Scottish Sentencing Council

Mental health, neurodivergence, and learning disability in sentencing

Conference hosted by the Scottish Sentencing Council on 30 August 2024

Report published December 2024

scottishsentencingcouncil.org.uk
sentencingcouncil@scotcourts.gov.uk

Scottish Sentencing Council
Parliament House, Parliament Square, Edinburgh, EH1 1RQ

Scottish Sentencing Council

Contents

Scottish Sentencing Council

Chair’s foreword

I am delighted to introduce this report about the Scottish Sentencing Council's conference on mental health, neurodivergence, and learning disability in sentencing.

Throughout my legal and judicial career, I have appeared in and presided over many cases where the complex relationship between offending and mental health has been a significant factor. During my time as Chair of the Council, it has also been an important feature in the Council’s research and engagement work. This is not surprising: the available evidence shows that mental health and related issues are more common in offenders than in the general population, which has obvious implications for sentencing.

In late 2023 and early 2024, the Council carried out research with members of the judiciary - something we are uniquely placed to do - to gain a better understanding of the challenges in addressing mental health in sentencing and inform our consideration of whether a guideline on this topic would be beneficial. This exercise also sought to identify any particular issues in relation to the provision of information and reports about mental health, and the availability and suitability of sentencing options for offenders with mental health and related issues.

The findings of this research have been published in an issues paper, "Judicial perspectives of mental health and sentencing", which should be read alongside this report. Many of the challenges identified by sentencers are not new and are well known to those who work in criminal justice or mental health, such as the complexity of the statutory framework; delays in psychiatric and psychological reports being provided to courts; shortages of psychiatrists and other relevant experts; and a perceived need for a wider and more robust range of community sentencing options.

As the issues paper notes, most of these challenges are outwith the Council's remit and cannot be addressed by a sentencing guideline. However, the paper highlights a number of key points that the Council intends to consider further. As a first step in this, we felt that we needed to learn more about the nature, prevalence, and effect of mental illnesses, learning disabilities, and neurological and neurodivergent conditions among the offending population and their relevance in sentencing. Without a greater understanding of these, it would be premature to explore some of the more systemic challenges highlighted around sentencing in this area.

Accordingly, we decided to hold a stakeholder conference in August 2024 and invited an array of expert speakers to give an overview of the legislative framework around mental health in our criminal justice system, before focusing in detail on the range of mental health and related issues many people accused or convicted of crimes experience. In particular, we

invited experts to speak about the traits and behaviours linked to each of these; how they might affect decision-making and contribute to criminal behaviour; whether they can best be treated medically or therapeutically; if not, what measures, if any, might be suitable to address them in the context of sentencing; and what level of risk to self and/or to others each may present, to the extent that it is possible to generalise about this.

Conference delegates included sentencers, medical practitioners, lawyers, social workers, government officials and many others with relevant skills and knowledge, who all took part in group discussions. This included discussion of whether a sentencing guideline would bring benefits for the courts, practitioners, and the wider criminal justice system. There was almost unanimous agreement that it would. This – together with the findings of the research and engagement we have carried out in this area to date – directly informed the Council's decision to prepare a guideline on the sentencing of people with mental health and related issues, as we recently announced in publishing our business plan for 2024-27.

Importantly, the conference also reflected the Council's statutory duties to assist the development of policy in relation to sentencing, and to promote greater awareness and understanding of sentencing policy and practice. It provided delegates with an opportunity to exchange ideas, forge new relationships, highlight examples of best practice, and to discuss areas where change and improvement may be required, and how both might be achieved. We hope that this report will be of assistance to policymakers and others, including practitioners and service providers across the criminal justice and mental health systems; and that it will also contribute to improvements for individuals with mental health and related issues who commit offences, those affected by their actions, as well as for the criminal justice system and society more generally.

On behalf of the Council, I would like to thank all participants for making the conference such an informative and thought-provoking event. It was the first in what we expect will be a series of events intended to explore in greater detail some of the other challenges in this highly complex area. We look forward to continued engagement with those who took part in this event and other key stakeholders as we begin developing our guideline on mental health and related issues.

Rt Hon Lady Dorrian
Lord Justice Clerk and Chair of the Scottish Sentencing Council

Introduction

1. The Scottish Sentencing Council held a conference, ***Mental health, neurodivergence, and learning disability in sentencing***, at The Royal College of Physicians of Edinburgh on Friday 30 August 2024. There were around 120 attendees from across the criminal justice and mental health systems.

2. The conference had three main aims:

   (i) to learn about the nature, prevalence, and effect of mental health issues, neurodivergence, and learning disabilities among the offending population and their relevance in sentencing

   (ii) to inform the Council's consideration of whether to develop a sentencing guideline on mental health, neurodivergence, and learning disability

   (iii) to inform the further development of policy in respect of mental health, neurodivergence, and learning disability in sentencing and in the criminal justice system more generally.

3. The format of the conference involved speaker presentations followed by discussion groups and a plenary feedback session. To facilitate open discussion, the event was held in accordance with the Chatham House Rule.

4. This report is not intended to be a verbatim account of proceedings but rather to draw out some of the key themes of the conference. A high level summary is provided of each speaker's presentation and of the key points raised in the group discussions.

5. The views expressed at the conference and in this report are those of the individual participants – they are not necessarily shared by the Council, or by other speakers or participants. The full presentations of each speaker are available on the Council's YouTube channel.

6. The language used in this report relating to mental health issues,[1] neurodivergence, and learning disabilities reflects the language used by participants and the differing legislative and professional contexts in Scotland and other jurisdictions. The Council recognises that different people have different views of how their conditions should be described, including in legislation. The use of appropriate terminology in sentencing guidelines will form an essential component of the Council's ongoing work this area.

7. Finally, this report should be read alongside the Council's issues paper, *Judicial perspectives of mental health and sentencing*.

[1] The terms "mental health issues" or "mental health and related issues" are generally used as shorthand umbrella terms in this report. They are intended to cover mental illnesses, neurodevelopmental and neurological conditions, learning disability and any related conditions.

Speaker presentations

8. The opening session of the conference consisted of presentations by, first, the Lord President, followed by the President of the Mental Health Tribunal for Scotland, Laura Dunlop KC.

Mental Health and the Criminal Justice System *– The Rt Hon Lord Carloway, Lord President of the Court of Session*

9. The Rt Hon Lord Carloway, Lord President, addressed the interaction between the law and issues raised by mental health disorders, which the courts have to deal with on a daily basis. He provided an overview of three key areas in which the accused's mental health can have a bearing on a criminal trial.

10. First, a mental disorder or abnormality of mind may have caused or materially contributed to the commission of the crime. There are two statutory defences available: the first is that the accused lacked criminal responsibility by reason of a mental disorder; and the second is that where a person would otherwise be convicted of murder, a conviction for culpable homicide can be substituted on the grounds of diminished responsibility. The test for diminished responsibility was put into statutory form in 2010: it applies where the accused was suffering from an abnormality of mind at the time of the offence which substantially impaired his ability to determine or control the conduct libelled.[2]

11. The second point at which the issue of mental health may arise is during the trial process. He observed that fitness for trial is not a defence to the charge libelled, but is a plea in bar of trial, taken on the basis that the fairness of any trial would be impaired. If the accused is suffering from a mental condition such that he is incapable of effectively participating in that process, he will be deemed unfit for trial.[3] It requires the judge to determine the accused's fitness on the balance of probabilities, on the basis of the evidence of two doctors.[4] The concern is his current mental state, not that at the time of the alleged offence.

12. The third, and most common, point at which the issue of the accused's mental health arises is at the stage of disposal and sentencing. He noted that the sentencing process guideline requires the sentencing judge to consider all relevant circumstances, including those of the offender, which includes, among other matters, the offender's mental health and, in particular, whether their mental health is linked to the commission of the offence.[5] He discussed how if a finding of unfitness for trial has been made, the

[2] Criminal Procedure (Scotland) Act 1995, s 51B(1).
[3] 1995 Act, s 53F(1) and (2).
[4] 1995 Act, s 54.
[5] "The sentencing process", sentencing guideline, Scottish Sentencing Council, Annex C at p 16 (scottishsentencingcouncil.org.uk).

court will order an examination of facts – the judge will determine whether it has been proved beyond reasonable doubt that the accused committed the act charged. If the court finds that he did, the same disposals are available as where the accused is acquitted on grounds of mental disorder.[6]

13. He also noted the important role of the Mental Health Tribunal for Scotland in the criminal justice process - once a person with a mental disorder has been through the criminal justice system, he will likely become subject to the tribunal under the 2003 Act.[7] As an inter-disciplinary and specialist tribunal, it is best placed to make ongoing decisions about the individual's care and any risk they pose to the public.

14. He concluded that it is important that the law, and the courts, do not maintain or foster outdated notions of, or stigma attaching to, mental illness.[8] It is important that an accused with a mental disorder is treated with care whilst in court. The courts rely upon those in the mental health and medical sectors to keep them abreast of the relevant developments in their field as not only does new, pertinent and peer-reviewed research have the potential to affect the outcome in an individual case, but can also affect wider questions of legal policy, such as has been seen in relation to the sentencing of young offenders.

The Mental Health Tribunal for Scotland: Three at a Time *– Laura Dunlop KC, President of the Mental Health Tribunal for Scotland*

15. President of the Mental Health Tribunal for Scotland, Laura Dunlop KC, outlined the Tribunal's structure and work.

16. The Tribunal, a non-departmental public body established under the Mental Health (Care and Treatment) (Scotland) Act 2003, is set to be transferred to the First Tier Tribunal for Scotland before the end of 2026. Supported administratively by the Scottish Courts and Tribunals Service, it is made up of three panels of members appointed by the Scottish Government, with a fourth panel of sheriffs. The main cohort of members consists of lawyers, psychiatrists and general members (around 100 each). The general members come from nursing, social work, psychology and occupational therapy, or are themselves service users (around 28%) or carers.

