hybrid orders for all MDOs was strongly resisted by the Royal College of Psychiatrists (DoH, 1994) and by the Law Society. It was seen as bound to require doctors to give expert evidence towards determining: (1) whether a particular offence was determined by mental disorder; (2) the extent of 'partial culpability' of the defendant, and (3) the degree of public risk that the MDO presented. Thereby, doctors would be giving evidence which

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would be used by the judge directly towards determining the prison sentence or tariff. This raises profound ethical questions, because it implicates doctors in the very stuff of criminal sentencing (equivalent to American psychiatrists sometimes recommending the death sentence for defendants who they perceive as posing a future danger (Eastman & McInemy, 1997)). Indeed, the Bill itself is even more unethical in its implications for doctors in that patients will, after release from some sentences, be 'supervised' with a potential condition they take medication, on pain of imprisonment. Such a provision may well contravene the European Convention on Human Rights.

An analysis of the implications of hybrid orders for all MDOs for the Department of Health and the Home Office, now published (Eastman, 1996), also emphasises that such a proposal would, if used extensively by the Judges instead of ordinary hospital orders, result in Health Authorities funding MDOs in high, medium and low secure care, as well as ordinary psychiatric care, beyond when it was 'needed' for their health and, therefore, solely in order for patients to finish their prison sentences (albeit not in prison). Doctors would not be likely to send schizophrenic patients whose florid symptoms had been successfully treated but who remained with chronic disabilities of the illness to be cared for by still poorly resourced prison health care services (Squires, 1996), particularly given that prison doctors could not, in any event, impose continued medication. To send patients to prison in that way would often be unethical. Hence, secure beds will clog up and the culture of forensic psychiatric secure services will, over time, move towards an unhealthy emphasis on custody rather than therapy. That was something which, for decades, bedevilled the Special Hospitals (see, for example, the Ashworth Enquiry (DoH, 1992)) and from which they are only now beginning to emerge. Clogging up secure hospital beds will also inevitably increase the number of MDOs in prison, again recently demonstrated as still high (Birmingham *et al*, 1996; Brooke *et al*, 1996).

So although there might be jurisprudential logic in sentencing mentally ill or learning disabled defendants, most of whom have been found guilty of an offence (not 'insane'), it flies in the face of NHS common sense. It also flies in the face of repeatedly stated government policy on MDOs which emphasises, through the Care Programme Approach (DoH, 1990), that continuity of care from institution to community is good for the patient and safe for the public (DoH, 1994). Such continuity will be near impossible for MDOs who spend the latter part of their sentences on a hybrid order in a prison far flung from their psychiatric services and community. Far from increasing public protection, in the long run the effect will be to decrease it.

The hybrid order seems likely, therefore, to revolutionise services adversely for MDOs. However, the Bill proposes an *added* element, beyond that envisaged in the Home Office Consultation document, which is even more radical and deleterious in its effects. As already described, it proposes that the new mandatory life sentence for two serious offences will extend to *any* defendant, including any MDO. Hence, it will be impossible, bar in 'exceptional circumstances' (which do not include the defendant's mental disorder *per se*), for judges to send seriously mentally ill or learning disabled defendants to hospital on ordinary hospital orders who fall into that category. In England and Wales their access to hospital will have to rely on the vagaries of transfer from prison under Sections 47 and 49 of the Mental Health Act, dependent upon prison recognition of their disorder and Home Office approval of transfer. Hence, whereas previously only those MDOs convicted of murder, and who therefore attracted the already heavily criticised mandatory life sentence, were subject to this uncertain route, now very many more MDOs will be so caught. Indeed, one would expect a high proportion of all admissions to special hospitals, as well as to some medium secure services, to come in future not from the Courts but from the prisons. This would be in direct contradiction of the government's own policy that MDOs detainable under the Mental Health Act should *not* go to prison (DoH, Home Office, 1990), even *ab initio*. Such defendants will include severely psychotic or learning disabled patients, some of whom fall little short of being legally 'insane'. Even if such defendants are eventually able, in England and Wales, to be given 'hospital directions' alongside their mandatory life sentences, is that a proper judicial response to their condition and offence?

For centuries the Courts have adopted a humane approach to sentencing of the seriously mentally ill based on the notion 'the illness is punishment enough'. The Bill is a profound attack on that principle. The availability of ordinary hospital orders to 'second strike and out' MDOs will be immediate. Absurdly, in the first instance only psychopaths will be able (via a hybrid order) to receive some form of hospital disposal in England and Wales. Even the original 'Reed advantage', to psychopaths, of hybrid orders, allowing courts to make such orders in circumstances of uncertain psychopath treatability, has been written out of the Bill by requiring satisfaction of the usual criteria for detention under an ordinary hospital order (including treatability for those with 'psychopathic disorder' and 'mental impairment') before

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a 'hospital direction' can be added to a prison sentence. Only when hybrid orders become available to the mentally ill or learning disabled will it then be possible for them to avoid going to prison, by way of a hospital direction being drafted onto the mandatory life sentence.

The Reed Committee suggested a sensible minor addition to sentencing instruments which would have been available specifically to psychopaths, based on scientific uncertainty about treatability and on ambiguity about whether such defendants are 'mad' or 'bad'. The government has hijacked and distorted a sensible idea so that, in conjunction with greater general use of the mandatory life sentence, the numbers of mentally ill and learning disabled in prison will be greatly increased and many MDOs in secure hospitals will remain well beyond that period which is necessary for their health. Doctors should resist the proposals since they represent a requirement on psychiatrists to behave unethically in Court, by assisting directly in sentencing, and because they represent a break with a centuries old tradition of treating the mentally ill and disabled with humanity. These proposals are trebly dangerous. They are immoral, they will damage professional morale, and they will also be extremely expensive to the NHS.

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