SCOTTISH EXECUTIVE

REPORT OF THE COMMITTEE ON
SERIOUS VIOLENT AND SEXUAL OFFENDERS

Laid before the Scottish Parliament by the Scottish Ministers

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We would also like to acknowledge the immense support we have received from our own Secretariat. When we first met in April 1999 our Secretary, Colin McKay, had only the assistance of Helen Ogg, and, of course, he had the burdensome task of serving both our Committee and the Millan Committee. Fortunately, he was later joined by Alison Bell, then Gavin Russell, and latterly by Bette Francis and Luke McGarty. Without the conscientious efforts of them all, it is unlikely that we would have been able to report as soon as we have, namely, in just over a year. We would, however, like to pay especial tribute to Colin McKay's contributions. Always imperturbable, he encouraged and cajoled us, and from time to time diplomatically reminded us of matters which we needed to consider in order to fulfil our remit.

INTRODUCTION

The MacLean Committee on Serious Violent and Sexual Offenders, hereafter referred to as our Committee, was established in March 1999 by the UK Government, with the following remit.

> 'To consider experience in Scotland and elsewhere and to make proposals for the sentencing disposals for, and the future management and treatment of serious sexual and violent offenders who may present a continuing danger to the public, in particular:
>
> to consider whether the current legislative framework matches the present level of knowledge of the subject, provides the courts with an appropriate range of options and affords the general public adequate protection from these offenders;
>
> to compare practice, diagnosis and treatment with that elsewhere, to build on current expertise and research to inform the development of a medical protocol to respond to the needs of personality disordered offenders;
>
> to specify the services required by this group of offenders and the means of delivery;
>
> to consider the question of release/discharge into the community and service needs in the community for supervising those offenders.'

The terms of the remit of our Committee indicate to us a concern on the part of government about certain types of offender: and it must be stressed that, in making recommendations concerning sentencing disposals, our Committee is concerned only with those who have offended but have yet to be sentenced or otherwise disposed of by the court. These offenders are those who have committed serious violent and sexual crimes. Later in this report we consider what may properly be regarded as serious violent and serious sexual crimes. As we see it, there is an apprehension that courts, when imposing sentences, have not always recognised the potential for some offenders seriously to recidivate. Or, if we may express it in another way, the risk of committing further serious violent or sexual offences, at least in some cases, has not been identified satisfactorily. Further, the question of imposing discretionary life sentences for such offences has not been considered by judges in any structured or systematic way.

There is also a further, but separate problem raised in our remit. Following the House of Lords decision in the case of Alexander Reid[1] the understanding was that some offenders within this group, who were made the subject of hospital and restriction orders by the court, and who may still present a danger to the public, could no longer continue to be detained within hospital because they were no longer susceptible to medical treatment. These are offenders, who are not suffering from mental illness, but who may have a personality disorder and who were made the subject of a hospital order before it was possible by law to make them subject to a hospital direction. We consider later in this report how this problem may be avoided in the future.

We were asked by Ministers to report within a year and have tried, as far as possible, to keep to this timescale. During the past year we have undertaken the following pieces of work:

- We met in full Committee on 15 occasions, the first being on 15 April 1999 and the last being on 12 June 2000. This included five two-day Committee meetings.

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[1] See Reid v Secretary of State for Scotland 1999 SC(HL)17

- We also divided into three sub-groups, which were charged with considering and making recommendations to the full committee on specific elements of the remit. These sub-groups met on a total of 15 occasions.
- Committee members undertook 16 visits to facilities in Scotland and England including prisons, hospitals specialising in the treatment of personality disorders, and secure and medium-secure psychiatric hospitals. See Annex 4.
- Committee members undertook a total of 14 visits to facilities in The Netherlands, Canada and the USA: these included visits to prisons, secure hospitals and other treatment facilities, and meetings with lawyers, medical professionals, security staff and policy advisors to local and national governments. See Annex 4.
- We produced a consultation document and distributed over 500 copies. We also made the document available on the Internet. We received 77 responses. See Annex 5.
- We took oral evidence from a number of specialists working with serious offenders: academics, psychologists, psychiatrists, and members of the Scottish Prison Service (SPS). See Annex 5.
- We commissioned a literature review and research into discretionary life sentences. See Annexes 2 and 3.

Our proposals may be summarised as follows. First, we consider that a new sentence should be introduced, to provide for lifelong control of the offenders with whom we are concerned. This sentence would largely replace the use of the current discretionary life sentence, and would be based on a thorough risk assessment.

The principles of risk assessment and risk management would continue to be important throughout the duration of the sentence. We propose the creation of a new body, the Risk Management Authority. This would establish, promulgate and continuously update best practice in risk assessment and risk management. It would also have operational responsibility for ensuring that an individualised risk management plan is developed and implemented for those offenders upon whom the new sentence is imposed.

In relation to those serious and violent offenders who have mental disorders, we propose a more systematic use of existing mental health disposals, particularly the interim hospital order and hospital direction. These would be integrated with the assessment procedures for the new sentence.

It is a fundamental aspect of the new sentence that the offenders should not be released into the community until they have served an adequate period of time in prison to meet the requirements of punishment, and do not present an unacceptable risk to public safety. At the same time, the period spent in the community should be regarded as being an integral part of the sentence. Our proposals envisage that community services for offenders serving this sentence would involve a greater degree of intensive supervision than is the current norm.

We believe that these proposals, taken as a whole, provide a comprehensive framework for dealing with this difficult group of offenders. They are intended to meet the requirements of public safety, while respecting human rights.

SECTION 1

A NEW APPROACH TO RISK MANAGEMENT

CHAPTER 1: DEFINITIONS AND CONTEXT

With whom are we concerned?

1.1 Our terms of reference require us to consider how society should respond to 'serious violent and sexual offenders who may present a continuing danger to the public,' including those with personality disorder. This is a complex set of terms, and our Committee spent some considerable time discussing which offenders might properly be regarded as coming within them.

1.2 One possibility would have been to define the target group of offenders by reference to a list of 'serious' sexual offences and a list of 'serious' offences of violence. Examples of such lists can be found in legislation[2] and these could have been drawn upon to identify, at least in part, the range of offenders with which we are concerned. It became clear, however, that this would not be a satisfactory approach, for a variety of reasons.

1.3 First, such lists are likely to be both over-inclusive and under-inclusive. While one might find general agreement that rape and assault to the danger of life are 'serious' offences, most offences against the person vary significantly in their severity according to the circumstances. This is particularly so for certain categories of sexual offending. So, for example, while unlawful sexual intercourse with a fifteen year old girl is an offence[3], irrespective of the age of the offender and the nature of the relationship between the parties, the gravity of this offence clearly does vary according to the context in which it is committed. Society would view the case of a seventeen year old youth who has sexual intercourse with his fifteen year old girlfriend in quite a different light from the case of a thirty-five year old teacher who has intercourse with his fifteen year old pupil. A further problem arises from the fact that some types of offending, which might fairly be described as 'serious', and which have a significant sexual motivation, would not necessarily be included in any list of 'sexual offences'. For example, sexually-motivated conduct which does not involve any overt sexual act, or any physical interference with the victim, may only be charged under some other category of offence - typically breach of the peace.

1.4 Second, many people who commit the most serious offences do not present a continuing risk to the public. The most significant example of this is the case of murder. While some persons convicted of murder undoubtedly present a risk of re-offending, a great many murderers do not. Simply to include all cases of murder in our target group would not reflect the characteristics of many persons convicted of murder.

1.5 Finally, attempting to define our target group by reference to a list of offences takes attention away from the ***offender***. We felt that the focus of our attention - as reflected in the language adopted in the terms of reference - should be on the offender who presents a 'continuing danger to the public'. While some persons who commit serious offences of violence or serious sexual offences will fall within this group, not all who do so will. At the same time, it is our view that some persons

[2] See, for example, the Sex Offenders Act 1997, Schedule 1

[3] Criminal Law (Consolidation) (Scotland) Act 1995. s. section 5. It is also potentially a 'serious' offence since it is punishable with up to 10 years' imprisonment if the girl is aged 13 or over, and up to life imprisonment if the girl is aged between

appearing before the court for sentencing may be regarded as 'serious' offenders, although they have not yet been convicted of a serious act of violence or a serious sexual offence[4].

1.6 The emphasis on serious sexual or violent offending means that we excluded from our consideration the large number of intractable recidivists who repeatedly commit minor offences against the person or property. These people are a considerable problem to society. Many may have personality difficulties, often combined with substance abuse. They may fail to respond to, or be deterred by, punishment, yet not be easily managed within existing mental health services. It may well be that more needs to be done for this group, but that was not a matter we could consider. However, the existence of this wider group may put into context the difficulty of accommodating the needs of the more serious offender, who may well be even more resistant to any attempt to modify his/her behaviour.

