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45 revolutions per minute: a qualitative study of Hybrid Order use in forensic psychiatric practice

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Abstract

Psychiatrists who recommend a Hybrid Order (Section 45A) as a disposal option at the point of sentencing in England and Wales accept that the convicted individual, as well as being mentally disordered and in need of treatment, is also culpable and deserving of criminal punishment. Ethical and clinical concerns have typically limited its clinical use. However, in 2015 the Court of Appeal specified in *R v Vowles and others* that the Hybrid Order disposal should be considered *first* in terms of potential mental health disposals. This judgement sets a high threshold for the use of the hospital order which has been the bedrock of inpatient forensic psychiatric practice since 1983. This study sought to explore the attitudes of consultant forensic psychiatrists towards the use of the Hybrid Order in the wake of the *Vowles* judgement. We interviewed 12 consultant forensic psychiatrists with longstanding experience of psychiatric sentencing recommendations. We found that the majority of consultants considered the Hybrid Order to be a valuable disposal option when used under specific circumstances. However, significant concerns were raised about its use in those with an enduring psychotic illness. Community aftercare arrangements for Hybrid Order disposals were viewed as inferior to community aftercare arrangements for Section 37/41 patients.

Keywords: hybrid order; hospital and restriction direction; Mental Health Act; culpability

Introduction

Mentally disordered offenders are categorically awkward; being neither exclusively ill nor uncomplicatedly bad, such offenders totter between two not always compatible discourses of state intervention (Webb & Harris, 1992).

The Hybrid Order (Section 45A) was inserted into the Mental Health Act (MHA) 1983 by the Crime (Sentences) Act 1997. The Order allows higher courts in England and Wales to direct psychiatric hospital admission for offenders facing sentences not fixed by law, whilst still imposing a prison sentence, after consideration of the sentencing recommendations made by doctors (typically forensic psychiatrists) trained and qualified in the use of the Mental Health Act 1983 ('section 12 approved'). The Hybrid Order is combined with a limitation direction for the duration of the sentence, with the convicted person subject to the restrictions set out in Section 41. If the available treatment in hospital is later deemed unsuccessful or if the individual's mental health improves to the point where hospital treatment is no longer required, then that person may be transferred to prison to serve the remainder of their sentence.

We have previously outlined the conceptual development of the Hybrid Order in comparison to its Scottish equivalent, Section 59A of the Criminal Procedure (Scotland) Act 1995 (Delmage et al 2015). We noted the modest increase in Hybrid Order uptake following the 2007 amendments to the Mental Health Act which expanded its potential use from just the legal category of psychopathic disorder to all categories of mental disorder. We concluded that no professional or legal guidelines existed at that time to help to structure professional

approaches to its recommendation or implementation. This changed with the Court of Appeal's consideration of the matter in *Vowles and others* (2015).

This judgement held that the Hybrid Order disposal should be considered *first* in terms of potential mental health disposals. The judgement set out four criteria which must be addressed when considering the appropriate disposal for a mentally disordered offender: (1) *the extent to which the offender needs treatment for the mental disorder from which the offender suffers*, (2) *the extent to which the offending is attributable to the mental disorder*, (3) *the extent to which punishment is required* and (4) *the protection of the public including the regime for deciding release and the regime after release*. A prison sentence component to the final disposal was viewed as desirable in terms of public protection. Release from prison on parole from life, indeterminate, extended or determinate sentences of four years or more is dependent upon the parole board being satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined. The released individual is made subject to a probation supervision regime which allows for recall in the public interest, when new offending behaviours or a pattern of concerning behaviour in the community suggest a recurrent risk of danger to the public. This was contrasted with the perceived greater dangers arising from a hospital disposal, where release is dependent upon the First Tier Tribunal being satisfied that the patient is no longer suffering from a mental disorder of a nature or degree which makes it appropriate for continued detention, or that it is necessary (inter alia) for the protection of others that the patient should continue to receive treatment. After a conditional discharge by the First Tier Tribunal, the community supervision regime could only effect recall when new offending behaviours or a pattern of concerning behaviour in the community were linked to a deterioration in mental condition.