17. Ms Dunlop explained that the Tribunal deals with certain patients including those on a Compulsion Order (CO) which is imposed by a court under the Criminal Procedure (Scotland) Act 1995 for certain offences either following conviction, or acquittal through mental disorder, or is for those found unfit for trial. A Restriction Order (RO) can also be attached to this, and restricted patients (RP) are mostly on a CO plus a RO (CORO). Another smaller group the Tribunal covers are those who were sentenced to

[6] 1995 Act, s 57.
[7] See Part 9 and Part 10 of the Act.
[8] *MH* v *Mental Health Tribunal for Scotland* 2019 SC 423, Lord Malcolm at para 53.

imprisonment with a Hospital Direction (HD), which is a direction that they be sent to hospital, or a Transfer for Treatment Direction (TTD) where they become unwell while serving a custodial sentence. A Compulsory Treatment Order (CTO) will involve civil patients.

18. Ms Dunlop noted that during the year ending in March 2023 there were: 55 COs made, the lowest number for at least 10 years, 1,783 CTOs, 22 TTDs, and no HDs. Of the RP group, 95% are men. For disposals under the 1995 Act more widely, 86% of those made subject to orders are men. Orders will last a varying amount of time and can be extended unaltered, varied or revoked during an ongoing review process which involves decisions made by either the Tribunal or a Responsible Medical Officer (RMO). Patients can apply for an order to be revoked or it can be revoked when the criteria are no longer met.

19. Tribunal hearings can be held in person, via video conference or telephone, and are conducted by three panel members. At a hearing, a trusted person appointed by the patient ('a named person') can attend. There is also a victims' jurisdiction, and there are currently 61 people who receive notice of specific hearings and may make representations. Patients on a CO/CORO stay in hospital or in the community; those on a HD are only in hospital; while those detained on a CORO will be in the State Hospital or a medium or low secure unit. The length of stay in a unit will rarely turn out to be 'just right'. Some people may consider mental health orders 'lenient', however one patient in a case from the early years of the Tribunal had been admitted to the State Hospital in 1970 following a conviction for breach of the peace and remained there until transferred to medium security in 2014.

20. Looking to the future, Ms Dunlop said that 'recorded matters', namely the stipulation of care, treatment or a service which the Tribunal thinks that the patient should have, are being introduced into a CO; they are currently only available for CTO patients. Also noteworthy is the different dynamic in decision-making when there is a therapeutic majority on a Tribunal: it is usually the case that the two non-legal members come from a background in the care and treatment of patients, rather than one of determining rights. Finally, tribunals are now part of the rhythm in the compulsory care and treatment of patients: this periodicity means it is part of the patient's therapeutic journey to appear before three people at specific points during their time on an order. Ms Dunlop paid tribute to all who engage with these patients, and carry out the painstaking work involved.

Panel discussion

21. The next session was a panel discussion involving four speakers:

- **Professor Lindsay Thomson** – Professor of Forensic Psychiatry at the University of Edinburgh and Director of the Forensic Mental Health Services Managed Care Network
- **Dr Adam Mahoney** – Consultant Chartered Forensic Psychologist and Lecturer in Forensic Psychology at Edinburgh Napier University
- **Dr Suzanne O'Rourke** – Senior Lecturer in Clinical Psychology at the University of Edinburgh
- **Dr Jana De Villiers** – Consultant Psychiatrist and Forensic Network Clinical Lead for Intellectual Disability

Sentencing for Psychosis - Does it Work? – *Professor Lindsay Thomson*

22. Professor Thomson began by outlining the World Health Organisation's (WHO) definition of a mental disorder: it is "characterised by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour". There is no definitive blood test or scan capable of diagnosing mental disorder. This means that WHO's International Classification of Diseases (ICD-11), which sets out the symptoms and signs of the various disorders, is very important in ensuing worldwide consistency in how disorders are referred to, treated, and researched. It was noted that the definition of mental disorder in the Mental Health (Care and Treatment) (Scotland) Act 2003 as any mental illness, personality disorder or learning disability however caused or manifested is very wide and discussions are underway about revising it in light of the Scottish Mental Health Law Review.

23. Professor Thomson then discussed specific disorders in detail. Schizophrenia is a severe mental disorder characterised by a breakdown of thought processes, contact with reality, and emotional responses. Delusions and hallucinations are common and the disorder is associated with impaired social functioning. Treatments have now been developed that can help with symptoms of the disorder, allowing people to live much of their lives in the community (however, with a lot of support).

24. Professor Thomson said that there is, however, a lot of stigma around schizophrenia and its association with violence. Research suggests there is a two to four times increase in the risk of violence for men with the disorder, and six to eight times for women (as women are much less likely to be violent in the first place). The attributable rate of violence to schizophrenia in Scotland is 5%. A challenge is that individuals with schizophrenia often lack insight and understanding around having an illness that may need treatment, although levels of insight can fluctuate. This plays into issues of responsibility, particularly with regard to offending and sentencing.

25. Personality disorder was discussed next. This a deeply ingrained and maladaptive pattern of thinking, emotions and behaviour that persists through many years. Just under one in 20 people in the community will have a personality disorder – it is likely to

be the dissocial and borderline subtypes that will be seen in the criminal justice system. 4% in the community are likely to have a personality disorder, increasing to 30-50% of psychiatric patients.

26. Professor Thomson emphasised that the relationship between mental disorders and offending is complex. There may be a clear link between the two (i.e. during psychosis) but people can also be affected by victimisation, substance misuse, genetic factors, peer groups, low intelligence, poor parenting, and social deprivation.

27. Professor Thomson explained that conditions for detaining mentally disordered offenders (MDOs)[9] are different to civil cases: the threshold for detaining MDOs is lower than for civil patients and there are multiple conditions. There must be a likely or definite mental disorder, making the order must be necessary, risk to the health, wellbeing or safety of the person or safety of others must be considered, and the order must be likely to alleviate symptoms or prevent their deterioration. There are many options available for sentencing MDOs. These include compulsion orders (40-50 per year), restriction orders (10 per year), hospital directions, guardianship orders, community payback orders, and transfer for treatment orders.

28. Professor Thomson noted the characteristics of the forensic inpatient population across all levels of security in Scotland. 65% are male in their late 30s/early 40s, often from deprived backgrounds. 40% have been physically abused, and 20% sexually abused. For all that are detained, 70% have schizophrenia, 17% have a learning disability, and alcohol/drug addiction are common. All prisons (apart from open prisons) have mental health teams with visiting psychiatrists and psychologists, as well as liaison services and community mental health teams.

29. Professor Thomson discussed a research project[10] into the long-term outcomes of the recovery approach in high security mental health, which involved a 20 year follow-up study of the forensic inpatient population. This found that, during the 20 year follow-up period, 88% of patients left high secure care, over 50% reached the community, symptoms of psychosis had generally improved, the recidivism rate was 22.7% (with violent recidivism at 7.9%), but that most had suffered stigma and isolation. Men lost on average 14.9 years and women 24.1 years of potential life most by respiratory or cardiovascular disease. Five lives (5.6%) among the cohort were lost by suicide and three (3.4%) by unnatural means.

[9] This term reflects the statutory definition in of mental disorder in the Mental Health (Care and Treatment) (Scotland) Act 2003.
[10] "Long-term outcomes of the recovery approach in a high-security mental health setting: a 20 year follow-up study", Lindsay Thomson, Cheryl Rees, Deanery of Clinical Sciences, Centre for Clinical Brain Sciences, Edinburgh Neuroscience (2023) https://www.research.ed.ac.uk/en/publications/long-term-outcomes-of-the-recovery-approach-in-a-high-security-me (accessed 02 December 2024)

30. Professor Thomson concluded by asking whether sentencing for psychosis or for other mental disorders works; what role mental disorders play as mitigating factors in sentencing; whether specialist courts should be introduced; and how prisons can be made more therapeutic.

Mental Health Issues in Justice-involved Populations: Prevalence and Response *– Dr Adam Mahoney*

31. Dr Mahoney focused on the prevalence of non-psychotic illnesses in prisons and how they are managed. In particular, he discussed: anxiety; depression; substance misuse; personality disorders; post-traumatic stress disorder (PTSD); dementia; and suicidal and self-harming behaviours.

32. Dr Mahoney said that the most recent research in Scotland estimates that 15.5% of the prison population have a long-term mental health condition, 30% have alcohol use disorder, 18% have depression, 17% have a history of self-harm, and 16% have anxiety. This research, however, is based on statistical procedures that have estimated the prevalence of mental health conditions in comparison to non-prison populations rather than actual diagnostic occurrences. Similarly, we may also underestimate the prevalence of mental health conditions as not all prisoners engage with mental health services. As such a key flaw in the mental health prevalence data is the lack of recent, in-depth research. This includes the most comprehensive Scottish Prison Service survey data provided in 2007 which has a lack of diagnostic rigour with no mention of many mental health issues such as PTSD.

33. Despite this there is recognition based on smaller samples that many mental health issues in justice involved populations stem from interpersonal trauma. Such studies indicate that there are gender differences with a greater prevalence of mental health needs for women in prison, and with men less likely to receive treatment. We therefore need to understand both the prevalence of interpersonal trauma, including complex post-traumatic stress disorder (CPTSD), and its association with offending behaviour. A recent study of male, sentenced prisoners in London found that 7.7% met the diagnostic criteria for PTSD and 16.5% for complex PTSD. This study also found that PTSD was associated with more recent traumatic exposure and that CPTSD is a very common comorbid condition in male prisoners.

34. With respect to the women's estate in Scotland, it has previously been found that 91% of inmates had experienced childhood and adult trauma, and 58% had PTSD. This trauma can lead to a pathway of self-harm, with a 58.4% reported history of it. Available data from HM Prison and Probation Service also indicate that rates for self-harm in the women's estate have increased dramatically.

35. Dr Mahoney went on to say that self-harm as well as other behavioural difficulties can be seen as the sequel to trauma and adverse life experiences. A better understanding

of this and the development of more sophisticated interventions are required. This is true for mental health issues in general, where there is an urgent need to develop person-centred, trauma-informed care for those in the justice system. Effective responses can include: talking therapies, which is the most offered intervention in prison; mental health screening at reception as well as comprehensive through care (this requires consistent staffing and expertise); joined up case management; therapeutic communities; better support on returning to the community; and gender-specific and trauma-informed services.