1.7 We have largely, although not entirely, excluded from our consideration those who are involved in organised crime, such as large-scale drug dealing. Such criminals may well commit, or have some involvement in, acts of serious violence, and often present continuing danger to the public over many years. However, it seemed to us that the main problems in relation to organised crime relate to the investigation and prosecution of such offenders, rather than the sentencing or treatment options available to the courts and prisons.

1.8 Any person who has committed a serious offence may be at risk of committing further offences, although in some cases the risk may be no higher than the risk that others who have not yet offended will do so in the future. We felt that the focus of our attention should be on those who may present a particularly high risk.

RECOMMENDATION 1

Special sentencing considerations are necessary for persons convicted on indictment of a violent or sexual offence, or exceptionally another category of crime, whose offence(s) or antecedents or personal characteristics indicate that they are likely to present particularly high risks to the safety of the public. We refer to them henceforward, in the context of this report, as 'high risk offenders'.

1.9 The underlying supposition in the terms of reference is that something special may need to be done for this group, over and above what is currently available in the criminal justice system. As will be seen, our view is that new arrangements are desirable for the identification and sentencing of this group, although they should build on the long-standing traditions of Scots criminal law.

1.10 Even within the relatively narrow terms of our remit, it is clear that we are not considering a homogenous group. There are many different ways in which people commit violent and sexual offences, and many different reasons why they may pose a continuing risk. What is needed is a sentencing framework which is sufficiently robust to take account of these multiple factors, and a service response which is flexible enough to address the needs of individual offenders in a way which offers proper protection to the public.

[4] In Canada, the Supreme Court has held that where the predicate offence consisted of minor acts of sexual assault, the offender's overall past conduct, including more serious offences, justified the designation of dangerous offender. 'I cannot imagine that Parliament wanted the Courts to wait for an obviously dangerous individual, regardless of the nature of his crime record, and notwithstanding the force of expert opinion as to his potential dangerousness, to commit a particularly violent and

1.11 This heterogeneity manifests itself in the different problems experienced at different stages in the criminal justice system, which can, in turn, lead to the risks and needs of an offender being imperfectly recognised.

1.12 For example, many of those who spend time in special prison units are likely to fall within our terms of reference. However there are others, notably paedophiles, who present no problems whatsoever in prison but who would be highly dangerous on release. This may be because their criminal behaviour is manifested in ways which would not be possible in prison. There is also a particularly worrying group of prisoners who may present as 'model prisoners' but will quickly resume their criminal behaviour when the opportunity presents itself.

The size of the problem

1.13 There is undoubtedly considerable public concern about the danger posed by high risk offenders. While this concern is quite understandable and legitimate, we feel it is important to place the danger in context.

1.14 The focus of concern tends to be on those who, following release from custody for a serious violent or sexual crime, go on to commit a further crime of similar kind. In 1998, 50 people were imprisoned for four years or more for a sexual or violent crime, having previously (since 1989) received a similarly serious sentence for a sexual or violent crime.

1.15 Although these crimes are serious, and should be prevented if at all possible, it should be borne in mind that members of the public face a greater likelihood of suffering violent crime at the hands of people who consume too much alcohol or illegal drugs, than as a result of the actions of any identifiable and separate group of high risk offenders with a propensity for acting violently. While it is right to reduce the risk to the public from this second group, so far as this can be achieved, this will only make a relatively small difference to overall violent crime.

The context of this report

1.16 Our terms of reference relate to the sentencing framework and the service needs of this group of offenders. We have not, therefore, considered other methods of risk reduction - for example the issues of police checks and job screening covered in the Cullen enquiry into the shootings at Dunblane[5]. Nor were we able to give detailed consideration to the needs of victims of violent crime.

1.17 Our Committee's work overlaps with that of two other important committees: the committee which is reviewing the Mental Health (Scotland) Act 1984, chaired by the Rt Hon Bruce Millan, and the Expert Panel on Sex Offending, chaired by the Hon Lady Cosgrove.

1.18 The Millan Committee is due to report later this year, and its terms of reference require it to take account of the report of this Committee. We understand that it will give thorough consideration to those aspects of the Mental Health (Scotland) Act 1984 which concern offenders. We have shared our emerging views with the Millan Committee and we hope that they will feel able to incorporate our mental health recommendations into their broader proposals.

[5] Public inquiry into the shootings at Dunblane Primary School on 13 March 1996: London HMSO 1996 Cm3386

1.19 Lady Cosgrove's Panel was established to take forward the recommendations of ***A Commitment to Protect,*** the report published by the Social Work Services Inspectorate into Sex Offending[6]. It is due to conclude its work next year.

1.20 Although the focus of the Expert Panel is different from ours, there are areas of mutual concern, notably those of risk assessment and information sharing. We have had several helpful meetings with representatives of the Expert Panel, which have helped us to clarify our thinking in these areas. On some issues of overlap, such as the operation of the Sex Offenders Act 1997, we have agreed that the Expert Panel should take the lead role in making recommendations to the Scottish Executive.

1.21 The offenders with whom we are concerned are predominantly male. On a visit to Durham prison, members of the committee heard of the very difficult problems that can be presented by some women offenders with severe personality disorders - particularly in relation to self-harming behaviour. This is a very troubling issue, but one which falls outwith our terms of reference, which are largely concerned with issues of public safety. These issues are, we understand, being addressed by the Inter-Agency Group on Women Offenders, which is chaired by Professor Sheila McLean, and was established following the publication of ***Women Offenders - A Safer Way***[7]. We have attempted to ensure that our proposals take account of offenders regardless of gender and age.

[6] Social Work Services Inspectorate (1997) ***A Commitment to Protect: Supervising Sex Offenders. Proposals for more Effective Practice***

[7] Social Work Services and Prison Inspectorates for Scotland (1998) ***Women Offenders – A Safer Way: A Review of Community Disposals and the Use of Custody for Women Offenders in Scotland***

CHAPTER 2: RISK

Risk assessment and management

2.1 Our Committee's terms of reference require us to consider serious violent and sexual offenders who may present a continuing danger to the public. The central question, before considering any special sentencing powers or management approaches is - To what extent is it possible to know who presents a high risk of committing a serious offence? Our view is that the state of knowledge on risk assessment has improved in recent years and is likely to improve further as assessment tools are refined and validated for a Scottish population.

2.2 It is reasonable for decisions in the criminal justice and mental health systems to be informed by risk assessments, and this should be done to a greater extent than is currently the case. However, no current risk assessment procedure, nor any which is likely to be developed, can predict future human behaviour with anything approaching certainty. The risk assessor can determine whether an individual has a greater propensity to use violence than others, but cannot know when an individual's volition, or the circumstances in which he/she finds him/herself, will precipitate a violent act.

Definitions

2.3 Although words such as 'risk' are in everyday use, it is important to be clear as to what is meant. For our purposes, we are particularly concerned with risk assessment in relation to future serious violence and sexual violence. A definition which we have found helpful is that of Dr Stephen Hart, who defines violence risk assessment as:

'...the process of evaluating individuals to characterise the likelihood they will commit acts of violence and develop interventions to reduce that likelihood'[8].

This definition is particularly helpful because it does not view risk assessment as an end in itself but links it to positive action to manage and reduce risk.

2.4 The term risk is preferred to 'dangerousness', because the term dangerousness implies a dispositional trait, inherent in an individual, that compels him/her to engage in a range of violent behaviour across a range of settings. That approach fails to take into account the complex interaction of psychological characteristics and situational factors in the production of violent acts. Violent individuals (including those who may have certain personality characteristics) are more likely to be violent in certain contexts. The response to risks presented by individuals should, therefore, not be restricted to an attempt to modify those characteristics in order to make the individuals less of a risk, but also seek to reduce the opportunities or triggers for violence.

2.5 We are concerned with risk of violence. Unfortunately, there is no universally agreed definition of violence or sexual violence in the risk assessment literature. This is important because it can be difficult to evaluate the effectiveness of different methods of risk assessment and risk management without a consistent definition of what is the particular undesired outcome.

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[8] Hart S D(1998) 'The Role of psychopathy in assessing risk for violence: conceptual and methodological issues' ***Legal and Criminological Psychology*** 3, 121, 137.