The judgement stated that a hospital order *may* be appropriate where *the offending is wholly or in significant part attributable to that [mental] disorder*. It considered a representative example in which the Court was considering a life sentence. In the judgement's view, a Hospital Order (Section 37) is an appropriate disposal option if *(1) the mental disorder is treatable, (2) once treated there is no evidence that (s)he would be in any way dangerous and (3) that the offending is entirely due to the mental disorder*. The ruling also sought to discourage the use of the Interim Hospital Order (Section 38) disposal, which enables further clarification of the illness and potential response to treatment prior to final disposal. This was justified in terms of victim sensitivities (the Interim Order fails to enable 'closure'), costs (of bringing a case back to Court) and pressures on secure bed availability.

The ruling therefore has the potential to considerably reduce the number of 'pure' hospital disposals in the mentally disordered offender population: the pure therapeutic approach takes second place to a mixed precautionary-punitive approach (Peay 2016). Ministry of Justice figures suggest that the number of Hybrid Order disposals continues to increase (from 18 in 2013 to 25 in 2017) while the number of hospital order with restriction disposals declines (from 294 in 2013 to 266 in 2017) (gov.uk Offender Management Statistics, 2018).

We sought to explore forensic psychiatric attitudes to, and use of, the Hybrid Order in the wake of the *Vowles* ruling. It was hypothesised that clinicians would typically seek to recommend the Hybrid Order in cases of personality disorder or where a mental illness was not deemed to be of primary importance in the commission of the crime and that there would

be a degree of professional disquiet regarding the new primacy of the Hybrid Order as a disposal option.

Method

Participants 20 consultant forensic psychiatrists were identified using purposive sampling to ensure that those interviewed were experienced in making sentencing recommendations. A total of 12 participants were interviewed (eight males, four females). 10 consultants worked in London or its immediate environs; one in Manchester; and one in Brighton. Participants worked in a remand prison setting (two), the acute admission ward of a secure hospital setting (one high, six medium, one low secure) or a community forensic setting (two) to help to ensure that a full range of existing views were interrogated. The consultants had a mean age of 45 (range: 34-61), with an average of 13.5 years as a consultant (range: 1-27 years). On average, consultants had made approximately 25 sentencing recommendations in the 12 months before interview (range: 5-70, median = 18).

Research Team The research team consisted of a clinical academic in forensic psychiatry (NB), an experienced forensic psychiatrist (TE), a legal academic (JP), a final year higher trainee in forensic psychiatry (CM) and a postgraduate psychology student (VB).

Procedures This study was approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee at Kings College London (reference LRU-15/16-3486). Participants were recruited from February-July 2016. Following completion of informed consent, participants completed a semi-structured interview designed by the research team. This consisted of 34

open-ended questions designed to assess the consultant's knowledge of, and attitudes to, Hybrid Orders. The interview adopted the style of 'directed conversation' (Pidgeon & Henwood, 1997), and was employed flexibly in order to explore novel concepts that arose. Interviews took place at a location of the interviewee's choice. Interviews were conducted by two researchers (VB and CM) and lasted approximately 30-45 minutes. All interviews were audio-recorded and subsequently transcribed verbatim. No more interviews were conducted after the 12th as the research team unanimously agreed that a saturation point had been achieved when no new themes were emerging from the data.

Analysis The qualitative approach of thematic analysis (Ritchie & Spencer, 1994) was adopted in order to identify relevant themes within the data. For the analysis, data was organised using the qualitative software NVivo (QSR International, Version 11). The initial analysis was conducted by VB and involved data familiarisation/ immersion and seeking and reviewing patterns within the data, which were then defined and categorised as specific themes. This preliminary analysis was subsequently modified by the research team until a 'best fit' consensus was achieved. Researcher triangulation ensured that a range of perspectives were represented in the discussion and interpretation of the data. Conflicting data were actively sought in order to reduce the potential for the researcher's prior biases and opinions of the Hybrid Order to affect the results. Sub-themes were classified into three categories according to their prevalence: 'uncommon' (one to three psychiatrists), 'variant' (four to seven psychiatrists) and 'typical' (eight or more psychiatrists). The final analysis was presented in a masterclass format to forensic psychiatrists at their annual Royal College conference meeting in Madrid in March 2017 to help to ensure that the interpretations made by the research team had respondent validity.

Results

Thematic analysis yielded five main themes and numerous sub-themes. Quotations from the participant interviews are used to support and contextualise the findings below.