36. There can be discrepancies in what is offered in different parts of the UK. For example, in England and Wales, 'psychologically informed planned environments' (PIPEs) are offered to those who have considerable difficulties with interpersonal functioning (i.e. personality disorders). These are specifically designed environments where staff have additional training to develop an increased psychological understanding of how to respond to such difficulties. This enables them to create an enhanced safe and supportive environment, and actively recognise the importance and quality of relationships and interactions. This resource has not been available in Scotland. While there is an increased awareness of a trauma-informed approach in Scotland more work needs to be done to fully implement such measures.

37. Dr Mahoney concluded with some key messages: it is necessary to fully understand the extent and nature of mental health problems in prison and an in-depth survey or study is long overdue; the complexity of interpersonal trauma and associated psychological distress needs to be fully understood to develop appropriate rehabilitative approaches in the justice sector; a person-centred, trauma-informed approach is required in which to structure treatment and rehabilitation; and a whole systems approach is required, in which poverty and social disadvantage are addressed, and appropriate workforce planning and funding is made available for forensic psychologists and other clinicians in the justice sector.

The Relevance of Common Neurodevelopmental Conditions in Criminal Justice *– Dr Suzanne O'Rourke*

38. Dr O'Rourke began by explaining that "neurodiverse" describes everyone, whether neurotypical or having a neurodevelopmental condition such as autism, attention deficit hyperactivity disorder (ADHD), developmental language disorder (DLD), foetal alcohol spectrum disorder (FASD), intellectual disability, and Tourette's/tic disorders. Her focus would be on neurodevelopmental disorder, a specific kind of neurodivergence where cognitive difficulties result in functional impairment, such that someone's functioning is significantly outside the range that would be achieved by most of the population. In particular, she would discuss traumatic brain injury (TBI), DLD, ADHD, and FASD. All of these conditions overlap to some extent, and co-morbidity is

the norm. It is estimated that as many as 15% of Scotland's population may have a neurodevelopmental condition.

39. There is an increased prevalence of such conditions within criminal justice, although most offenders will not have received a diagnosis by the time they come into contact with the system. Although there are few UK data available, worldwide data indicate that DLD is most common (60%) among prison populations, closely followed by TBI (51%) and FASD (17-55%), with all three potentially affecting half of studied populations. However, these numbers still represent a small minority of those affected by these conditions, the majority of whom will never have any contact with criminal justice.

40. Dr O'Rourke discussed DLD, a communication disorder that interferes with learning, understanding, and using language, which will affect a child's speaking, listening, reading, and writing, often becoming more apparent as they start school. Without early recognition, these difficulties could be misinterpreted as behavioural issues in school and the workplace. A Lancashire study of young offenders identified that 60% met the criteria for DLD despite being undiagnosed, and that those with DLD were twice as likely as their peers to reoffend within the one-year follow-up period.

41. The second disorder discussed was ADHD, characterised by a persistent pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development. It is thought to affect 5% of children and 2-4% of adults in the UK. Poor risk assessment and risk taking behaviours are common in the disorder, which is particularly pertinent to the offending population. A 2020 review of offenders with ADHD found that they became involved in criminal justice at an earlier stage, had a higher rate of recidivism, and were more likely to make false confessions.

42. Dr O'Rourke then addressed FASD, which describes the range of physical and cognitive developmental differences that may affect a person if they were exposed to alcohol in the uterus. It is estimated that this affects 3-5% of the Scottish population, and 20% of individuals with FASD have cognitive difficulties in the intellectual disability range. International studies indicate that more than one in five people, and perhaps as many as half, of those in contact with the criminal justice system are likely affected. They may be more easily led by others, unable to learn from previous experiences, and be highly suggestible.

43. The final condition discussed was TBI, the results of which can be both widespread and permanent. Any cognitive ability may be affected, but these commonly include working and verbal memory, inhibitory control, intellectual functioning and executive functioning. A 2018 study found that TBI is a risk factor for earlier and more violent offending, linked to earlier reconviction, poor engagement in treatment, and increased custodial infractions. In the absence of a diagnosis, many will find themselves self-medicating or experiencing mental illness.

44. Dr O'Rourke observed that neurodevelopmental conditions are likely to be particularly prevalent among repeat offenders as they are not able to learn from their mistakes and keep repeating the same patterns of offending. Neurodivergent offenders may be more likely to have poor judgement, engage in risk taking, have difficulty understanding the views of others, and have trouble organising themselves to attend court mandated appointments. The trial process is also challenging for those affected, as they will likely find it difficult to give a coherent account of events or explain their actions.

45. Dr O'Rourke highlighted a potential solution: Canada has led the way in the introduction of specialist therapeutic courts, specifically for FASD (but the model could be easily extended to other conditions). Offenders with a FASD diagnosis who wish to plead guilty are brought before judges who consider how their condition may have contributed to the offence. An assessment is prepared in advance, which discusses the offender's strengths and challenges and includes a plan of action. The process is informal, slowed down, and distractions are minimised. It is reputedly in very high demand.

46. Dr O'Rourke concluded that neurodevelopmental disorders and TBI are significantly overrepresented in criminal justice and can both increase the propensity to offend and decrease the ability to desist from offending. Such difficulties should be identified and their influence considered, and a risk assessment should always consider whether a neurodevelopmental condition exists but is yet to be diagnosed.

Forensic Aspects of Autism and Intellectual Disability *– Dr Jana de Villiers*

47. Dr de Villiers began by noting that worldwide figures show there is a slight over-representation of people with intellectual disability in criminal justice at 7%, compared to around 2% in the general UK population, but for autism the rates in criminal justice reflect those in the general population at around 2%.

48. Dr de Villiers then discussed autism, which is characterised by deficits in social interaction, communication, and repetitive behaviours, manifests early and is persistent. Within forensic settings, individuals have often experienced high levels of childhood adversity, including abuse and neglect. Such experiences can affect the development of social and communication skills in a way that superficially resembles autistic traits. This may contribute to the impression of over-representation in criminal justice settings. A comprehensive developmental history helps to distinguish autism from the effects of childhood adversity. Robust studies indicate that autism spectrum disorders (ASD) – and obsessive-compulsive disorder – do not increase violent crime risk, while ADHD can.

49. People with autism are generally no more likely to commit offences than the general population and may even be at a lower risk, as they prefer structured rules to navigate social interactions. Those who come into contact with the criminal justice system often

struggle to understand and adhere to societal rules. Resistance to following rules can be linked to narcissistic traits, which are associated with violent offending but are rarely assessed in autistic people. Offenders with autism typically have another co-occurring condition that significantly influences their risk of violent offending. It is crucial to identify these additional conditions for effective risk management.

50. Dr de Villiers said that crimes related to special interests are rare even though this is something often associated with autism. Online child sexual exploitation offenders without autism often exhibit a lack of victim empathy, cognitive distortions, repetitive behaviours, and large collections of images. She emphasised the need for careful court procedures, as these traits do not necessarily indicate autism but may reflect offending patterns. A crucial aspect is *mens rea* (criminal intention) – whether offenders took steps to conceal their actions, which suggests awareness of illegality, distinguishing them from someone who does not understand social norms and engages in activity on that basis. While cyber-dependent crime can sometimes be associated with autism, literature indicates that individuals with autism are not more likely to engage in such offences than others.

51. Systematic reviews show individuals with ASD are not overrepresented in criminal justice, but treating those with autism who commit serious offences is difficult due to cognitive rigidity. Treatment often focuses on encouraging behavioural change or implementing external safety measures, complicating management of such cases and potentially prolonging risk reduction.

52. In Scotland, there are no specialised health services for people with autism convicted of serious offences who do not have a co-occurring intellectual disability. Forensic intellectual disability services commonly manage people who have both conditions, which is about a third of the people, and forensic mental health services have much less experience and are generally not set up to meet those sorts of needs. Prison environments can be very challenging for people with autism and, even though some may benefit from structured routines, they remain at higher risk of serious mental illness and suicide.

53. Dr de Villiers highlighted the importance of robust autism diagnosis in criminal justice, emphasising comprehensive assessments that consider developmental history. She noted the importance of understanding whether and if so how ASD is relevant to the offence; addressing communication and sensory needs; and identifying co-occurring conditions. She warned against diagnostic overshadowing, where almost any feature or behaviour is attributed to autism to the exclusion of alternative diagnoses, as this can impede effective care and risk management.

54. Dr de Villiers discussed intellectual disability, which involves significantly below-average intellectual functioning and significantly impaired social functioning with onset

before age 18, affecting about 1-2% of the population. Only a very small proportion will come into contact with the criminal justice system. In 2018, 85 forensic patients with intellectual disabilities were reported in Scotland, 75 of whom were male. This is a highly complex clinical group, with high levels of co-occurring conditions, including FASD and autism, and physical health issues such as epilepsy. The vast majority have significant communication and sensory impairments.

55. Long-term studies of forensic intellectual disability services for inpatients and in the community show that treatment led to improved outcomes and lower recidivism rates. Although recidivism rates in the community were disappointing, harm reduction data suggests that assessment and treatment for offenders with intellectual disability can be highly successful in terms of public safety.

56. Dr de Villiers concluded by referencing New Zealand's removal of autism from mental health legislation, which raised public safety concerns and resulted in increased incarceration of people with learning disabilities, a decline in specialised services, a loss of clinical expertise, and no improvements in their physical or mental health outcomes.

Q&A

57. Delegates were then invited to put questions to the panel. There was discussion of how best to deal with people who have a persistent but limited delusion (believing that they are a famous actor, for example) and are able to function and hold down employment. It was said that a key consideration is what effect the delusion has on the individual and potentially also what effect it has on others. If the individual has a very specific, fixed delusional disorder but can hold down a job and peacefully function in a domestic setting, there may be no need to do anything. If they are on medication but stop taking it and start to act on the delusional belief, it could lead to more serious behaviour and a risk to others. The action required always depends on an individualised assessment of how well the individual can function, whether or not they are taking medication, and if there is a risk not only to their welfare but to the welfare of others.