2.6 In our view, the 'continuing danger to the public' referred to in our remit is the danger that the offender will commit further acts of serious violence, or sexual crimes. We have excluded from our consideration the risk that an offender may commit less serious crimes, such as minor breaches of the peace. The effect on the public and victims of less serious crimes is not to be minimised, but is a broader social problem than we are able to address.

2.7 Less serious offending behaviour may nevertheless be relevant to risk assessment, particularly if it suggests a pattern of behaviour that might lead to an act of serious violence.

2.8 The definition of risk assessment given above emphasises that it is a process, not a once-and-for-all event; the process should include assessment, review and re-assessment.

2.9 In short, risk assessment should be seen as an aid to making decisions as to what combination of controls and interventions should be applied to a person in order to manage the risk he or she presents.

Making better use of risk assessment

2.10 In our view, it is possible, within limits, to identify those offenders who pose a risk of future violence. No approach is without error. Furthermore, any assessment of risk is not necessarily wrong simply because an outcome occurred for which a low risk was predicted, whereas an outcome judged to be high risk did not. It is in the nature of any assessment of relative probabilities that such results will, from time to time, happen.

2.11 Nevertheless, the degree of accuracy with which we can predict risk of violence is comparable to, or greater, than that achieved in other important human decisions; for example, the likelihood of cardiac bypass surgery improving mortality rates, the effect of small class size on academic achievement, or the impact on mortality of chemotherapy for breast cancer.

2.12 Risk assessment is central to many decisions in the criminal justice process; overtly so in the case of decisions by the Parole Board and Scottish Ministers in relation to release of prisoners, but also in relation to sentencing, and the many day-to-day decisions that are made about offenders, such as whether to allow a prisoner to move to open conditions, or to allow home leave. Similarly, in mental health law, risk is a factor in the decision to detain or to discharge from detention (particularly for restricted patients following the Mental Health (Public Safety and Appeals) (Scotland) Act 1999), and it influences decisions concerning the level of security or freedom a patient may be accorded.

2.13 It is our view that the role of risk assessment in sentencing, management and release needs to be more clearly acknowledged, and the different types of risk assessment and management need to be better integrated.

2.14 Nevertheless, as a number of respondents to our consultation pointed out, any risk assessment process creates significant numbers of 'false positives' (people assessed as high risk who do not in fact offend) and 'false negatives' (people assessed as low risk who do offend).

2.15 More generally, risk assessment is an example of David Hume's famous dictum, that one cannot derive an 'ought' from an 'is'. Decisions about what level of risk justifies some form of special measure are, ultimately, matters of social policy, not scientific measurement. Where thresholds are set, those who are just above the threshold may not differ markedly from those just below the threshold. Therefore, a graded and flexible set of responses is needed, not simply an attempt to 'catch' the individuals presenting the highest risk.

2.16 Although, as we have said, risk assessment has developed markedly in recent years, it is likely to develop still further. We have sought, therefore, to recommend systems and procedures which will allow for the continued development and application of improved assessment methods.

2.17 Society, through its politicians, and the media, must learn to accept that, in dealing with human behaviour, risks can never be eliminated. Nothing is more likely to dissuade agencies, who may have something to contribute, from offering services than the certain knowledge that they will be pilloried if 'things go wrong'. If society is not prepared to accept any risk then it seems to us fundamentally wrong to expect any professional to carry what is an impossible burden. The issue is one upon which politicians must decide and then give a clear lead.

Approaches to risk assessment

2.18 There are three broad approaches which have been adopted to risk assessment in relation to future violent behaviour: **clinical**, **actuarial**, and **structured clinical judgement**. The distinction between the approaches lies in the process used rather than the variables considered; clinical variables (for example, a diagnosis of substance misuse) may be used in all three approaches. No approach has yet been fully validated for a Scottish offender population. In that connection, we will later go on to make recommendations about current research priorities. However, we believe that, on current evidence, the approach of structured clinical judgement is the most suitable one for the purposes of our criminal justice system.

2.19 The **clinical** approach to risk assessment is the approach that is currently most widespread in Scotland - both in clinical settings such as hospitals, and in non-clinical settings where decisions about future risk of violence are taken, e.g. in relation to parole and probation. Essentially, the clinical approach has been criticised as relying on 'an informal, "in the head" impressionistic, subjective conclusion, reached (somehow) by a human clinical judge[9].' This characterisation sounds harsh, but the evidence is unequivocal that clinical judgements, even by experienced practitioners, are poor predictors of future violence. In his classic review of the field in 1981, John Monahan indicated that only one in three positive predictions of violence made by mental health professionals was accurate.[10]

2.20 A subjective, perhaps even instinctive, approach to risk assessment is not confined to the medical profession. It has historically been the case that sentencers, and those making decisions on release of offenders, have made such decisions with limited information and little guidance as to how to make use of what information they had. Decisions have, of necessity, been based as much on 'feel' as on solid evidence. We believe that, on the basis of developments in the evidence base for risk assessment, this approach should now change.

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[9] Grove and Meehl. 'Comparative efficiencies of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: the clinical-statistical controversy', Psychology, Public Policy and the Law 2. pp. 293-323

[10] Monahan J. (1981) The clinical prediction of violent behaviour Crime and Delinquency Issues

2.21 This is not to deny that a professional with experience and specialist skills can contribute greatly to risk assessment. It is simply to say that for any such assessment to have real predictive power it must be carried out in a structured way, having due regard to all relevant factors. Without this, the continued use of a clinical approach to risk assessment for violent and sexual offenders cannot be supported.

2.22 It must be stressed that we do not recommend that sentencing policy in general should be made more rigid. A sentencer must take account of many factors in determining the appropriate sentence for a particular offence. Most sentencing decisions are not based primarily on dealing with risk of future violence on the part of the offender, but on issues of appropriate punishment, deterrence and so forth. These are complex decisions, and it has long been the tradition in Scotland that it is for judges to have a wide discretion in making them.

2.23 However, there are some decisions, even with the system as it currently stands, which predominantly concern an appraisal of risk. It is our view that such decisions should be made on the best available evidence, and using the most accurate techniques. The unstructured clinical approach can amount to little more than an assertion by a clinician as to the level of risk, often set against a competing assertion by another clinician, with little basis for the court to decide between them.

2.24 The **actuarial** approach has been put forward as a more valid means of identifying risk of future violence. There is a variety of actuarial methods; the essence of them all is that they involve a formal, algorithmic, objective procedure to reach the decision as to risk. Annex 6 summarises the main actuarial instruments in current use.

2.25 We found the actuarial approach to be particularly favoured in the USA. There is strong evidence that actuarial approaches have greater predictive power than unstructured clinical approaches. However, they have a number of weaknesses, which lead us to the view that they should not be used, on their own, as the primary mechanism for undertaking risk assessment.

2.26 There is little evidence as to their accuracy for a Scottish population. This is not a trivial point. Many of the actuarial tools were based on analysis of re-offending amongst a specific, and often highly selected, population. The evidence we received in the USA and Canada was that the Violence Risk Assessment Guide (VRAG) was the most widely used and reliable predictive tool but there is as yet no evidence as to its applicability to Scotland.

2.27 Even their predictive capacity may be compromised if there are factors particular to the individual which affect risk levels, but are not contained in the instrument, e.g. the fact that the individual has acquired a physical disability, or made overt, specific threats.

2.28 Actuarial methods are limited to prediction: they do not generate any strategies for ***managing*** risk. Furthermore, many of the risk factors are historical, e.g. history of childhood disturbance, and cannot be modified, so they may be of little assistance in considering when a person should progress through a progamme of care with changing levels of security.

2.29 An actuarial approach is also difficult for a court to apply confidently, since what it gives is an overall 'score'. It is often difficult to dispute the score, and so the court may have little choice other than to accept the actuarial finding, or enter into debate about its scientific merit, rather than the more relevant issue of the risk presented by the individual before it.

2.30 In recent years a new approach to the assessment of risk has been developed, that of **structured clinical judgement**. It should be stressed that this is an approach, not a particular instrument. The approach seeks to combine the systematic and evidence-based elements of the actuarial approach with the sensitivity to individual risk factors of the clinical approach. It both assesses risk and aids discussion of how best the risk should be managed.

2.31 Structured clinical judgement requires consideration of risk factors that have received empirical support in the literature. Decision making is assisted by guidelines that have been developed to reflect the current state of knowledge. Guidelines of this sort are increasingly common in general medicine, and are becoming more prevalent with the drive towards evidence-based medicine, although they are less frequently used, to date, in psychology or psychiatry.