Theme 1: Appropriate scenarios for the recommendation of a s.45A disposal (see Table 1)

1.1. For specific mental disorders

1.1a Psychotic illnesses characterised by short periods of psychosis and prominent personality disorder and/or substance misuse comorbidities

All consultants believed that in such cases, the psychotic component could be successfully treated relatively quickly, but that the underlying personality pathology may not be responsive to treatment in hospital and that a return to prison would therefore be appropriate.

'... my thinking was that they would... improve in terms of their psychotic illness but still have underlying personality pathology that might be better off managed in the prison system...'

'...I think if issues such as personality disorder or substance misuse are significant contributing factors to the offending behaviour... the ones with a kind of dual diagnosis of mental illness and PD, often a triple diagnosis because of substance abuse... I think it's [section 45A] useful.'

1.1b Primary Personality Disorder

Many consultants also raised primary personality disorder (mainly cluster B type with antisocial and/or emotionally unstable features), with the rationale that the manifestations of their personality disorder may be partially responsible for the offence and that the offender may be reluctant to engage in treatment or unresponsive thereto.

'...people who have a personality disorder.... either primarily antisocial or borderline.'

'...there's real concern about the degree to which the [personality disordered] person might be able to make any therapeutic use of a hospital order...'

1.2. When the offender's culpability is such that a degree of punishment is warranted

Most of the consultants argued that section 45A is only appropriate when the individual's mental illness is not considered wholly responsible for their offending behaviour.

'...I think if they were culpable to a certain degree... could have made choices and didn't make them for reasons other than mental illness then there's a reason to choose punishment...'

'...say for example someone who's got a long history of robbing banks and associates with other bank robbers, but they happen to have schizophrenia. I think regardless of whether you treat the illness or not... the risk factors will be better managed by the criminal justice system and punishment may be a better deterrent than mental health treatment.'

1.3. For higher-order offences where an extended determinate or life sentence is likely

The majority of consultants agreed that section 45A should only be considered when the offence is of a serious nature likely to incur extended determinate or discretionary life sentences.

'... perhaps you should only recommend a 45a if there's a high likelihood of an extended determinate custodial sentence because the 37/41 is indefinite...if you're going to recommend a 45a for a short determinate sentence then someone's going to be eligible for release by the

time you get to the point of returning them to prison so it feels a bit pointless in those circumstances...'

1.4. When long-term mental health treatment is unlikely to be required

Several consultants noted that section 45A was suitable for offenders who had acute mental illnesses which would be unlikely to require ongoing mental healthcare.

'... [S45a is appropriate] for mentally ill patients, if at the time of sentencing the patient needs inpatient psychiatric treatment, but you don't think there's going to be a long-term treatment need.'

'...the patient was mentally ill, he was currently an inpatient, and there was a significant degree of collateral criminality....it was a brief acute psychotic episode ... I thought he was going to respond to treatment.... I thought he only had short term mental health treatment needs and didn't want to recommend a hospital order for them...'

Theme 2: Inappropriate Scenarios for a recommendation of s.45A (see Table 2)

2.1. When the offender has a primary or enduring psychotic illness

Many consultants argued that section 37 (often with restrictions) is more appropriate in order to manage the individual's mental illness and its associated risks.

'I just think it was a wrong (judicial) decision: this was a case of a patient who had no offending, no criminality whatsoever, he perpetrated an extremely violent homicide but very clearly related to his schizophrenia and very clearly had long term mental health treatment needs that needed to be carefully rehabilitated via the psychiatric services in the community,

but the judge gave a section 45a. The rationale seemed to just be the magnitude of the violence'

'...I think people with psychotic illness always need to be under a 37/41 and I think that's the safest way to manage them...'

'...I would not use 45a in someone who had a steadily deteriorating condition for whom the prognosis seemed to be poor, because they're more likely to require hospital in the longer term...'

2.2. When the offender's culpability is deemed to be low

Half of the consultants argued that section 45A was not suitable in scenarios where the mental disorder is deemed responsible for the offence.

'...the 37/41 should apply when the offending is clearly related to the mental illness...'

2.3. When the offender is considered to be particularly 'vulnerable' in a prison environment

The prison component of section 45A was viewed by a minority of consultants as potentially deleterious for specific 'vulnerable' groups of offenders.

'...they [the Tribunal] were also very concerned about him returning back to prison because they thought that he was a vulnerable person and... he'd go backwards if he was sent back to prison...'

Three main potential vulnerabilities were raised: enduring mental illness; relapse due to substance misuse and radicalization.