58. There was a question about the effect of Covid-19 lockdowns on the mental health of prisoners. It was said that there is conflicting research on this. There are indications that for some prisoners, particularly in the women’s estate, spending more time in their cells led to reductions in interpersonal stress and self-harm and other difficulties arising from contact with others, but it is difficult to draw definitive conclusions and there are questions around the levels of care and treatment provided during the pandemic.

59. While the statistics on the prevalence of mental health issues were felt to be dispiriting, it was suggested that there is cause for optimism around the low reoffending rates among those returning to the community after a period of detention on mental health grounds. It was noted that the evidence shows individuals get better in forensic settings

and public safety is improved by this. However, it was said that the system does not work as well as in alleviating stigma and isolation in the community.

60. A point was raised around the introduction of Medication Assisted Treatment Standards for people with substance use issues, which include the right to trauma-informed care.[11] It was suggested that this was a positive step which would hopefully be adopted across the prison estate given the high number of prisoners who have difficulties with addiction. In this context, there was reference to the six high-level and strategic recommendations made by the Forensic Network in its response[12] to the Scottish Government's draft Mental Health and Wellbeing Strategy,[13] the first of which suggested that trauma-informed care in prisons is a model that should be considered.

61. There was a question about what should be taken into account in sentencing individuals who have borderline personality disorder or antisocial personality disorder, particularly at sheriff court level, where the incidence of such disorders was perceived to be higher. This was felt to be a challenging matter, as such disorders can appear to be difficult to manage. It was noted that, depending on the study, between 30% to 70% of prisoners have a personality disorder diagnosis. In the past, there may sometimes have been a hesitance to make such a diagnosis, particularly of antisocial personality disorder, in criminal proceedings as it was thought that it could result in a more severe sentence. However, the position has changed as more treatment options are now available. Evidence suggests that borderline personality disorder declines as a person ages: what is true of someone in their 20s and 30s is not the same as in their 40s and 50s. Dealing with antisocial personality disorder was said to be more difficult. Whether or not the person is able to express contrition may make a difference.

62. There was discussion of variations in the ways in which sentenced prisoners are dealt with after being transferred from prison to hospital for treatment where they have a significant mental health issue. It was felt that some may be returned to prison after responding to treatment but clinicians may sometimes feel it would be better for them to remain in hospital. It was noted that there has been a reduction in such transfers (which are made under a transfer for treatment direction[14]), and that some individuals may wish to return to prison as they may feel they have more certainty about what is expected of them in that environment. If the reason for imprisonment was not related to a significant mental health issue, the individual would be treated in hospital in broadly the same way as for a medical issue, although their stay would be longer. They would

[11] https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/ (accessed 02 December 2024)
[12] https://forensicnetwork.scot.nhs.uk/wp-content/uploads/2023/02/20230223_Response-to-the-first-draft-Mental-Health-and-Wellbeing-Strategy.pdf (accessed 02 December 2024).
[13] The final version of the Mental Health and Wellbeing Strategy is here: https://www.gov.scot/publications/mental-health-wellbeing-strategy/pages/2/ (accessed 02 December 2024).
[14] s136 of the Mental Health Care and Treatment (Scotland) Act 2003.

stay until they improve, but if there is a repetitive pattern involving relapse, they should remain in hospital.

Afternoon session

63. The afternoon session began with a recorded presentation from Dr Danny Sullivan, Director of the Sentencing Advisory Council of Victoria, Australia, and was followed by the final presentation of the day delivered by the Rt Hon Lord Beckett.

The Precedent of Verdins, Buckley & Vo as a Sentencing Framework for Mental Impairment in Australia *– Dr Danny Sullivan*

64. Dr Sullivan provided a brief overview of the approach taken to sentencing of mentally disordered offenders in the state of Victoria, Australia, as well as, increasingly, in other Australian jurisdictions, and in some Pacific nations.

65. In the case of *R v Verdins; R v Buckley; R v Vo [2007] VSCA 102,* the Court of Appeal of the Supreme Court of Victoria reconsidered the impact upon sentencing of mental disorder falling short of insanity, and applied this to the three named cases. These are now commonly referred to as the '*Verdins* Principles'.

66. In contrast to earlier precedents, diagnostic labels are considered "the beginning and not the end of the enquiry". Expert evidence must establish the existence of mental impairment at the time of the offending, the sentence or both. It should characterise the nature, extent and effect of impaired mental functioning on the offender, including how it may impact their experience of imprisonment, and must take into account the circumstances of the offending.

67. Even if uncontested, the court need not accept the evidence and may give it only limited weight if the author of an expert report is not called to give evidence. Because expert reports are frequently based upon information given by the offender which may be self-serving, the court must be cautious in accepting that the *Verdins* Principles have been invoked. The sentencing judge is expected to explain clearly the way in which impairment has been taken into account in the sentence handed down.

68. Dr Sullivan explained that the Court of Appeal identified that mental impairment may be relevant to sentencing for the following reasons:

- It may reduce an offender's moral culpability and so affect what is considered to be a just punishment and lessen the need for denunciation.
- It may have a bearing on the kind of sentence that is imposed and the conditions under which it should be served.
- General deterrence (where the sentence imposed on an offender is intended to make other potential offenders less likely to offend) may be moderated or eliminated

as a consideration, depending on the nature and severity of the offender's symptoms, and their effect on the impairment at the time of the offending.

- Specific deterrence (where the sentence imposed on an offender is intended to discourage that offender from offending again) may be similarly moderated or eliminated in the same circumstances.
- The existence of a mental impairment at the time of sentencing, or its reasonably foreseeable recurrence, may mean that a specific sentence may weigh more heavily upon that offender than it would upon a person who is in normal health.
- Finally, if there is a significant risk that a sentence of imprisonment will have a serious adverse effect on the offender's mental health, this will also be a mitigating factor.

69. However, the principles are not applied routinely as some form of checklist, but must be invoked, typically by the defence. The onus is on the defence to prove their relevance, generally through the introduction of expert evidence. There may be other ways in which impaired mental or intellectual functioning may be considered relevant, outwith the listed principles. A causal connection between the impaired mental functioning and the offence is a critical element of *Verdins*. It is also considered a matter of degree, and the court should consider the gravity of the offending and factors which go to the extent of contribution of impaired mental functioning to the offending.

70. The judge may moderate any mitigation or reduction of culpability, for instance where the offender was fully aware of the nature and gravity of what they were doing and its wrongfulness. Features such as planning or avoiding detection may reflect such knowledge. The consequences of imprisonment may be relevant if they will weigh more heavily on the mentally impaired offender, compared to other offenders. However, this does not simply apply to the generally unpleasant and unwanted effects of incarceration, or stress at its prospect.

71. While mental impairment may reduce culpability, it may also impact negatively upon community protection. Thus, any mitigating effect may be balanced by a sentence which takes into account community protection. The presence of a mental impairment may increase the relevance of rehabilitation as a primary consideration for sentencing purposes, and may therefore impact upon the type of sentence and its duration.

72. Finally, judges report that the *Verdins* Principles assist in constructing an appropriate sentence and help them to take into account impaired mental or intellectual functioning without it derailing their sentence or overriding the need to take into account the multiple purposes of sentencing.

The Judicial Perspective: What Happens in Practice *– the Rt Hon Lord Beckett, Senator of the College of Justice*

73. Lord Beckett discussed the sentencing principles the Scottish Sentencing Council identified in its first guideline,[15] namely the need for a judge to consider all relevant circumstances, including those of the offender. This includes physical and mental health.

74. He noted that the Council's second guideline, on the sentencing process, is a synthesis of statutory requirements and sentencing practice as it has developed over time. It identifies culpability, i.e. blameworthiness, as one of the key considerations when sentencing, alongside the harm caused. It also specifies mental illness or disability, especially where linked to the commission of the offence, and a demonstrated willingness to address (amongst other things) mental health issues,[16] under a list of generally mitigating factors. These are long-recognised in sentencing practice but their significance must always be carefully evaluated in light of the circumstances of the particular case.

75. He recognised that the prevalence of neurodivergence, learning disabilities, and other mental health issues was almost certainly under-represented in those cases in which he learnt of them when passing sentence. He noted that it is less common for such conditions to be identified in the sheriff court. In summary cases, where Parliament has discouraged prison sentences of 12 months or less, a solicitor may not feel it is in their client's interest to carry out an investigation with potential to result in compulsory detention in hospital. In the vast majority of cases, there will be no condition capable of meeting the criteria for intervention under Part VI of the 1995 Act relating to mental disorder.

76. He discussed how mental health issues can bear on the extent of a person's culpability, reduce the justification for punishment, and indicate leniency, whilst protection of the public may weigh heavily on the other side of the scales. A culpability-reducing condition may increase the importance of protecting the public from serious harm. It may necessitate a substantial prison sentence up to and including an order for lifelong restriction.[17]

77. He noted that in other cases the identification of a treatable condition, and an accused who is amenable to treatment, may make rehabilitation a prominent consideration.

[15] "Principles and purposes of sentencing", sentencing guideline, Scottish Sentencing Council, (scottishsentencingcouncil.org.uk).
[16] "the offender has demonstrated a willingness to address their personal problems and to change their offending behaviour, including addressing any drug, alcohol, or mental health issues."
[17] For which there is a mandatory sentence of life imprisonment; Criminal Procedure (Scotland) Act 1995 s 205.

Successful rehabilitation can be the most effective and most proportionate way of protecting the public from serious harm.

78. He concluded that input from doctors and psychologists can be essential in sentencing. He stated that professionals must be scrupulous in confining themselves to their specialism and careful not to make unwarranted assumptions about the circumstances; and judges must be astute in evaluating specialist opinions in light of the law and the facts of the case on which the court is bound to proceed.

Summary of group discussions

79. Following the speaker presentations, a session involving discussion groups – consisting of 12 groups each facilitated by a judicial office holder – took place.