2.32 Our terms of reference ask that we inform the development of a medical protocol to respond to the needs of personality disordered offenders. As we go on to explain [see paragraph 11.19], we are not convinced that a medical protocol is the best mechanism for dealing with services for, and treatment of, offenders with personality disorders. We do believe, however, that protocols need to be developed for the multi-professional assessment of risk and risk management, and a structured clinical approach is the most suitable foundation currently available for such protocols.

2.33 Our Committee received an extremely helpful presentation from one of the authors of the HCR-20, one of the best known and best researched of the risk assessment tools which are based on the structured clinical approach. Annex 6 describes the main features of this tool. Early results suggest that the HCR-20 shows considerable promise for the prediction of future violence and the management of those who pose a risk of violence, although, again, research is needed into its suitability for the Scottish population.

2.34 The structured clinical approach is based on assessment by trained people with appropriate expertise. It supports a multi-disciplinary approach, rather than the more traditional model of investing a particular professional with an assumed unique insight into the danger presented by an individual. At its basic level, it requires due consideration to be given in risk assessment to a wide range of factors which have been shown empirically to have a bearing on risk. These include both historical factors (such as a history of previous violence) and those which may be subject to change (such as active symptoms of mental illness). It also has regard to questions relevant in risk management, such as the extent to which the individual would be exposed to destabilising factors.

2.35 The outcome can be presented in various ways, according to the purpose of the assessment. In the context of assessment for a court, the outcome may be represented as indicating high, medium or low risk. It can also be used to prepare a full description of the level and type of risk presented by an individual.

2.36 In our Committee's view, it is necessary to have a risk assessment process that is not only defensible in terms of its scientific basis, but also one which can be applied for practical purposes. In particular, it must meet the needs of sentencers and others who take decisions on release and discharge of offenders. A court considering a special disposal based on risk should require evidence that is soundly based, and that can be tested: in cross-examination and against competing evidence. In the Scottish tradition it is also important that the expert witness does not take over the decision-making authority from the sentencer. It is the sentencer who decides what weight to attach to the expert evidence.

2.37 The structured clinical approach, in our view, meets these requirements. It was, after all, developed with these requirements very much in mind. The basis of a finding by an assessor that an individual presents, for example, a high risk of future violence, can be set out and the individual components of that assessment can be challenged.

RECOMMENDATION 2

Systems of risk assessment should be based on the best available research. Current evidence suggests that the structured clinical approach to risk assessment should be seen as the most helpful approach in relation to risk assessment for forensic purposes, and this should be reflected in guidance and training.

2.38 While knowledge is improving, there is a great need for more research. In particular, we recommend:

RECOMMENDATION 3

There is a need for research on risk assessment issues relating to serious violent and sexual offenders, and in particular research on:

- the numbers of such offenders who may present a continuing risk to public safety;
- the application of risk assessment instruments and techniques in a Scottish context; and
- recidivism, including factors which may predict recidivism.

The Committee recommend that national grant-giving bodies are encouraged to include such aims in their research agendas.

Developing a co-ordinated risk assessment and management process

2.39 It is our view that a properly co-ordinated risk management process should be developed for serious violent and sexual offenders. We believe that this should have the following key features, namely it should:

be based on best practice:

- be empirically based

- take a multi-disciplinary and multi-modal approach to information
- be based on access to all relevant information
- allow sufficient time for assessment - where appropriate on a residential basis
- use all appropriate technology

be dynamic:

- be sensitive to changing conditions
- continue over time

produce practical outcomes:

- identify factors which aggravate or mitigate risk
- lead to management strategies
- involve systematic monitoring of risk outcomes

be open and regularly monitored:

- be transparent and open to challenge
- contain quality control systems

Best practice

2.40 Risk assessment should be empirically based, i.e. supported by acceptable scientific evidence. For many years, risk assessment was not based on any evidence. Such evidence as was available suggested that attempts to gauge risk were little or no more successful than chance. In such circumstances, it is understandable that people relied on intuitive approaches. Today, the developing body of evidence in relation to risk assessment and risk management has rendered the intuitive approach unsustainable.

2.41 We received evidence that the practice of risk assessment could be greatly improved. In particular a great many respondents (including the majority of local authority respondents and bodies such as the Mental Welfare Commission, the Royal College of Nursing, and the Association of Directors of Social Work) called for a multi-disciplinary approach to the assessment of offenders with personality disorders or mental disorders, particularly prior to sentencing.

2.42 A number of local authorities specifically called for a national framework for such multi-disciplinary assessment. The Scottish Executive has produced a framework for risk assessment in local authorities[11], and this could form the basis of a broader approach. We address this in our recommendations regarding the Risk Management Authority (See Chapter 3).

2.43 Several respondents took the view that risk assessment should be uniform across different agencies. Consistency is to be welcomed, but uniformity may not be possible nor desirable since the different agencies are assessing risk for different purposes. We believe that there should be compatibility between different approaches, and that quality should be standardised.

[11] Management and Assessment of Risk in Social Work Services (Social Work Services Inspectorate)

A dynamic approach

2.44 The dynamic approach, continuing over time, assumes that a decision about risk should not be seen as a 'once and for all' event. Risk requires to be assessed at many stages. Many factors will be common to each risk assessment, and so it is in the interests of accuracy and efficiency if risk assessments are carried out using a common language, and sharing common information. It is also important to be able to assess what may have changed in the presenting risk, which can only be done if assessments are carried out in a consistent way.

2.45 It is also important that risk assessment is consistent with, and leads to, practical outcomes. The goal is not simply to measure risk, but to work out how best to reduce risk.

Access to information

2.46 An area where considerable improvement is possible is that of access to relevant information[12]. In our recommendations on sentencing, we emphasise that any risk assessment is ultimately dependent on the quality of available information. Many people have pointed out to us the difficulty faced by a person seeking to assess the risk presented by an offender when the principal source of information is the offender him/herself. Among the factors that are of great significance in assessing risk is knowledge of all the circumstances of the current crime, and those of previous crimes. It is often of great importance to be aware of matters such as episodes of antisocial behaviour in childhood and adolescence.

2.47 Lady Cosgrove's Expert Panel has undertaken a considerable amount of work on this issue, and we are grateful to them for sharing it with us. In overcoming the barriers to the proper use of information it is important to identify the nature of the various difficulties. Some of these are structural (for example, issues about where information is stored and in what form). Some are attitudinal, arising at worst from mistrust of other professionals, and reluctance to give up control of knowledge. Related to these are issues of professional duties of confidentiality. It has been argued that the problems presented by confidentiality are often overstated, and can be alleviated by a clearer understanding of the limits of client confidentiality. Nevertheless, the problem does exist. Finally, there are serious issues over the extent to which information that may be contested, or unproven, can be taken into account in a sentencing process (discussed at paragraphs 5.11-5.26).

New procedures

2.48 In North America, considerable reliance is placed on technological devices for risk assessment which are little used here, notably the penile plethysmograph. In our view the penile plethysmograph, when operated by appropriately trained staff, may add to the evidence available in a risk assessment for sexual violence and avoid the reliance on self reporting by the offender.

2.49 The Home Office, as part of its initiative on Dangerous Severely Personality Disordered People, is carrying out work on techniques for improving risk assessment. Although our recommendations do not accord in every respect with the current English proposals, many issues of risk assessment are common to both, and we would encourage the Scottish Executive (in due course, the Risk Management Authority) to make arrangements to share information with the Home Office on the development of risk assessment procedures.

[12] We were advised that for Greater Glasgow, a protocol for sharing information between health bodies, local authorities and the prison service is being developed.

Training issues

2.50 A more systematic use of risk assessment, and a more consistent understanding of its application, require a considerable investment in training. This is increasingly recognised in some professions, such as social work, but needs to be more widely adopted for all who participate in risk assessment, or have to make decisions based on risk. We include in this the Judiciary and the Parole Board, Scottish Executive officials (insofar as they provide advice to Ministers on risk assessment and management), social workers, prison officers, prosecutors, psychiatrists and psychologists.

2.51 As we will say in Chapter 3, the proposed Risk Management Authority would play a role in setting standards, but it will be for the individual agencies and professional bodies to ensure that the necessary training is delivered. We would encourage the development of joint training across professional boundaries, and also evaluation of the effectiveness of training in risk assessment.

RECOMMENDATION 4

All agencies operating in the criminal justice system should ensure that professionals who evaluate risk, or make decisions based on risk, are appropriately trained.

CHAPTER 3: A RISK MANAGEMENT AUTHORITY

The need for a Risk Management Authority

3.1 As the work of our Committee progressed, it became clear that apart from the developments in sentencing options and offender management practice to which we were working, there was a need for structural improvements in the existing arrangements for the management of seriously violent and sexual offenders.