'... it's not part of our training generally to send people back to prison who we know are vulnerable, who have been very unwell. We know what the prison systems are like... they don't have the same sort of therapeutic environment...'

'...at the point [when] we send him back, even if he's done all the drug work, he would still be very vulnerable in prison because of the amount of drugs in prison... you could say well it's testing it out, if [the] treatment is effective, you know, he won't succumb in prison. But actually, you don't really want to put somebody in that position if you don't have to...'

'...the other worry about sending this patient back to prison is that I don't think he is radicalized now but I think he's at serious risk of becoming seriously disenchanted with the system and very vulnerable to radicalization...'

Theme 3: The perceived advantages of a s.45A disposal (see Table 3)

3.1. Section 45A avoids 'bed-blocking'

The majority of consultants highlighted the fact that section 45A may help to reduce the pressures on secure hospital bed provision by ensuring that those patients held to be failing to make progress due to lack of engagement with, or unresponsiveness to, treatment in a hospital environment can be returned to prison.

'The advantages are that you have a solution for those people who are no longer benefiting from treatment in hospital but are unlikely to be discharged by a tribunal because of risk. There are benefits to the running of your full, oversubscribed secure hospital so that you don't get people like that blocking beds...'

3.2. Section 45A may provide enhanced safeguards compared to a Hospital Order

A minority of consultants held that section 45A enhanced public protection. These potential benefits obtained from the mechanism determining release (Parole Board vs First Tier

Tribunal) and the process of supervision (probation service monitoring vs community forensic team monitoring).

'...[the parole board] have the power to take into account things beyond mental disorder and response to treatment and so on, when deciding whether to release someone. And also they have explicit power to keep people in prison for further rehabilitation, if they feel they're not yet ready to come out...'

Some consultants argued that probation supervision allows additional conditions to be imposed on the offender which the community mental health teams do not have the authority to impose. Such additional conditions promote greater protection of the public when mental illness is not the only factor contributing to risk.

'... coming back to my perspective as a community consultant, where there's a real likelihood that you'll be left with someone who poses a significant risk of harm to others but who nevertheless isn't progressing in hospital, needs to come out of hospital but how do you then keep society safe? There, I think it's very helpful to have the option of probation ...because they have the legitimacy and the tools in a way that we don't, when it's not a treatable medical condition that's causing the risk of harm...'

3.3. Benefits of combining healthcare and criminal justice services

A number of consultants suggested that combining the two services has benefits for both patients and the responsible psychiatrist. Some held that a Section 45A disposal would be preferable to a prison sentence for patients who have had a period of assessment in hospital but who do not meet criteria for a Hospital Order disposal:

'...you know if the alternative for some of these people would be a straight forward prison sentence. So [if] you're actually pulling them out of hospital at sentencing when their treatment may not be fully done... I think the 45a is preferable...'

One consultant also noted that a section 45A disposal may allow the patient to conceptually separate their time in hospital from their time in prison. The psychiatrist and patient were able to build a strong therapeutic relationship when the patient acknowledged that their period in hospital was for their own benefit (rather than to contain or punish them).

'I think there's a big advantage in being able to separate out the treatment of the health problem from managing the residual risk... for many of the patients we have to do both roles, which we can do, but when it's clearer that we really are here to try and help you feel better and function better, and its Joe over there who's going to be the one to wield the stick if you don't follow the rules, that makes it easier for us to have a strong therapeutic relationship.'

3.4. Offending behaviour may be better managed in prison

A minority of consultants felt that section 45A may be preferable for individuals with both mental health and offending behaviour treatment needs.

'...there's good evidence that the prison service can do reasonably well with offending behaviour programmes, forensic psychology and so on. You know, they have an evidence base... and we may not be able to manage the offending side of it as well in health services...'

Theme 4: The perceived disadvantages of a s.45A disposal (see Table 4)

4.1. No benefits of using section 45A over a section 47/49 hospital transfer order

A number of consultants revealed that their colleagues saw no advantage in using section 45A over a subsequent transfer of the sentenced prisoner to hospital under section 47.

'...I think my peers would prefer to be able to say 'right, give the person a prison sentence and then we can discuss with the prison the necessity for transfer under a 47.' So, I think there would be a group who can't really see the point of it from a psychiatric point of view... it doesn't really make any difference, whether someone was on a 47 or a 45a.'