80. This session was in two parts. The first involved consideration of questions of a general nature. The purpose was to discuss challenges, examples of best practice, and potential changes in relation to how individuals with mental health and related issues[18] are dealt with in the criminal justice system, and whether a sentencing guideline in this area would be beneficial. There were four general questions – half the groups discussed questions 1 and 2, while the other half focussed on questions 3 and 4 to ensure all were addressed. Where time permitted, groups were able to discuss the other two questions.

81. The second part of the session invited discussion of sentencing/disposal scenarios where mental health and related issues were a consideration. This is summarised at pages 32-34 of this report.

82. The following is a summary of the key issues raised by delegates in relation to the discussion of the general questions. Due to the nature of the questions and the issues under consideration, there was a degree of overlap in the points raised – this summary attempts to capture the key themes without repetition, although this is unavoidable to a degree as many issues are interlinked.

Question 1: What do you consider to be the biggest challenges in relation to the sentencing of offenders with mental health issues?

83. Key challenges highlighted were around resource constraints; availability of expert reports; identifying mental health and related issues; information gaps; disposals; the statutory framework; and the impact of these challenges on victims.

Resource constraints

84. Reflecting the findings of the Council's research with members of the judiciary, an overarching theme in discussions was the lack of resources across relevant parts of the criminal justice and mental health systems, which was said to affect, in a number of different and important ways, how accused and convicted people with mental health and related issues are dealt with in criminal proceedings.[19]

[18] As noted at footnote 1 on page 3, "mental health issues" and "mental health and related issues" are used as shorthand umbrella terms in this report, which should be read as covering mental illnesses, neurodevelopment and neurological conditions, learning disability, and any related conditions.
[19] Resource constraints were also an underlying concern throughout the discussions of the other questions and scenarios, even if they are not explicitly mentioned in relevant parts of this report.

85. One of the main issues discussed was a lack of resources to screen and assess accused and convicted people for mental health and related issues and sentencing. This was seen to be compounded by a discrepancy between the levels of resource in sheriff courts compared to the greater level in the High Court. With the high level of prevalence in busy sheriff courts, particularly at summary level, there was said to be insufficient time, capacity, or resource to identify mental health and related issues.

86. Resource constraints were also felt to extend beyond the courts to hospitals and psychiatric units: the unavailability of beds to allow courts to make assessment and treatment orders under sections 52D and 52M, respectively, of the Criminal Procedure (Scotland) Act 1995 was said to be an unacceptable problem. General staffing resource and infrastructure challenges across both the criminal justice and mental health systems were ultimately said to be attributable to a lack of funding.

Availability of expert reports

87. Many delegates felt that one of the main challenges concerns delays in the provision of court reports. It was common for psychiatric and psychological reports to be provided a considerable time after conviction perhaps 12 weeks or more, so the information can come very late in the proceedings and meantime the accused might be held on remand. The initial difficulty is often in finding a psychiatrist to prepare a report, as a person might be remanded in one local authority area but resides in another and is only known to services there. This difficulty is exacerbated by shortages in the number of approved medical practitioners across the country.

88. Some areas were said to have local agreements between the Crown Office and Procurator Fiscal Service (COPFS), the health board, and others, to retain psychiatric services for these purposes. It was said that such contracts are in the interest of both COPFS and health boards, and were a solution used in the past. The main barrier is cost as contracts can be very expensive to maintain. Previously, local partnerships would allow regular meetings with COPFS to coordinate work, but now requests for psychiatric reports at the pre-conviction stage can come from different prosecution teams, each responsible for specific types of offence. These teams are based in different parts of the country, which can sometimes mean, for example, that a service in Edinburgh requires liaison with relevant teams based elsewhere, such as Dundee or Glasgow, resulting in a disjointed process.

89. As a result, courts may not get all of the information that they need, either in respect of the individual concerned or about what is available in terms of disposals. In contrast, the Mental Health Tribunal for Scotland (MHTS) was said to have more robust processes than the courts for obtaining psychiatric and psychological reports.

90. A further issue discussed was that health boards are independent across Scotland, which may result in screening and assessment being inconsistent in terms of timing,

the quality of reports, and professional involvement. It was suggested that there should be a systematic, standardised, and national method for providing court reports, which would reduce delays and make them more effective.

91. From the perspective of a defence lawyer, it was said to take a long time to instruct psychology reports due to issues in obtaining legal aid to cover the costs. It was suggested that there should be a discussion over whose responsibility it is to get information about mental health at the pre-conviction stage.[20] Due to the increasing numbers of people presenting with mental health and related issues, it was said that the prosecution should perhaps be more active in providing information at the initial stages of court proceedings.

92. For some, the differences between the roles and responsibilities of psychologists and psychiatrists leads to challenges. Psychologists may not be obliged to write court reports as part of their contract, whereas this may be a contractual requirement for psychiatrists. If a psychologist is not under a contractual obligation to prepare court reports, it means fewer reports are prepared than required, and relevant information does not enter the medical records of accused people or offenders, and as a result, can be easily lost. To address this, there should be an accredited list like the register of current accredited risk assessors published by the Risk Management Authority and a legal requirement for the information provided in a psychological assessment to go to courts.

Identifying mental health and related issues

93. There was a suggestion that accused people with mental health and related issues are often not identified as such. They may either have an undiagnosed issue or may not share their diagnosis with their lawyer. At the same time, even if a defence lawyer feels that "something isn't right", they are not qualified to diagnose mental health and related issues and do not always have access to medical professionals for assessments and reports due to resource issues.

94. An additional challenge was felt to be the significant difference between mental health issues such as psychosis compared to neurodivergence or learning difficulties. The cohort of people involved is not exclusively those with high-level forensic needs, who require complex health care: there are many more who commit lower tariff offences whose needs centre around social care to support their cognitive difficulties rather than health, although it can sometimes be difficult to disentangle social issues from mental health issues. It was argued that something is not working effectively if an individual

[20] Under s52 of the 1995 Act, where it appears to the prosecutor that a person charged with an offence has a significant mental health issue, the prosecutor has a statutory duty to bring before the court such evidence as may be available of that person's mental condition. This duty applies pre-conviction, as the prosecutor has no involvement in requesting psychiatric or other mental health reports for sentencing purposes.

has to enter the criminal justice system in order to get a diagnosis and help for mental health issues.

Information gaps

95. A further main challenge was said to be the difficulty in sharing information between the relevant agencies and bodies. There was a suggestion that unless prescribed medication is involved, there tends to be a gap between the information held by the NHS compared to that which is made available to the police. There are many barriers to getting the right level of information. Accessing medical records can take a long time and relevant information might have been redacted. It was suggested that standards should be put in place for this, which would provide, or improve, governance and quality.

96. On the judicial side, sheriffs do not always know what resources are available in the community. A mechanism to improve information-sharing around sentencing is required. While Community Justice Scotland has an online directory[21] providing information about the community interventions and support available in each local authority area, it was suggested that some of this information may be out of date by the time it is issued.

97. Overall, there was felt to be a clear need to connect the whole pathway of an individual's journey through the criminal justice system: current arrangements mean that no one has all the necessary information at the right time and communication between relevant parts of the system is lacking. Prisons, for example, do not always have access to the same information provided to the court. Officials across the criminal justice and mental health systems[22] are also often not sure what information can be shared and with whom, which can mean, among other things, that assessment orders do not filter through to everyone who needs to be aware of them.

Disposals

98. A central challenge was felt to be deciding whether an offender with significant mental health issues should be in prison or in hospital. It was said that prisons can still receive people for whom a more effective solution could not be found elsewhere: custody can become a default because a hospital bed is unavailable for the person or because there is an absence of suitable alternatives and resources in the community.

99. In respect of community disposal options, a key question is whether the individual has the ability to engage with a community payback order (CPO) because of the issues

[21] https://communityjustice.scot/community-justice/community-intervention-and-support-directory/ (accessed 02 December 2024). As this resource notes, information contained within it is not exhaustive in relation to what is available in each local authority.
[22] It should be noted that there is a distinction between mental health services and services which assess and support those with cognitive difficulties.

they are facing. Even something as simple as turning up for an appointment with a justice social worker might prove difficult for an individual with mental health issues, resulting in such orders being breached very quickly. Often people do not present with issues that are readily identifiable when they first come into contact with the criminal justice system. Those issues may only become apparent once they start a CPO. At the same time, it was felt that there is an under-utilisation of CPOs with a mental health treatment requirement.[23]

Statutory framework

100. A challenge was noted around a lack of understanding of the applicable legislation which leads to it being applied inconsistently. It was suggested that there should be better access to training for legal practitioners and those involved in applying relevant mental health provisions. Court time can be taken up when the provisions are not known or not fully understood. It was also proposed that there should be more training for all involved in the criminal justice system on neurodivergence, autism, and learning disability to improve understanding and ensure appropriate measures can be put in place.

101. It was suggested that some of the provisions in Part VI of the Criminal Procedure (Scotland) Act 1995 relating to establishing if a person has a "mental disorder" are too narrowly framed as they do not take into consideration the full personality of the person. It was suggested that this is particularly true when there is a guilty plea – the person may want to plead guilty despite their lack of culpability at the time due to a significant mental health issue.

Impact on victims

102. It was observed that the delays and shortages caused by the challenges noted above, and frequent and long adjournments in cases, increase the distressing time victims need to wait to see a resolution to their case.

Question 2: Can you give any examples of best practice in relation to the treatment of accused or convicted people with mental health issues, from either within Scotland or elsewhere?

103. While not all groups found it easy to come up with examples of best practice, it should be noted that such examples were given in response to other questions, particularly question 3. Key examples given in response to question 2 concerned screening;

[23] Barriers to the imposition of a mental health treatment requirement as part of a community payback order have been highlighted in the Council's issues papers "Judicial perspectives of community-based disposals" (Scottish Sentencing Council, 2021) "Judicial perspectives of mental health and sentencing" (Scottish Sentencing Council, 2024) [https://www.scottishsentencingcouncil.org.uk/media/r1ebkfec/judicial-perspectives-of-mental-health-and-sentencing.pdf].

community justice programmes; multidisciplinary approaches; and psychological therapies.