3.2 Both in our work looking at developments in the United Kingdom and in our fact-finding visits abroad, we were presented with evidence of a rapidly developing expertise in assessing the risks presented by violent offenders and in developing interventions designed to lessen the risks. We saw evidence of a lively but small international community working in this field, and in Canada, in particular, there was evidence of effective communication between that community and policy makers. The developments we saw offer a real opportunity in Scotland to achieve better protection for the public from this group of offenders. What we did not find, however, were effective mechanisms in Scotland for benefiting from the developments we saw. We see a need, if that opportunity is to be realised, to introduce means for keeping abreast of the methodologies and technologies of risk management as they are developed, and for making them available to practitioners.

3.3 We saw examples in the prison services of Scotland and England and in the Correctional Service of Canada of the introduction of systems of independent accreditation of programmes and programme delivery systems for work being done with offenders in addressing their offending behaviour. We also saw a great deal of well-intentioned work being done in both assessing offenders' needs and designing programmes intended to address those needs for which the practitioners were unable to offer us research validation. In Chapter 2 we discussed the relative merits of three approaches to the assessment of the risk presented by offenders, namely clinical judgement, actuarial methods, and structured clinical methods. The first of these approaches - a reliance on the judgement of those with expert knowledge and experience - is the predominant methodology in criminal proceedings in Scotland and in our systems for conditional release from prison. It is the least reliable of the three approaches. We are optimistic that better protection of the public can be achieved if we better inform our approach to risk management by research evidence, the accreditation of methods used and the assessment of the competence of all those working in the field to work with the methods that are demonstrably the most effective.

3.4 Finally, we saw some evidence of the development of good inter-agency co-operation in the management of some groups of offenders. We learned of planning for the release into the community of particularly high risk prisoners from Edinburgh Prison, of the quadrapartite agreement in Glasgow between Strathclyde police, the Social Work and Housing Departments of Glasgow City Council and Barlinnie Prison on co-operation in managing the release of sex offenders, and of the initiative taken by Greater Glasgow Health Board to promote an inter-agency co-operation in the care of mentally disordered offenders. Despite these encouraging initiatives, the overwhelming impression we received was of the frustration experienced by practitioners in each of the organisations in achieving effective inter-agency working with the group we were considering. The general experience we

encountered was of a feeling that the contribution each agency could make both in enabling the successful rehabilitation of the offender and in offering better protection to the public was compromised by problems of inter-agency communication and information exchange, by incompatibility of systems or by differences in therapeutic or management approach. We consider that a significant weakness exists in our present arrangements in that there is no authority responsible for the overall risk management of particularly problematic offenders and for bridging the incompatibilities that clearly exist between the many agencies that have to play a part if improved protection is to be offered to the public.

3.5 We do not feel that any of these shortcomings in our present arrangements can be resolved by specific recommendations for improvements that we could make now. The issues are essentially dynamic and developmental. For them to be effectively addressed there must be continuing review of expertise and methods, effective and on-going quality assurance, and an identified authority responsible for ensuring that offenders made subject to the order we propose in Section Two remain under as close supervision as the courts intend for the remainder of their lives.

RECOMMENDATION 5

A new authority, to be called the Risk Management Authority, should be created with a view to securing the protection of the public from seriously violent and sexual offenders while restricting their freedoms no more than is necessary in the public interest.

The Authority should have three main roles: a policy role, a standard setting role and an operational role.

3.6 Our recommendation is made in respect of the offender group that we were asked to consider. In making it, however, we are aware that we are proposing a standard of rigour for the management of that group that might well be appropriate to others. We have in mind those serving mandatory life sentences, those serving extended sentences and those subject, under mental health legislation, to restriction orders and restriction directions. We also anticipate that only small numbers of offenders, of the types we were asked to consider, are likely to become subject to the new sentence for high risk offenders which we propose in Section Two. If this recommendation is accepted, therefore, the Executive may wish to consider giving the Risk Management Authority terms of reference broader than simply to include the group on whom we are reporting.

The constitution of the new Risk Management Authority

3.7 The committee has not given detailed consideration to the constitutional and management arrangements of the new body. We set out below the broad framework which we recommend.

3.8 We believe that the Authority should be operationally autonomous with a policy framework set by Ministers, and with an independent board. It is essential that it be independent of any professional, organisational or political identity.

3.9 The Authority will have to be demonstrably expert in the field of risk management. To achieve that, it will have to derive its expertise from a wide range of disciplines. As much of its work will be in influencing and co-ordinating the work of existing agencies, its authority will derive not only from its relationship to the Scottish Executive but from its credibility with those agencies.

3.10 Its role should not be restricted only to influencing, however. It must have executive authority in a number of areas. These should include:

- commissioning research;
- accrediting risk assessment and management methods and processes;
- setting the standards by which the competence of practitioners to work in the area will be assessed;
- commissioning services from agencies working with offenders subject to the new order and deploying a budget for that purpose;
- reviewing and developing the risk management plan for an offender within any specific licence requirements that have been set by the Parole Board.

3.11 In order to exercise such executive authority effectively, it should manage an operating budget. This budget, for which it would bid, would be sufficient not only for its own running costs but also to allow it to commission such work as will ensure that the most effective risk assessment and management processes are being introduced into Scotland. We recognise that giving effect to this advice will be problematic. We do not foresee the Authority we are proposing assuming responsibility for budgets currently managed by, for example, the SPS or social work departments. We would expect them to continue to provide the core services to this group of offenders as they do at present. We do consider, however, that if the Authority we are recommending is to be effective, it will have to have budgetary capability in three areas.

3.11.1 It will need the capability, as it becomes aware of new risk assessment or management processes or technologies, to commission their development, assessment and introduction into Scotland. Two examples, from our examination of developments elsewhere will illustrate this need. First, as work is being undertaken in a number of jurisdictions with sex offenders, the extent to which they are a heterogeneous offending group, with widely varying risk management needs, is becoming clear. Work being undertaken at present suggests that certain classes of sex offenders, for example, have a low probability of reoffending, while others present a high risk. Work is now being undertaken to improve understanding of the dynamics of that and to develop better targeted responses. That work can be expected to lead to concrete and usable results in the near future. The results are likely to include assessment tools, programmes and guidance on management in the community - any or all of which the Authority could be expected to wish to see developed for use in Scotland. Managing a budget would give it the capability to commission the work it needs from the agencies that are responsible at present for protecting the public from sex offending. Second, we saw a system of satellite tracking of 'tagged' offenders in operation in Phoenix, Arizona. While such use of electronic technology seems far removed from our present expectations, the capability to restrict

and monitor offenders' movements automatically may well have potential that an Authority might wish to explore. It would need to command a budget to be able to do that. There is a need for a budget to stimulate new processes and technologies.

3.11.2 Second, particular offenders may require specific risk management processes that are beyond the resources of the agencies working with them. The Authority may wish to see specific work that is not normally available being undertaken with someone in prison, or it may wish to have supervisory processes in place for an offender living in a small or remote local authority area that the authority could not reasonably be required to provide without financial support. There is a need for a budget to be able to ensure that the best programmes of risk management that can be developed for individual offenders can be successfully implemented.

3.11.3 Finally, and in the long term most importantly, we see the Authority using its budget over time to develop strategically the response we are able to make to these serious forms of offending. We anticipate that by commissioning work with this offender group that can be shown to be effective, and by withdrawing support and recognition for work that cannot demonstrate efficacy, it will increase the impact of the investment made and secure improved value for money as well as public safety.

3.12 Clearly, if the Authority is to be voted money to secure its ends, it should be expected to agree a long-term strategic and an annual management plan with government and to report annually to Parliament on its performance

RECOMMENDATION 6

The Risk Management Authority should:

- be headed by a board that reports to Ministers;
- produce strategic and annual management plans;
- have an operating budget for the purposes of securing the continuing development of services to high risk offenders, and for commissioning specific services that are required for the management of individual offenders;
- produce an annual report on its work to Parliament.

The policy role of the new Authority

3.13 We are aware that the approach we are proposing is premised on an emergent knowledge base. What is convincing about the knowledge that we have is the rigour with which it has been developed. That is sufficient for us to propose new procedures based on it. In doing so, however, we are conscious that those working in the field are going to be working in an area where knowledge can be expected to develop rapidly. This part of our recommendations therefore focuses on the role of the new Authority in keeping abreast of, and promoting, the best practice that is available internationally.