4.2. The prospect of a return to prison limits potential therapeutic gains in hospital

Two sub-themes emerged.

4.2a The prospect of a return to prison is a potential deterrent to recovery

A number of consultants suggested that patients may not truly engage in therapy or seek meaningful recovery if they understand that their recovery means a return to prison.

'I think it's very hard for people to truly engage in treatment if [when] they get better, they're going to prison... that's a different quality of engagement because it's motivated by something other than wanting to get better...'

4.2b The prospect of a return to prison limits the progression of rehabilitation

Consultants highlighted that the progression of rehabilitation is limited on section 45A as the Ministry of Justice may not accept requests for community leave periods, which underpin wider aspects of rehabilitation such as securing sheltered housing, employment or other community structured activities.

'We were really keen to start to give him some escorted ground leave ... because we thought that was a very important step forward and part of it is testing out rehabilitation... and if he was to get a 45a, there was no way we were going to get the MoJ to agree to give him leave.'

And so he'd be very stuck and he'd find that very frustrating. And it would be quite anti-therapeutic we thought...'

4.3. Release and aftercare under section 45A is inferior to section 37/41

A main theme emerged that consultants believed that the release and community aftercare effected by probation services following completion of the s45A order had considerable disadvantages for mentally disordered offenders compared to the aftercare effected by community forensic services under section 37/41. Three subthemes emerged:

4.3a. Increased risk for the mentally disordered offender and the public when released from prison

Consultants expressed concerns that release processes from the penal system are riskier for the offender as they are not as robust as the resettlement programs on a section 37/41.

'...I think 37/41 and CPA processes back to the community are probably more robust than resettlement release processes from prison. We know that the period of release from prison is associated with a risk around self-harm/suicide/substance misuse/ relapse into mental illness and so on. Although we have the probation and community rehabilitation companies...unfortunately the join up between those and health [services] isn't as good as it could be...the ability to judge when it's safe for him to be released would also be better if this were done from hospital than through the penal system...'

4.3b. Lack of compulsory psychiatric care after release

Many consultants expressed concern that there was no guarantee that offenders would receive adequate mental health care after release from section 45A, whereas section 37/41 offers long-term psychiatric oversight under the auspices of a robust legal framework.

'...when he's released there is no guarantee that he will get any mental health team after his release. No way to compel a team, and also there's a likelihood that he'll go to some kind of probation run hostel which might have a mental health team attached to it... but it's not guaranteed, so I was more concerned about the lack of certainty... about the follow up for his mental illness...'

This was closely related to the need to manage the mental illness within the community in order to manage the risk for the protection of the public.

'... the main reason was unrelated to his immediate treatment, the main reason was about 10-15 years in the future when he was released. So my main concern with someone like him was that... of course there are other factors that contribute to violence, but if you're going to actually manage the risk of violence then the one thing you can really manage is the mental illness...'

4.3c. Community follow up is more complex

Consultants noted the complexities of managing the mental illness of the patient in conjunction with probation services.

'...The other reason that I don't like them hugely is community follow up... it's so much more complicated. If you have somebody who you know is going to need mental illness follow-up. ... a section 41 order where you know the relationship is very direct. It's you as a clinical supervisor and that patient. If something goes amiss you would recall that patient by virtue of

a letter to the Ministry of Justice. As compared to managing somebody through a probation office or on a probation service license, I think it's a much more complicated arrangement. it's not an arrangement that works very well in practice.'

Theme 5: Factors influencing the recommendation and use of s.45A (see Table 5)

5.1 Ethical Concerns

Two sub-themes emerged.

5.1a. The psychiatrist's circumscribed involvement in determining culpability and punishment

An ethical issue that was often raised was the idea that the psychiatrist was uncomfortably implicated in the punitive element of section 45A.

'...It's the idea that you as a psychiatrist are placing punishment on somebody...I think that that thinking still permeates forensic psychiatry and I think that people feel sometimes that they can't send patients back into the prison system because of its essentially punitive nature. Not that they can't, but that they're reluctant to. Or that the threshold for doing it would be quite high...'

However, many consultants highlighted the fact that that the psychiatrist's role was to provide information regarding the disorder's part in the offending behaviour, and the offender's health and risk, and that the Court ultimately makes the final sentencing decision regarding whether a punitive element to disposal is warranted.