Screening

104. The importance of early screening for mental health issues was a common theme in the discussions and some potential examples of best practice from England and Wales were provided:

- The Metropolitan Police were said to have screening conducted by custody sergeants at the point of arrest using a general, broad brush tool.
- Some police forces, for example Northumbria Police, may operate a street triage where police officers are paired with psychiatric nurses who attend certain call-outs where there is concern around mental health. The nurse will assess whether there is an issue and whether further mental health input is required.
- The Crown Court[24] was thought to have a triage system in place for people being held in the cells or appearing in court if a concern is raised over their mental health. They will be seen by a mental health nurse who will write a report, usually of several pages, which assesses whether there is a history of issues, if medication has been prescribed, if there is risk of self-harm, or if a full psychiatric assessment is necessary. This information will be made available to the court.

Community justice programmes

105. A number of community-based services and programmes were highlighted as successful examples of the support that can be provided to offenders (particularly women) with mental health issues:

- Shine, which provides a national mentoring service for women offenders
- Sacro, which provides a wide range of services in community justice, community safety, and public protection
- Grace Chocolates, which supports women who have experienced the justice system by helping them into employment
- Willow, a service for women aged 18 and over involved in the criminal justice system, which can be delivered either as part of a court order or by choice. It takes a trauma-informed approach and has a strong mental health focus
- 218 in Glasgow (this service is now closed).

106. However, it was said that these, and similar, services always face overwhelming demand, which ends up far exceeding their capacity, indicating, again, the challenges

[24] The Crown Court deals with the most serious criminal offences in England and Wales.

of resources across the system. It was also noted, though, that there had been a lack of referrals to the Shine service.

107. More generally, it was observed that Community Justice Scotland produces a yearly summary of local authority annual reports on CPOs, which highlights good practice around the country.

Multidisciplinary approaches

108. The holistic, multidisciplinary practice in the Australian state of New South Wales[25] was noted. This involves psychiatrists working with education professionals, legal practitioners, and psychologists via weekly meetings. Sometimes these add time to cases, but overall the benefit is positive and the system works well in allowing people to get attention from the right services who are able to assist. Progress of individual cases, and how the partnership is performing are regularly monitored, resulting in a reduction in violent crime.

Psychological therapies and therapeutic environments

109. It was suggested that the Netherlands has a robust forensic mental health system with in-depth psychological therapies, which have been a key reason for a reduction in the Dutch prison population.[26]

110. Although a specific example from Scotland was not provided, it was suggested that therapeutic courts and a more therapeutic prison structure could promote best practice.[27] The latter, for cases where a custodial sentence was considered the only appropriate sentence, was felt to be a good solution to the increasing prevalence of neurodevelopmental disorders in the offending population, as opposed to sentencers trying to work out how much particular conditions are linked to the commission of the offence at the sentencing stage.

Question 3: What changes do you think would most improve the way in which the criminal justice system deals with people with mental health issues?

111. A wide range of areas for improvement was identified: accessible communication; screening; specialist courts and dedicated court teams; a new model based on the Children's Hearings System/Mental Health Tribunal; training and trauma-informed practice; community sentencing and diversion; public perceptions; solicitor fees; and standardising information sharing.

[25] https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/work.aspx (accessed 02 December 2024)
[26] A recent article in *The Guardian* highlighted research showing that between 2005 and 2015 the Dutch prison population decreased by 44 percent.
[27] On example of a therapeutic approach in Scotland is the "Female Offenders Court" at Glasgow. It does not involve medical staff, but its ethos is a trauma-informed approach, with social work agencies involved taking a holistic, multi-faceted approach to addressing each offender's issues, including mental health.

Accessible communication

112. There were strong arguments put forward in favour of more accessible communication and assessment of the communication needs of accused and convicted people. It was felt there should be an overhaul of interactions with accused and convicted people as many have speech and language needs, with a smaller number with learning disability, FASD, or autism needing specialist treatment and input. The system should be designed with that in mind. Northern Ireland's Registered Intermediary Scheme was cited and said to be very successful for people who need it. It involves communication specialists assisting vulnerable victims, witnesses, and accused people with significant communication deficits to communicate their answers more effectively during police interviews and trials.

113. Practical steps could include expanding justice social work to include speech and language therapists, making bail conditions easier to read and asking an accused to explain what they understand their bail conditions to be. It was pointed out that making CPOs easier to read might be challenging as there is a template and national guidance currently in place, but if an offender does not have the skills to understand what a CPO requires of them, they will not be able to comply and will end up breaching it. This was said to happen frequently with people with learning disabilities as the way in which the order is framed limits their ability to understand it. Addressing these communication barriers could reduce reoffending, as many individuals with communication needs are repeat offenders.

Screening

114. As with responses to question 2, the importance of screening and early access to assessment was frequently raised. There was general agreement that current approaches are quite disjointed and that mental health issues should be addressed from the earliest stages rather than in a comparative rush at the point of sentence. Understanding early on what led a person to come into contact with the criminal justice system would allow the relevant services and/or the court to identify the best approach for handling their case and in turn the best sentence for them. It was suggested that there should be an expansion of Child and Adolescent Mental Health Services[28] and neurodevelopmental pathways,[29] including new centres. This would mean that information about the mental health and cognitive development of any young people who subsequently came into contact with the criminal justice system would already be

[28] NHS Scotland Child and Adolescent Mental Health Services are multi-disciplinary teams that work with children and young people up to the age of 18 years who present with significant mental health problems.
[29] The Scottish Government has published standards for services to support children and young people with neurodevelopmental conditions aged up to 24 (and up to 26 if they are care experienced): https://www.gov.scot/publications/national-neurodevelopmental-specification-children-young-people-principles-standards-care/ (accessed 03 December 2024)

available. It would require sustained investment for a period of 20 years but would deliver long-term benefits.

115. Many offenders lack awareness and understanding of the criminal justice system, making it difficult for them to engage with the trial process (e.g. instructing a solicitor) and court orders. There was a clear sense that the existing system can set them up to fail, although it was suggested that this is as much a medical issue as a criminal justice issue. The Right Care, Right Person model used by the Metropolitan Police, which is being introduced elsewhere in the UK, was highlighted as an approach aimed at making sure the right agency deals with health related calls, instead of the police being the default first responder as is currently the case in most areas.

Specialist courts and dedicated court teams

116. The possibility of specialist courts dealing with mental health was discussed. It was suggested that one of the main advantages with specialist courts is that relevant experts and practitioners are attached to them so that individuals can be assessed quickly. This reduces delay with the provision of reports to the courts, and the reports are written in a way understood by the courts. Specialist courts might also create different disposal options and improve awareness of the statutory framework. It was noted that some specialist courts already exist in certain jurisdictions, such as the young person's court, alcohol court, and drug court in Glasgow.[30]

117. However, a number of caveats around specialist courts emerged in the discussions, which resulted in most groups reconsidering their value in this area. It was felt that it would take some time to set them up, specialisms may differ in each court, and it may be difficult to ensure that offenders receive equal treatment. In addition, the usefulness of a minority of cases being targeted by specialist courts was questioned And it was suggested that the comparatively low numbers would not justify such an approach in most areas and may actually cause delays (e.g. a court may only sit every few weeks).

118. Two different approaches were proposed for consideration. First, a dedicated centre, or centres, in each sheriffdom could concentrate the response, with a settled team of expertise and cases cited to call there. More efficient access to dedicated assessment may limit the resources required for preparing reports. It may also lead to specialism by sheriffs without requiring the time and resource of dedicated courts as such.

119. Second, in Sweden there is an integrated *mens rea* test, which has the potential to allow for greater equality and a recognition of disabled people's rights to legal capacity. It was suggested that this can involve an "alternative approach that considers all defendants to be equal in terms of accountability, or capacity for responsibility, and lacks any rules that excuse or exempt a defendant with a severe mental disorder or

[30] Problem-solving courts also operate in other areas including Aberdeen, Forfar, Edinburgh, and Hamilton.

disability". [31] Whereas this approach exists in a very different legal context, it was put forward that lessons can be learned from both the strengths and critiques of this alternative approach. These include:

- the importance of respecting disabled people's rights including a right to legal capacity
- being wary of relying on assumptions based on legal constructions of the person that undermine these rights, and
- being mindful of the importance of understanding and managing the relationship between legal concepts and questions and psychiatric and/or medical concepts and questions (that is, how expert evidence is used and the role it plays/ought to play in relation to sentencing).

Children's Hearing System/Mental Health Tribunal model

120. There was discussion of whether the Children's Hearings System (CHS) or Mental Health Tribunal for Scotland (MHTS) could provide a model for the kind of approach that might improve the effectiveness of criminal justice approaches to offenders with mental health issues, although it was felt that this would not be a suitable role for the MHTS itself to undertake, as it is not resourced to undertake the volume of work required.

121. Cases falling short of compulsion could be referred to a panel of experts – including both medical and community justice practitioners – for advice on disposal. This would involve a similar skillset to the MHTS but follow the process in the CHS for the provision of advice to the court. The advice panel could draw on local resources and recommend treatment or a programme, or support in the community, which could bring the offender into the relevant system. The court may end up using a structured deferred sentence, but whether through such an approach or a different disposal, may be better placed to address persistent offending by a person with mental health issues, which can cause significant harm to neighbours and the public.

122. Such a forum would bring a number of benefits and have a number of important purposes and functions. It could:

    - involve experts on specific conditions, such as autism, who would be better placed to explain what is happening to accused and convicted people
    - provide education about the issues involved as well as views on the harm caused by offending and the impact of likely sentences on the offender
    - be better placed than the court to evaluate mitigating factors not immediately apparent in the trial process, or which have been highlighted in a criminal justice social work report

[31] See https://link.springer.com/article/10.1007/s10609-024-09484-0 (accessed 02 December 2024).

- potentially remove from the criminal justice system what are often health and social care issues
- recommend disposals for offences committed by people detained in hospital on mental health grounds, where a sheriff's options are often limited.