3.14 The development of the understanding of the risks presented by the offenders we have been considering, and of methods for managing those risks, is taking place internationally. The research is specific to a variety of offender groups and to the cultures from which they come. It is not possible simply to assume the effectiveness of tools developed elsewhere. As understanding moves forward, its consequences for the Scottish population have to be researched here. Progress is being sustained through a lively international exchange of conclusions and cross-cultural testing of emergent conclusions and procedures. If the people of Scotland are to be afforded the most effective protection from those offenders judged to present the greatest risks, cost effectively and by means compatible with the legal rights of the offenders, it is essential that we take full advantage of new approaches and technologies as they emerge and participate effectively in their development. There is some evidence of that already happening, examples of which arise out of the interest and expertise of particular researchers and practitioners working in Scotland.

3.15 At a policy level, two essential functions are not being performed. First, we reached the conclusion that funding of research and the introduction of new risk management techniques is not being shaped by a clear policy priority to lessen the risk presented by the group of high risk offenders. Second, where benefit is being derived from developments that have taken place, it is unco-ordinated. Though, within their own frames of reference, the approach to risk assessment used within the health service, social work departments, and SPS has been informed by research, their approaches are different. Reports from psychiatrists, forensic psychologists or social workers to the courts or to the Parole Board are sometimes written from confusingly incompatible intellectual positions. They may use the same words with meanings different both from each other and from the meanings that those reading them would normally use. They are based on distinctive and not always compatible explanatory models.

3.16 There is a clear need, if adequate protection is to be afforded to the public, for the assessment and management of the risks presented by very violent offenders to be conducted within a shared framework of language and techniques. The Authority would play a key role in the production of guidelines and protocols that would provide a common framework within which all the agencies that participate in managing these risks would operate.

3.17 The Authority would be able to keep abreast of developments in risk management as they emerge and to communicate these in the form of guidelines and protocols to agencies working in the field. As understanding, techniques and technologies develop, the Authority may have to make recommendations for changes in the law and redirection of funding.

RECOMMENDATION 7

The Risk Management Authority's policy work should fall into three main areas:

- monitoring international research and practice in risk management and commissioning Scottish developments;
- disseminating best practice and developing guidelines and protocols;
- reviewing current practice and making proposals to Government for change.

The standard setting role of the new Authority

3.18 We have been able in this report to describe the approach to risk assessment and management that we see underpinning the new sentence which we propose in Section Two for high risk offenders. We have emphasised that the best of the work is based on rigorous research and subject to critical evaluation. While there is evidence that such work is effective in improving public protection, there is also considerable evidence that much well-intentioned and established work cannot be shown to be effective and may, indeed, increase risk.

3.19 An essential part of our recommendations is therefore that the introduction of the approach we are proposing be supported by a stringent standard setting role to be exercised by the new Authority. We see that quality control operating in three main ways, as set out below.

3.20 First, the Authority would accredit the methods for advising decision takers of the size and nature of the risk posed by offenders who present particular concerns. We envisage a role for the Authority in approving risk assessment techniques for use. The accreditation process would extend both to the procedures or tools that could be used and to the circumstances in which they could be employed. We would anticipate that the Authority would wish to accredit the procedures or tools themselves, the situations in which they could be administered, and the agencies and practitioners who could use them. We would also anticipate that the Authority would require, as part of the accreditation process, that guidance be given on the interpretation of the evidence generated by any tool to all who may subsequently use it in reaching decisions on the management of offenders. Implicit in the approach we are advocating is that the risk assessment methods recognised by the Authority would be accredited and that official reports submitted to the courts and to the Designated Life Tribunal of the Parole Board (DLT) would have been prepared by assessors of established competence using accredited methods. In Section Two we propose a formal process of assessment before our suggested new sentence is imposed; that assessment would require to be conducted using accredited methods, as would any subsequent assessment co-ordinated by the Risk Management Authority for consideration by a DLT.

3.21 Second, the Authority would accredit the methods and processes of risk management that may subsequently be deployed. These will take many different forms:

Interventions and programmes designed to modify behaviour

Methods of monitoring the offenders behaviour and habits

Controls on the offenders movements or contacts

Supports for the offender in gaining accommodation, work or training

Progress review and assessment interviews

3.22 We would anticipate that the new Authority would monitor international developments in each of these areas, would evaluate their effectiveness and application to the Scottish context and, where appropriate, would accredit programmes, technologies and best practice for use by the service-providing agencies in managing the offenders. We use the term 'where appropriate' in recognition that in some areas of practice the rigorous procedures of accreditation

may not be the best way of achieving effective performance. In these areas we would see the role of the Authority being to promulgate best practice.

3.23 In anticipating this role for the Authority, we are aware that SPS, in particular, has already established a rigorous process of independent accreditation of programmes within prisons. It may well be that the Authority would wish to capitalise on the work that is already performed by that process. The focus of the accreditation that will be operated by the Authority, however, will be sharply on lessening the risk of future serious violence. We would expect, therefore, that the two authorities would work closely to satisfy themselves that the work that each does complements the work of the other.

3.24 Third, we see a need for the Authority to establish a firm basis of competence by all involved in the processes of managing the risks presented by the very difficult client group with which we have been concerned. In the course of our work as a Committee, it became clear that major differences of approach exist between practitioners in the fields of managing the offenders we were considering, but also that the approach used by practitioners was very often widely different from the conceptual approach that decision makers in the courts and the Parole Board bring to the issues they consider.

3.25 A key role for the Authority will be to build a common basis of intellectual understanding of the nature of the problem, the methods of assessing risk and the range of effective processes for managing risk that are available to service providers. In British Columbia we saw initiatives that had been taken to improve the training of practitioners and decision takers involved in implementing the relative Canadian dangerous offender legislation. Such training is essential if the risks presented by this group are to be addressed. But the provision of training is not sufficient. For there to be confidence that decisions and practice will be effective, the public need to know that all who work in the field are competent. The role of the Authority in this area would be similar, say, to that of, for example, the Council for the Registration of Forensic Practitioners or more generally to the role of National Training Organisations in that it would determine the standards of competence that all who work in the area need to demonstrate and the means by which that competence will be assessed. In carrying out this role, it will require to consult with the appropriate professional bodies, including the Royal College of Psychiatrists and the British Psychological Society.

RECOMMENDATION 8

The Authority's standard setting work should fall into three main areas:

- accrediting risk assessment systems;
- accrediting risk management processes;
- the training and competence assessment of practitioners.

The operational role of the new Authority

3.26 In considering the operation of our proposals, we wished to address shortcomings that we have been told exist in the current arrangements for the management of high risk offenders. Two characteristics of the existing arrangements gave us particular concern.

3.27 First, we felt that the existing arrangements inadequately give effect to the intention of a sentence imposed to manage systematically the risk presented by particularly violent offenders for life. The distinction between the period in prison and that in the community is too marked and the step change in circumstances at the end of the custodial period is too great. There is an expectation that if offenders conform to the requirements made of them - both in prison and when under supervision in the community - then controls over them are progressively relaxed and intervention decreased, not exclusively as an outcome of an assessment of risk (though we recognise that such assessments continuously, if informally, influence decision making), but in recognition of acceptable behaviour. The arrangements we are proposing are designed to ensure that following the sentence that we anticipate, there will be regular and systematic review of the risk presented by the offender, that this will be supported by a risk management plan and that those arrangements will continue for the rest of the offender's life. They are also designed to manage the transition from custody and back into the community in such a way as to minimise the scale of change in circumstance that the offender faces at any point.

3.28 Second, we were concerned that there is no clear identification as to where responsibility lies for protecting the public from the risk presented by the group we were considering. At differing times, the prison service and local authority social work departments, whose responsibilities extend beyond the group we were considering, take a lead responsibility. It is our view that their objectives are less focused on the issues that concerned us than we think they should be. The police, housing departments, health services, the employment service and, very often, voluntary agencies also impact on the circumstances of the group and can offer services relevant to the risk they present. With the introduction of electric monitoring, in particular, private sector organisations may also contribute.

3.29 The Parole Board exercises a co-ordinating influence over these agencies. Its impact, however, is properly focused on release and recall decisions. It does not have authority to require action by any of the other agencies.

3.30 Our proposals are designed to establish a clear responsibility, to be vested in a new Authority, for the maintenance and delivery of a systematic risk management plan throughout the lives of offenders assessed as presenting high risk of violence to the community. We considered a number of means by which this might be achieved.

3.31 We were particularly interested to see the operation in Canada of the Correctional Service which combines responsibility for both prisons and supervision in the community. We were not convinced, however, that the benefits of retaining responsibility in one organisation for the management of offenders throughout the period of intervention outweighed the costs of isolation of the correctional service from other social agencies. A unified correctional service simply shifts the boundaries between organisations. It would be beyond the scope of our report to recommend such an approach in general, and what we saw did not persuade us that we would wish to do so.