'...psychiatrists are not making recommendations about punitive disposals, they're making health recommendations based on an assessment of risk, and it's up to the judge to pass a sentence. As long as you're clear that it's up to the judge to pass a prison sentence and that doesn't sit within the remit of psychiatry, then as far as I'm concerned the ethics are okay...'

5.1b. Considering instead of recommending section 45A

A number of consultants highlighted the fact that psychiatrists should consider section 45A instead of actively recommending the order.

'...I have discussed it rather than recommended it... I think the reason I am cautious in saying I recommend it is because I don't think a psychiatrist should ever recommend a custodial sentence... I mean I think you do have a role in explaining to the judge what the medical implications are of the alternative routes, so that they can then make the ultimate judgement... and its subtle but I think it's different from saying I recommend s45a...'

5.2. Lack of familiarity with section 45A and lack of outcome data

The majority of consultants argued that there is a reluctance to use section 45A because psychiatrists have less experience with the order compared to the more commonly used section 37 and are unsure of the section's therapeutic outcomes.

'...I think people are maybe a bit anxious about 45a, simply because they don't have the experience of using it. And there perhaps hasn't been enough discussion around... because people have seen so few cases. We haven't really built up a body of knowledge, particularly about what is the history... what's the course taken by these patients who get given a 45a, what's the outcome?'

5.3. Judicial pressures

A number of consultants explained that they had experienced novel pressures in court post *Vowles*. Two subthemes emerged:

5.3a. Pressure to consider 45A disposals

'...I routinely consider S45a now... just because I'm aware that the judges have it [the R v Vowles judgement] in their mind... [they're] looking at these things in the opposite way that we do. I think our view historically has been, the first thing you think of is a hospital order and they're looking at it from the point of view of... everyone should receive a kind of penal sentence unless there [are] very good reasons not to... [a hybrid order is] something that the judge would be thinking about even if it hasn't been raised as a possibility...'

5.3b. Pressures to restrict the usage of section 38

'...My experience is, judges are less and less willing to extend section 38 orders...in the legislation you can extend it up to a year but my experience is judges are very reluctant to extend it more than 3, 4, 5 months- they want an answer... you're sometimes forced, as I was in that case, to recommend a 45a...'

Discussion

This qualitative study suggests that forensic psychiatrists now consider that the Hybrid order has a potentially useful role as a disposal option at the time of sentencing, despite early professional concerns (Eastman, 1999). It has a role for offenders with personality disorders (in both primary and comorbid forms) due to the perceived uncertainty about therapeutic gains made by such patients in hospital settings. Psychiatrists typically held that offending behaviours are better managed in prison despite the existence of randomised controlled trial evidence that hospital rehabilitation programs such as Reasoning and Rehabilitation (Cullen et al. 2012) can be effective in the management of co-morbid antisocial behaviours. Further potential benefits of s.45A use include a period of assessment and treatment in hospital for

offenders who would historically have received a prison sentence alone and increased flexibility in managing patients who were not engaging optimally with hospital therapeutic regimens.

Psychiatrists questioned the notional superiority of risk management by the parole board and probation services for mentally disordered offenders and documented their concern about the lack of outcome data for the Hybrid Order Group. The optimal regime after release has received further judicial attention in the cases of *Ahmed* (2016) and *Edwards* (2018). In *Ahmed*, where a causal connection was posited between the individual's enduring mental illness (schizoaffective disorder) and violent offending behaviours, the judges held that public safety would be better secured by the regime under a restriction order than under the life licence regime. The system of monitoring under the latter regime was held to be '*much less close and much less frequent*' (paras 31-33); '*it is imperative that he is subject to appropriate expert supervision on his release and thereafter. This is not possible under S45A*' (para 35). However, *Edwards* subsequently held that public safety was *not* necessarily better secured by the conditional release regime of a s37/41 order in comparison to that of an offender on licence from a s45A, noting that '*each case turns on its own facts*' (para 34). The extant scientific evidence (Fazel et al, 2016) suggests that a hospital disposal is associated with reduced reoffending rates on ultimate release into the community in comparison to imprisonment and subsequent release. This finding holds when comparison is made between individuals with violent index offences, with prisoners with longer sentences as comparators, and when rates of violent reoffending are specifically examined. Rates of repeat offending are consistently lower in patients released from hospital in comparison to those released from prison. Such data are nowhere to be found in *Vowles* and subsequent judgements: it is a

judicial shibboleth that the Parole Board and probation supervision protect the public to a greater extent.