Training and trauma-informed practice

123. Similar to points raised in response to question 1, it was suggested that more training is required for practitioners and those involved in applying legislative provisions relating to mental health, as it can take up court time when the provisions are not well understood. Legal practitioners should also have access to training on neurodivergence.

124. Alongside this, there should be a focus on trauma and trauma-informed practice in relation to accused and convicted people with mental health issues. It was felt that going through the criminal justice system can be traumatising, so measures must be taken to reduce re-traumatisation.

Community sentencing and diversion

125. Recognising that community support is often not available for those with mental health issues, it was argued that it would be better to focus on community sentences and provide additional support and funding in this area. Alongside this, it was said that there is a need for relevant bodies to work with COPFS around consideration of diversion and alternative disposals, as it is difficult to get charges cancelled once a case is in court, even if mental health issues emerge as an important consideration at that stage. There is a need for the police to look at other background factors like adverse childhood experiences and education before views are reached on charge and prosecution. Effective diversion was also said to offer the prospect of long-term benefits, both by reducing criminality and, as a consequence, reducing costs in the criminal justice system, although it was felt that it may be challenging to convince the public of this.

Public perceptions

126. Public and media perceptions of mental health issues, community sentencing, and rehabilitation were felt to lack understanding of the complex issues involved. However, it was thought that public perceptions can be changed by public education campaigns, with the Council's video on community sentencing being cited in this regard.

Solicitor fees

127. The view was expressed that solicitors get paid the same amount, regardless of the complexity of the case. An example was given of acting for a child or young person who has been in care and has complex trauma-related issues, compared to representing a mature adult appearing in court for the first time for possessing drugs. It

was felt that the system does not recognise the differing degrees of work involved and is set up in a quantitative, rather than a qualitative, way. This should be looked at, given the important role defence lawyers have, often being the first to bring mental health issues to the court's attention, and given the time and attention required to enable them to do so.

Standardising information sharing

128. The lack of a standardised approach in respect of screening or sharing information causes a range of difficulties: if a UK-wide approach was introduced, someone with a mental health issue coming into the criminal justice system would most likely be flagged at a much earlier stage, leading to more effective outcomes.

Question 4: Do you think a guideline on sentencing offenders with mental health issues would be beneficial?

129. Among the delegates who discussed this question, there was all but unanimous agreement that a guideline would be beneficial. Potential benefits of a guideline were discussed, but challenges were also noted around the need to involve professionals in its development; how difficult it would be to cover all of the relevant issues; public perceptions; the need to avoid automatically equating certain issues with reduced culpability; and whether it would be effective due to the discrepancies in different local authority areas regarding what support and resource is available.

130. It was suggested that it would be very important to have mental health professionals involved in the development of a guideline as they have the specific, up to date knowledge required. It was noted that guidelines should not just be about culpability but also about the disproportionate impact mental health issues can have on individuals and therefore their mitigating role in sentencing.

131. A guideline might mean people may be more inclined to raise a neurodivergent condition. This might lead to a safer society, as courts need to know about conditions to manage risk and choose the most appropriate sentence. A guideline might also "upskill" people in forensic investigation and help inexperienced defence lawyers.

132. It was felt that there is a lack of public awareness around the fact that certain mental illnesses will potentially lead to reduced culpability. Each person is different and their condition will affect them and their culpability in different ways. Explaining to the public why culpability may differ as a result of a mental health issue is extremely important. Public confidence in a guideline is vital. Development of a guideline should be linked with work to raise public awareness of the ways in which mental illness can impact sentencing decisions.

133. A key challenge highlighted was around whether a guideline could encompass every issue/condition. There was some discussion of whether it would, or should, cover

people who have depression, low-level mental health issues, and/or trauma. It was suggested that almost every accused person has a form of trauma and this meant a guideline should be comprehensive. However, it was also noted that trauma affects everyone differently. A guideline could provide a framework around differing degrees of trauma. This may help to form a fuller picture of the person being sentenced, and acknowledge that everyone is different.

134. At the same time, there were questions as to what impact issues such as depression, anxiety, and ADHD should have on selection of a sentence, which it was hoped a guideline might address. There was also discussion of a guideline providing more information about, for example, the impact and traits of autism. This may include information about "theory of mind", and other common traits which may affect culpability for different forms of offending. This would support sentencers in making a robust and person-centred assessment of culpability in each case.[32]

135. Some support for a guideline came with caveats. There was a need to be wary of the possibility of a guideline leading, or being regarded as leading, to a certain diagnosis resulting in a person being considered less culpable purely for that reason. To avoid this, it should emphasise an individualised approach, encouraging the court to ask how the issue impacts on the person. It should not be a shortcut or tick-box exercise: it needs to be of assistance to people. It should highlight reports and other factors that have to be taken into consideration and be properly acknowledged and applied in a meaningful way. A well drafted guideline could fill a gap and be a starting point for experts to refer to when preparing reports or giving evidence. It would, however, need to be "infinitely variable" to account for the distinct and unique circumstances of the offenders it would have to cover.

136. There was discussion of how a guideline could be prepared if it was not known what community treatments and programmes were available in local areas. There was a need to be aware of the discrepancies in different communities and local authority areas regarding what support and resource is available. If a service is unavailable, this was not felt to be a good enough reason to give someone a custodial sentence. It was suggested that the Council, the NHS, and the third sector could work together in order to collate the relevant information.

137. It was suggested that the sentencing young people guideline offers an example of an approach that could be adopted in a sentencing guideline on offenders with mental illnesses, neurodevelopmental or neurological conditions, or learning disability.

Sentencing/disposal scenarios

[32] In psychology, theory of mind refers to the capacity to understand other people by ascribing mental states to them. A theory of mind includes the knowledge that others' beliefs, desires, intentions, emotions, and thoughts may be different from one's own.

138. The groups then discussed sentencing/disposal scenarios based on circumstances (not real cases) sentencers who have engaged with the Council have said they find challenging. Six scenarios were provided, one for every two groups.

139. A number of neurodevelopmental conditions discussed in the morning presentations were discussed in the context of the scenarios. The risk of stigmatisation in relation to autism spectrum disorder came up, with it being noted again that ASD does not necessarily make it more likely a person will commit certain offences. For FASD and TBI, it is not simply a case of saying the individual has reduced culpability: there is a need to identify what aspects they struggle in: is it memory or is it adaptive behaviour? No assumptions should be made as everyone is different but a profile for what each person can and cannot manage can be created, which will inform the sentencing decision, particularly in respect of whether this should involve custody or a community disposal.

140. Challenges relating to personality disorders were discussed: there are very few treatment options available and a further issue is that medication may not always be taken, and help may be refused, by people with personality disorders. The high proportion of people in prison with antisocial personality disorder was noted.

141. There was a clear recognition that public protection is of central importance and that custodial sentences are necessary and appropriate for serious offences committed by individuals with mental health issues, where these issues do not affect criminal responsibility or require hospital treatment. However, the lack of suitable treatment programmes in prisons was a concern.

142. At the same time, for some cases at the custody threshold, it was felt that, where available, a treatment programme in the community, including third sector support, will be more beneficial to public protection than a short term prison sentence where there is no time for programmes to address mental health issues and offending behaviour. It was also felt that supervision in the community, including, for example, by welfare guardianship, can be effective in appropriate cases, and that liaison and diversion at earlier stages may help to prevent further involvement in the criminal justice system.

143. Whatever the eventual sentence might be and irrespective of the offender's condition, there was general agreement about the overriding need for courts to have earlier and more detailed information. Determining whether culpability is reduced was clearly felt to be extremely difficult without significant levels of information and expert input.

144. A number of additional examples of best practice were discussed. In terms of custodial sentences, two approaches were noted:

- The Lilias Centre was highlighted as a safe and supportive environment for female offenders with mental health and related issues. This is one of a number of Community Custody Units (CCU) in Scotland designed to provide safe and secure

accommodation, which is trauma informed and gender specific. The CCUs support the needs of women who would benefit from closer community contact and access to local services. Women will be supported to live independently in accommodation based on a 'shared house' principle to develop a range of independent living skills, which are reflective of real life.

- It was suggested that Finland's open-prison approach,[33] which allows offenders to leave prison during the day for employment, could be looked at, possibly as part of a "suspension of detention plan" in a low secure unit, involving a hybrid community based sentence that would still include restricted liberty.

145. There were also two examples of best practice in relation to community or hybrid sentencing options:

- The Enhanced Combination Order (ECO), which is available in Northern Ireland,[34] was compared to a more extensive and intensive version of a community payback order due to the extra support and resources put in place.
- Probationary suspended sentences, which are available in Belgium[35], were noted as an example of a hybrid sentence. In this context, the potential value of such sentences was noted as prison can disrupt the protective factors in an individual's life, such as their job, family life, friends, etc.

146. The value of third sector services and programmes in addressing offending behaviour was highlighted, particularly where formal or statutory criminal justice options are unavailable. The work of two organisations was mentioned:

- Stop It Now! Scotland (now called the Lucy Faithfull Foundation Scotland), which provides support services to prevent and stop child sexual abuse.
- Circles UK, which operates in England and Wales to rehabilitate and reintegrate those who commit sexual harm by providing a support network of trained volunteers working alongside family members, the Probation Service, Multi-Agency Public Protection Arrangements (MAPPA), police; and other professionals from statutory or partner organisations.

[33] A recent report on global recidivism rates — that is, the tendency of a criminal to reoffend after release — found that despite Finland's perceived 'soft' approach to punishing crime, the reoffending rate of 36 percent was one of the lowest. By comparison, the recidivism rate in the United Kingdom was 48 percent, and in Sweden it was 61 percent.
[34] ECOs focus on targeted interventions, restorative practice, desistance and victims work, with service users also required to complete unpaid work within their local communities (Community Service). Every person subject to an ECO is assessed by PBNI psychologists, with those who need it receiving a bespoke mental health intervention. Where appropriate parenting/ family support work and accredited programmes are also part of the order.
[35] This involves a period of imprisonment suspended for a certain period, during which the person must fulfil certain conditions. See https://www.euprobationproject.eu/national_detail.php?c=BE (accessed 02 December 2024).