3.32 We considered making specific recommendations about multi-disciplinary working. We also took account of improvements that have been achieved in inter-agency co-ordination in managing the release of sex offenders and considered the possibility of recommending a more formal framework for regionally based structures.

3.33 We concluded that the ends that we wished to achieve would best be met by responsibility for the management of the risk presented by particularly violent offenders being vested in one Authority that would commission services as most appropriate from existing agencies. In order to achieve that, it should control a budget allocated for the express purpose of achieving effective risk management of high risk offenders.

3.34 We considered vesting that responsibility in the Parole Board, within the Scottish Executive or in a new authority. The Parole Board is ruled out by the need to separate decisions on release from executive authority for managing restrictions on freedom. We had already decided to recommend a new Authority to monitor advances in risk assessment, to develop policy and to supervise standards of risk assessment and risk management techniques. We see this Authority developing as a centre of excellence in the field. It is a short step to recommend that the Authority should assume the responsibility for commissioning and supervising the delivery of programmes of risk management to individual offenders. (We discuss this further in Chapters 8 and 9)

Further implications of the creation of the new Authority

3.35 We set out below additional benefits flowing from the creation of an Authority.

3.36 In conducting our research we have been made aware of the risk and need assessment techniques that have been developed by the SPS psychology service. We have also seen the risk assessment techniques introduced by the Social Work Services Inspectorate. We have learned about the system for independent research-based accreditation of programmes operated by the SPS and have examined programmes designed to address a range of criminal behaviours in Scotland and the other administrations we have visited. The technologies of risk assessment and risk management are rapidly developing. If the Scottish community is to derive the greatest benefit available from those developments, it is important that decisions to use new technologies can be made, and new approaches introduced, quickly. A commissioning authority controlling an operating budget would be able to focus resources where they are most effective. The result would be strategic development of a more cost effective response to the risks presented.

3.37 We recognise that our proposal will have consequences for the existing agencies that operate in this area. It would compete with them for resources. It would have authority to require approaches it considers the most effective to be developed. By advancing or withholding financial support, by recognising or not the validity of treatment interventions, its authority would supersede, in this area, that of the service providers.

3.38 But these costs can be compensated for by the impetus the approach we are suggesting would give to the sort of research-based work SPS has initiated, the benefits it would bring in aligning the work of each agency with that of others, and the progressive benefit of focusing resources where their impact is greatest.

3.39 We see further potential benefit in the approach we are recommending in that the model of an authority supervising the contributions of each of the service delivery agencies may well come to be seen as appropriate not just for the small but particularly threatening group of offenders with which we are concerned, but for serious offenders in general. In particular the approach may be expected to be appropriate for the management of all life-sentence prisoners and for prisoners in general who are serving extended sentences. It is also relevant to the management of persons under restriction orders imposed under mental health legislation.

RECOMMENDATION 9

The operational role of the Risk Management Authority is to manage the risks presented by serious violent and sexual offenders, by agreeing a risk management plan for each and by commissioning appropriate risk management services from the agencies it considers give best value for money in protecting the public.

SECTION 2

A NEW REGIME FOR HIGH RISK OFFENDERS

CHAPTER 4: SENTENCING OPTIONS

General approach

4.1 Sentencing policy, legislation and practice should be designed to reflect the aims of sentencing. There are of course several such aims, including retribution, deterrence, restitution to the victim and society, rehabilitation and incapacitation. It is because these aims are so diverse, as of course are offenders and the crimes they commit, that sentencers have traditionally enjoyed a wide discretion in Scotland, within the boundaries set by statute and any guidance given by the High Court in decisions on appeal.

4.2 In the case of serious violent and sexual offenders, it is right that a sentence should be sufficiently severe to constitute appropriate punishment for the offence which has been committed. However, we believe that it is also right that reducing the risk of future harm to society is a legitimate sentencing aim. This can be achieved both by increasing control over offenders, whether in prison or in the community, and by seeking to modify their behaviour.

4.3 It is our general belief, then, that in addition to imposing sentences for punishment reasons, it is appropriate to sentence serious violent and sexual offenders differentially, in order to reflect the risk they present. But this approach can be fair only to the extent that the way in which we evaluate levels of risk can be shown to be reasonably reliable. Furthermore, the imposition on individuals of additional sanctions on top of proportional punishment, because it is felt that they present additional risk, should carry with it the expectation that society will take some measures to help an offender to reduce that risk. Indeed, it would be a poor use of resources if the costs of incarcerating and supervising such offenders were incurred without any attempt to address the behaviour that led to their sentences.

4.4 Nevertheless, our approach must be tempered with realism and the knowledge that the 'treatment effect' of most interventions is modest. Some offenders will not improve. Since it is impossible to predict the outcome of treatment in advance, the principles of rehabilitation should mainly inform ***the way*** a sentence is served, rather than ***the overall length*** of the sentence. Different issues apply to those who are acutely mentally ill at the time of the commission of a criminal act, both because their culpability may be less or even non-existent, and because in many cases effective medical treatment can greatly reduce the future risk.

4.5 In terms of sentence management, it is our guiding principle that a sentence must be viewed as a whole. Too often, time spent in prison has been regarded as the 'real sentence', with time on parole or licence being viewed as a separate entity with different aims. For the group of offenders with which we are concerned, it is crucial that the whole length of a sentence is used in an integrated way to manage and reduce risk. Our recommendations are designed to 'blur the boundaries' between prison and the community. We also wish to ensure that throughout a sentence there is active quasi-judicial oversight to ensure fairness to the offender and appropriate protection for society.

Sentencing offenders who commit serious violent or sexual crimes

4.6 In our consultation paper, we outlined the options currently available to sentencers, and these are set out again in Annex 7. So far as those not suffering from mental disorder are concerned, the majority of serious violent and sexual offenders receive a determinate sentence. Most of those receiving sentences of four years or more will be released after serving between one half and two thirds of their sentence in prison. A very few will receive an extended sentence which allows for a further period on licence after release, which period can, in the case of a sex offender, be for up to ten years. A few will receive a discretionary life sentence. Those convicted of murder will receive mandatory life sentences. We deal with those suffering from a mental disorder in Chapter 7.

4.7 There are two fundamental concerns when dealing with offenders who present a high and enduring risk. The first is that with determinate sentencing, including the imposition of an extended sentence, both the period in prison and the period under any form of supervision must come to an end at a specified date, regardless of the extent to which the offender presents a continuing risk. Second, although there is flexibility in fixing at the date of its imposition the overall length of the sentence, up to and including life imprisonment, the procedures for deciding what sentence to impose or whether to release an offender may not be sufficiently discriminating to use the discretion effectively.

4.8 As we have said, sentencers in Scotland have traditionally enjoyed a large measure of discretion. Except in cases of murder, mandatory sentences are almost unknown. Many of the relevant offences are non-statutory, allowing the sentencer, at least in the High Court, to impose any sentence from a non-custodial disposal to discretionary life. This has many advantages, but one possible disadvantage is that guidance which might assist a sentencer in selecting an appropriate sentence is relatively unsystematic.

4.9 Although the High Court has power under sections 118(7) and 189(7) of the Criminal Procedure (Scotland) Act 1995 to pronounce sentencing guidelines to which, in terms of section 197, a sentencer must have regard in passing sentence, the Court has not so far seen fit to do so. But it has, in the course of several cases, given some guidance as to the appropriateness of discretionary life sentences. The current position appears to be that such a sentence will only be appropriate in the case of a grave offence and where there are expert reports indicating that the offender represents a significant danger to the public at large, or to one particular group thereof, such as women or children.

4.10 Our Committee was interested to discover what factors influenced a judge in deciding whether to impose a discretionary life sentence, as opposed to a determinate sentence. We commissioned research studying all adult discretionary life sentences between 1994 and 1998, and comparing them with a representative sample of comparable offences for which determinate sentences were imposed. The results are set out in Annex 2. It can be seen that all the discretionary life sentences were for offences falling within our terms of reference. It also appears that the main justification for imposing a discretionary life sentence was the level of continuing risk presented by the offender. Interestingly, given our terms of reference, the category 'personality disordered' does not appear in the research as a determining factor. It also appears from the research that the offences committed by and the

antecedents of the control group of offenders receiving long determinate sentences are strikingly similar to the discretionary life group.