The majority of consultants appeared unperturbed by the increased need to consider culpability to inform a potential penal element when making sentencing recommendations. A minority of consultants were reluctant to recommend the section because they believed that individuals with mental illnesses should ideally not be in prison and felt uncomfortable about being involved in punitive decision making. However, other psychiatrists noted that disposal was ultimately a judicial decision and that their role in this process was defensible. Some consultants suggested that this ethical conundrum could be avoided by considering s.45A in their written and oral evidence rather than actively advocating for the imposition of the order. *Edwards* acknowledged that assessing culpability for a serious offence where the offender also has mental health problems *may present a Judge with a difficult task* (para 14). Nevertheless, the penal element has to be considered by judges in order to comply with the purposes of sentencing in s.142 of the Criminal Justice Act 2003 (which explicitly includes punishment) and the ruling in *Vowles*. However, the ruling in *Edwards* failed to note that s142 sentencing purposes explicitly do *not* apply when dealing with offenders under part 3 of the MHA 1983 (see CJA 2003 s.142 (2) (d)).

Half of the consultants interviewed highlighted the need to reconsider aspects of the *Vowles* judgement. Most notably, s.45A was seen as unsuitable when a mentally disordered offender's risk was significantly associated with their mental illness. In such cases, s.37 (with restrictions) was considered more appropriate not only for the patient's mental health needs but also for the protection of the public, particularly since psychiatric care is not a compulsory

component of community aftercare by probation services. The subsequent *Edwards* judgement sought to address this issue by relying upon the aftercare requirements afforded by Section 117 for patients who have ceased to be detained under the Act. The role of healthcare in conjunction with probation under Multi Agency Public Protection Arrangements (MAPPA) was to ensure that risk was properly managed in the community. For patients consenting to psychiatric treatment, it was advised that the offender's ongoing cooperation with treatment (including medication) should be added to license conditions as part of an offender's release plan. Controversially, they concluded that in cases where the offender did not consent to treatment, that they would be liable to recall as '*the inference can be drawn that the risk of serious harm is not being addressed and the purpose of supervision/rehabilitation undermined*' (para 28).

Study Limitations

This research project is the first to investigate the current views of psychiatrists concerning the recommendation and use of s.45A in the wake of the *Vowles* ruling, using a representative sample of forensic consultants with active involvement in sentencing hearings. Such purposive sampling introduces the possibility of selection bias, but consultants were sought who were likely to have had direct experience of s.45A and therefore the methods employed were appropriate given the current rarity of s.45A disposals. The generalisability of the findings could be further questioned as the majority of interviewees were based in London. The views of other interested parties (other Section 12 approved doctors, lawyers and judges) could usefully be sought in further research.

Conclusions

Forensic clinicians consider the Hybrid Order to be of some use in cases where major mental illness was not deemed to be of primary importance in the commission of the crime. However, there is a degree of professional disquiet regarding the newly envisaged primacy of the Hybrid Order as a disposal option. Consultants argued that in cases where mental illness significantly contributes to risk, a hospital order remains the most appropriate disposal option, because release through the Criminal Justice System is insufficient to optimally treat the offender in the long-term and to protect the public. Consequently, from a psychiatric perspective, s.37 should remain the predominant disposal option for mentally disordered offenders, and s.45A should only be used in specific scenarios: where the offender has primary personality disorder, a short lived psychosis with comorbid PD, has a high degree of culpability for the offence, and is likely to otherwise receive an extended determinate or discretionary life sentence. Half of the consultants thought that a period of assessment was necessary prior to the consideration of s.45A, in order to determine whether this section is appropriate for a given case. The *Vowles* call for a reduction in the use of s.38 should be reconsidered.

Subsequent to our study, *Edwards* sought to clarify '*a level of misunderstanding of the guidance offered in Vowles*' (para 12). The judgement concluded that if a hospital order is considered appropriate, the next step for '*those representing and sentencing offenders with mental health problems*' is to consider all sentencing options (including s.45A) and to be reminded of the importance of the penal element in a sentence. Furthermore, they clarified that even if an offender would not have committed the offence but for their mental illness, this '*does not necessarily relieve them of all responsibility for their actions*' (para 34). It noted

that there were differences between release regimes, but that a hospital order could not be assumed to offer greater protection. If, as a consequence, each case does indeed ‘*turn on its own facts*’ (para 34), further research is urgently required into the clinical characteristics and outcomes for s.45A offenders to critically inform the sentencing process. The ‘carceral city’ (Foucault, 1975) continues to expand.