Conclusion

147. The Council is extremely grateful to the speakers and delegates who took part in the conference. The presentations and discussions were highly informative and of great assistance to the Council in reaching its decision to develop a guideline in this area. In particular, the presentations on the nature, prevalence, and effect of mental illnesses, learning disabilities, and neurological and neurodivergent conditions among the offending population and their relevance in sentencing provide essential context around considering the scope, content, and approach of a guideline.

148. The discussions also highlighted a range of challenges across the criminal justice and mental health systems in relation to the sentencing of people with mental health and related issues. Many of the challenges discussed echoed those raised by sentencers in the research carried out by the Council and highlighted in the issues paper, "Judicial perspectives of mental health and sentencing", which should be read alongside this report.

149. There are challenges of a structural nature, relating to the complexity of relevant legislation and the availability and suitability of sentencing options; practical challenges arising from resource constraints, which can result in delays and affect the ability of courts to get the level of information needed to sentence effectively (whether through lack of hospital beds for assessment or the length of time it takes to get expert reports); and also challenges relating to the need to balance considerations around treatment and welfare alongside public protection and punishment. While these were discussed at the conference, they were not a direct focus, as the Council intends to explore them in detail across a series of future stakeholder events. Most of these challenges fall to others to address, however, given that they are matters outwith the Council's direct remit, and would potentially require legislative change and additional resources to address.

150. Importantly, however, the discussions also looked at examples of best practice, and gave rise to various proposals for change and improvements to services and procedures. These have provided the Council with much food for thought. While it does not necessarily endorse the proposals, many of which, again, fall outwith its remit, it welcomes constructive input aimed at improving the effectiveness of sentencing in this area. It will consider the proposals alongside the key points for further consideration noted in the issues paper as part of the guideline development process.

151. The Council looks forward to continuing engagement with stakeholders and others with an interest in this important work and once again thanks conference participants for their contributions.

Speaker biographies

The Right Hon Lady Dorrian, Lord Justice Clerk and Chair of the Scottish Sentencing Council

Lady Dorrian was appointed as a judge of the Supreme Courts in 2005, having served as a temporary judge since 2002. She was appointed to the Inner House in November 2012. She is a graduate of the University of Aberdeen and was admitted to the Faculty of Advocates in 1981 before becoming Standing Junior Counsel to the Health and Safety Executive and Commission between 1987 and 1994. She served as Advocate Depute between 1988 and 1991, and as Standing Junior to the Department of Energy between 1991 and 1994. In 1994, she was also appointed Queen's Counsel. Between 1997 and 2001 she was a member of the Criminal Injuries Compensation Board. She is a Fellow of the Royal Society of Edinburgh.

Lady Dorrian was installed as the Lord Justice Clerk on 26 April 2016 and by virtue of the office became Chair of the Council on that date. The Lord Justice Clerk also holds the office of President of the Second Division of the Inner House of the Court of Session.

The Right Hon Lord Carloway, Lord President and Lord Justice General

Lord Carloway was appointed as Lord President of the Court of Session and Lord Justice General of Scotland in December 2015. He has been a Senator of the College of Justice since February 2000. He was appointed to the Second Division of the Inner House in August 2008, before becoming Lord Justice Clerk in August 2012. His report into criminal law and practice was published in November 2011.

He is a graduate of Edinburgh University (LLB Hons) and was admitted to the Faculty of Advocates in 1977. He served as an advocate depute from 1986 to 1989 and was appointed as a Queen’s Counsel in 1990. From 1994 until his appointment as a judge he was Treasurer of the Faculty of Advocates.

Lord Carloway is an Honorary Bencher of Lincoln’s Inn in London and King’s Inn in Dublin. He is a Fellow of the Royal Society of Edinburgh. He is an assistant editor of “Green’s Litigation Styles” and contributed the chapters on “Court of Session Practice” to the Stair Memorial Encyclopaedia and “Expenses” in Court of Session Practice. He was the joint editor of “Parliament House Portraits: the Art Collection of the Faculty of Advocates” and is a former president of the Scottish Arts Club.

Laura Dunlop KC, President of the Mental Health Tribunal for Scotland

Laura Dunlop called to the Bar in 1989 and has been senior counsel since 2002. She has been Standing Counsel to the Kirk (until 2023), a part time Law Commissioner (2009 to 2015), Counsel to a public inquiry and a legal member of the Pensions Appeal Tribunal. In 2016, she was appointed as a legal member of the Mental Health Tribunal, of which she has

been President since October 2019. Laura was also appointed as a deputy judge of the UK Upper Tribunal (Administrative Appeals Chamber), in 2018. In 2020-21, she conducted a review for the Scottish Government of procedures for the handling of harassment complaints by civil servants against Ministers.

Professor Lindsay Thomson, Professor of Forensic Psychiatry at the University of Edinburgh

Professor Lindsay Thomson is Professor of Forensic Psychiatry at the University of Edinburgh and Director of the Forensic Mental Health Services Managed Care Network and the School of Forensic Mental Health. She has been Medical Director of the State Hospitals Board for Scotland since 2007. Professor Thomson's research interests include recovery and outcomes in mentally disordered offenders, risk, the impact of legislative change, and interventions and service design. Research findings are implemented through the Forensic Network. She has a particular interest in teaching and established the School of Forensic Mental Health. The School won the Scottish Public Service Award for Employee Engagement and Skills in 2014.

Professor Thomson was presented with a Lifetime Achievement Award in 2015 at the NHS Education Scotland Medical Directorate Awards. She co-authored the first textbook on psychiatry and the Scottish legal system and legislation: *Mental Health and Scots Law in Practice* which is now in its second edition.

Dr Adam Mahoney, Consultant Chartered Forensic Psychologist and Lecturer in Forensic Psychology at Edinburgh Napier University

Dr Adam Mahoney is a Consultant Chartered Forensic Psychologist who has 20 years' experience working in prisons and forensic settings. This includes 10 years working as a Psychology Manager within the Scottish Prison Service's women's estate. His research and practice-based interests include gender responsive approaches to offending and interpersonal trauma. Dr Mahoney also seeks to integrate mindfulness and compassion-focused approaches into his therapeutic work and has design various interventions to help survivors recover from their abusive experiences. He is a lecturer in Forensic Psychology at Edinburgh Napier University, Chair of the BPS's Division of Forensic Psychology- Scotland and provides consultancy services to various forensic and mental health organisations.

Dr Suzanne O'Rourke, Senior Lecturer in Clinical Psychology at the University of Edinburgh

Suzanne is a senior lecturer in clinical psychology at the University of Edinburgh and consultant in clinical, forensic and neuropsychology at the State Hospital, where she holds the roles of Neuropsychology and Research lead. Historically, Suzanne's research interests have been focused on the inter-relationships between psychosis, neuropsychology and

offending behaviours particularly the contribution of cognitive impairment to inpatient violence, or violent and sexual offending in the wider population.

Suzanne was the lead author for the Scottish Sentencing Council's 2020 review on the development of cognitive and emotional maturity in adolescents and its relevance in judicial contexts. More recently, her focus has moved to Fetal Alcohol Spectrum Disorder (FASD). Since 2020 Suzanne has been a Director of the Scottish Government funded Fetal Alcohol Advisory Support and Training Team (FAASTT). The FAAST Team has a national remit to provide training and clinical consultancy to Scotland's NHS and Social Care workforce alongside research.

Dr Jana De Villiers, Consultant Psychiatrist and Forensic Network Clinical Lead for Intellectual Disability

Dr Jana De Villiers is the Forensic Network Clinical Lead for Intellectual Disability. She is Consultant Psychiatrist for the High Secure Intellectual Disability Service for Scotland and Northern Ireland, based at the State Hospital. Prior to her appointment at The State Hospital, she was the Consultant Psychiatrist for the Fife Forensic Learning Disability Service from 2011 until 2018, with responsibility for a regional low secure ward, a forensic learning disability locked ward and the Fife-wide community forensic learning disability team. She has presented on forensic aspects of neurodevelopmental disorders at both national and international conferences, and contributed a chapter to the reference textbook 'Forensic Aspects of Neurodevelopmental Disorders: A Clinician's Guide', published in October 2023. She is currently Chair of the Intellectual Disability Faculty for the Royal College of Psychiatrists in Scotland.

Dr Danny Sullivan, Director of the Sentencing Advisory Council of Victoria, Australia

Dr Danny Sullivan is a Director of the Sentencing Advisory Council, Victoria, Australia. He is a consultant forensic and adult psychiatrist, who works in the public mental health sector and is an experienced expert witness. Danny trained in psychiatry in England and Australia and also holds Master's degrees in Bioethics (Monash), Health and Medical Law (Melbourne), and Management (McGill). He has held senior management roles including as Executive Director of Clinical Services for Forensicare (the Victorian Institute of Forensic Mental Health) and as Board Director at ACSO. He has extensive clinical experience working in prisons and community and inpatient forensic mental health services in England and Australia over the last 25 years. He holds academic posts as Adjunct Associate Professor (Swinburne University) and Honorary Senior Fellow (University of Melbourne).

The Right Hon. Lord Beckett, Senator of the College of Justice

John Beckett is a graduate of the University of Edinburgh and was admitted as a solicitor in 1986, working in private practice before being admitted to the Faculty of Advocates in 1993. He was appointed an Advocate Depute in 2003 and took silk in 2005. He served as Principal

Advocate Depute and then Solicitor General for Scotland in 2006. He became a sheriff in 2008 and was appointed as an Appeal Sheriff on the establishment of the Sheriff Appeal Court in 2015. He was appointed a judge of the Supreme Courts in May 2016, having served as a temporary judge since September 2008. He was elevated to the Inner House in July 2023.

Scottish Sentencing Council

Scottish Sentencing Council
Parliament House
Parliament Square
Edinburgh
EH1 1RQ

scottishsentencingcouncil.org.uk
sentencingcouncil@scotcourts.gov.uk

ISBN: 978-1-912442-65-2

December 2024