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Statute

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Case law

R v. Vowles (2015) EWCA Crim 45

R v Ahmed (2016) EWCA Crim 670

R v Edwards (2018) EWCA Crim 595

Hybrid Order use data

<https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2017> (Restricted Patients, 2017)

Table 1:

Theme 1: Appropriate scenarios for the recommendation of a s.45A disposal

	Sub-themes	Prevalence*
1.1. For specific mental disorders	Brief episodes of psychosis with comorbid PD/SUD	❖ Typical
	Primary PD	❖ Typical
1.2. When the offender's culpability is such that a degree of punishment is warranted		❖ Typical
1.3. For higher-order offenses where an extended determinate or life sentence is likely		❖ Variant
1.4. When long-term mental health treatment is unlikely to be required		❖ Variant

**The prevalence of the themes across the interviews was classified as follows: 'uncommon' (one to three psychiatrists), 'variant' (four to seven psychiatrists) and 'typical' (eight or more psychiatrists). PD=Personality disorder. SUD= Substance misuse disorder.*

Table 2:

Theme 2: Inappropriate scenarios for a recommendation of a s.45A disposal

	Sub-themes	Prevalence*
2.1	When the offender has a primary or enduring psychotic illness	❖ Variant
2.2.	When the offender's culpability is deemed to be low	❖ Variant
2.3	When the offender is particularly vulnerable in the prison environment	
	Enduring mental illness	❖ Uncommon
	Substance misuse relapse	❖ Uncommon
	Radicalization	❖ Uncommon

**The prevalence of the themes across the interviews was classified as follows: 'uncommon' (one to three psychiatrists), 'variant' (four to seven psychiatrists) and 'typical' (eight or more psychiatrists)*

Table 3:

Theme 3: The perceived advantages of a s.45A disposal

	Sub-themes	Prevalence*
3.1. s.45A avoids ‘bed-blocking’		❖ Typical
3.2. s.45A provides enhanced safeguards compared to s.37	The Parole Board is more robust than the Mental Health Review Tribunal when determining release	❖ Uncommon
	Probation is more effective at managing risk than community mental health teams after release	❖ Uncommon
3.3. Benefits of combining healthcare and criminal justice services	s.45A allows a period of treatment for those who would otherwise receive a prison sentence	❖ Variant
	The conceptual separation of treatment and containment by the patient allows for a stronger therapeutic relationship	❖ Uncommon
3.4. Offending behaviour is better managed in prison		❖ Uncommon

**The prevalence of the themes across the interviews was classified as follows: ‘uncommon’ (one to three psychiatrists), ‘variant’ (four to seven psychiatrists) and ‘typical’ (eight or more psychiatrists)*

Table 4:***Theme 4: The perceived disadvantages of s.45A***

	Sub-themes	Prevalence*
4.1. No benefits of s.45A over s.47		❖ Variant
4.2. The prospect of return to prison limits therapeutic gains within hospital	The prospect of a return to prison is a deterrent to recovery	❖ Uncommon
	Return to prison limits the progression of rehabilitation	❖ Uncommon
4.3. s.45A community aftercare is inferior to s.37/41	Increased risk to offender and public following release from prison	❖ Typical
	Lack of compulsory post-release psychiatric care	❖ Typical
	Community follow up is more complex	❖ Variant

**The prevalence of the themes across the interviews was classified as follows: 'uncommon' (one to three psychiatrists), 'variant' (four to seven psychiatrists) and 'typical' (eight or more psychiatrists)*

Table 5:

Theme 5: Factors influencing the recommendation and use of s.45A

	Sub-themes	Prevalence*
5.1. Ethical concerns	The psychiatrist's circumscribed involvement in determining culpability and punishment	❖ Typical
	Considering instead of recommending s.45A	❖ Variant
5.2. Lack of familiarity with s.45A and lack of outcome data		❖ Typical
5.3. Judicial pressures post <i>Vowles</i>	Pressure to use s. 45A	❖ Variant
	Pressure to restrict the usage of s.38	❖ Uncommon

**The prevalence of the themes across the interviews was classified as follows: 'uncommon' (one to three psychiatrists), 'variant' (four to seven psychiatrists) and 'typical' (eight or more psychiatrists)*