4.11 Although any results taken from this limited piece of research must be tentative, we think three conclusions can be drawn, namely:

- risk of future serious harm to the public is the main reason for imposing a discretionary life sentence;
- judges are alert to some of the key factors which create higher risk, but
- the decision about risk is taken in an unstructured way.

The way forward

4.12 In our consultation paper we commented that:

'...the Scottish system would seem to have the flexibility to impose lengthy and, indeed, indeterminate prison sentences, where these are warranted by the circumstances. However, it can be difficult to assess dangerousness at the time of sentencing, and the Committee is interested to consider whether the current procedures for considering release on licence, and post release supervision, are adequate'.

4.13 Having considered evidence as to the operation of systems both in Scotland and elsewhere, we remain of the view that the basis of the Scottish system is sound, but that more needs to be done to make the assessment of risk an overt and transparent part of that system. In other respects, our views have developed. In particular, we now believe that more emphasis should be placed on the management of the whole sentence, rather than on maintaining the sharp division between time spent in prison and time in the community. In arriving at these conclusions, we considered a range of possible new sentencing options.

Option one: mandatory life imprisonment for crimes other than murder

4.14 Currently, mandatory life sentences are imposed only in cases of murder. While Section 1 of the Crime and Punishment (Scotland) Act 1997 also provides for an automatic life sentence in certain situations, essentially where a person is convicted of two or more serious offences, that section has not been brought into force. As enacted, it provides for a wide element of judicial discretion as to whether a life sentence should be imposed in particular cases, arguably leaving the sentence positioned uneasily somewhere between mandatory and discretionary life.

4.15 Almost no support was received in our consultation for an extension to the circumstances in which mandatory life sentences should be applied. It was suggested as a possible option by the Association of Chief Police Officers in Scotland (ACPOS) but without being particularly favoured; and one local authority suggested it might be considered, but only if release and recall decisions were not the responsibility of Ministers.

4.16 A case can be made for saying that to require judges to impose mandatory life sentences for repeat serious offenders will enhance public safety. This is based both on the assumed deterrent effect of such a sentence and the fact that people who have shown themselves to be a danger to the public on repeated occasions can reasonably be assumed to present a continuing danger in future.

4.17 We received no evidence directly bearing on the issue of deterrence, but we are sceptical that the current legal status of a provision such as Section 1 of the 1997 Act plays a significant part in the calculations of the kind of offender with whom we are concerned. Given that we are considering serious offenders who, whatever the statutory provisions, will be likely to spend long periods in custody if convicted, it seems reasonable to suppose that the greatest impact on deterrence is likely to be by improving the prospects of catching the offender and obtaining a conviction in the first place.

4.18 As to the argument that incapacitation will increase public safety, it is clearly the case that incarcerating for longer periods people who have committed serious offences and making them subject to lifelong recall may prevent some of them committing further crimes. The question is whether, if public safety is the goal, the mechanistic approach of imposing life imprisonment on some offenders solely on the basis of the particular offences of which they have been convicted is the best way to achieve this. In our view, it is not.

4.19 For one thing, such an approach will fail to catch some people who do present a high risk but whose offences ***do not fit*** the statutory criteria. If adopted on its own, then, such an approach would fail to meet its primary aim of protecting the public against those serious offenders who present a continuing risk.

4.20 On the other hand, such an approach will bring into the scope of the legislation people whose level of risk may be extremely low. This could include people whose offences were many years apart, and in widely differing circumstances; those whose offences were not in fact particularly serious but happened to meet the statutory criteria; and those where there were significant mitigating factors.

4.21 While it is understandable that some sections of the public would be content for such offenders to receive life sentences 'to be on the safe side', in our view this approach has two major flaws. It is potentially unfair to the offender, who may receive a more severe sentence than another offender who has committed a more severe offence or offences, but who does not meet the statutory test. Just as importantly, it is not an efficient way of using the limited resources available to society to deal with crime. It is a waste of money and scarce professional skills to imprison and keep under supervision offenders who do not require that level of custody and control. There is also a danger that dealing with low risk offenders as if they were high risk could lead to carelessness and cynicism in the operation of the system.

4.22 These problems tend to lead to one of two outcomes in relation to mandatory sentences. Either the law is applied rigidly, leading to unfairness and inefficiency, or some means of ameliorating the worst effect of the sentence is found, either by an element of judicial discretion, or by mechanisms to disapply (or circumvent) the provisions in particular cases. One example of this is the plea of diminished responsibility in relation to murder, which plea, if successful, will lead to a conviction for culpable homicide and usually a determinate sentence or mental health disposal. These mechanisms may effectively make the mandatory sentence a discretionary one, or create new anomalies.

4.23 In short, we believe that in non-murder cases the mandatory life sentence is a blunt instrument. It does not address the key aim, which is to control more effectively those who present the highest level of risk. We believe that mandatory life sentences

should be confined to cases of murder. We regard section 1 of the 1997 Act as wholly anomalous; for the reasons stated, we see no place for it in the armoury of disposals presently available and no role for it in the scheme which we later propose for the sentencing of high-risk offenders. It should be repealed.

RECOMMENDATION 10

Section 1 of the Crime and Punishment (Scotland) Act 1997 should be repealed.

Option two: longer determinate sentences

4.24 We received little evidence that sentence lengths should be increased in order to protect public safety. It is not an approach we favour.

4.25 First, such an approach would be difficult to introduce in the Scottish system, where selecting the length of sentence has traditionally been a matter of judicial discretion. Introducing minimum sentences would be a major change and would be subject to the same objections as those made in relation to an extension of mandatory life: that the sentence is based not on the seriousness of the offence or the risk to the public, but on the name of the offence. In our view, it is simply not possible for a statutory formula adequately to encompass the range of factors to be considered in determining the length of a sentence.

4.26 Nor would such a change do what is needed: first, because an offender would still at some stage reach the end of his/her sentence, and a few would still present a high risk; and second, because huge resources would be tied up in imprisoning those who did not need to be in prison.

4.27 Our experience of the system in parts of the USA, particularly as it deals with sex offenders, was highly instructive. Despite the fact that sentence lengths are typically extremely long (and often mandatory), legislation striking at the sexually violent predator has been introduced in several States. Such laws are used to incarcerate offenders thought to present a high risk, but who have reached the end of their prison term. It may also be significant that, in some cases, offenders appear to have received lower sentences than the seriousness of their crimes would justify, apparently because of plea bargaining to avoid charges attracting a higher sentence.

4.28 It also appears to be the case that, in these States, sentence lengths are continuing to increase for sex offences, with terms of 50 or 60 years, or 'natural life without parole', not uncommon. During that period, little is done to deal with the underlying causes of the offending behaviour, and the increasing numbers of prisoners contributes to a harsh and under-resourced system.

4.29 Another possibility, which we do not favour, is to increase the time spent in custody during a sentence, and reduce the length of time spent on parole or licence. This matter was carefully considered by the Kincraig committee[13], and we believe its findings are still generally appropriate. The major objection to reducing time spent on parole is that the offender must be released from supervision at the expiry of the whole sentence, and shortening the time spent under supervision in the community makes it more difficult for community services to engage with the offender and work on managing risk in a community setting.

[13] Report of the Review Committee on Parole and Related Issues in Scotland Cm 598, 1989

Option three: more Extended Sentences

4.30 Extended Sentences are still new. They are competent only in cases of crimes committed after 30 September 1998 and were specifically designed to meet, at least to some degree, the problem under consideration by the committee: that some violent and sex offenders continue to present a risk to the public even after they have reached the end of a determinate sentence.

4.31 Our consultation found general support for the option of Extended Sentences, although the Scottish Human Rights Centre expressed the view that a simple determinate sentence is a more appropriate option. A number of respondents, including the Association of Directors of Social Work, the Law Society and SACRO, suggested that Extended Sentences should also be available to offenders charged in summary proceedings. However, many respondents pointed out that because the sentence is so new, and so few such sentences have been imposed, it is too early to assess its impact.

4.32 Although we have not researched the matter, it would not surprise us if the Extended Sentence has been little used so far because there are not in place sufficiently effective mechanisms to assess its appropriateness in a particular case and to make the necessary recommendations to the court.

4.33 We conclude that it is too early to recommend any major changes to the basic nature of the extended sentence. If our recommendations for a new lifelong sentence for the most dangerous offenders are adopted, we believe that the extended sentence will be an important bridge between that new disposal and the normal determinate sentence, in cases where the proposed statutory criteria for the new disposal are not met. We deal with this more fully at paras. 6.17 to 6.18.

4.34 There is one aspect of the law relating to the extended sentence which we believe should be changed. At present, under Section 210A(3) of the Criminal Procedure (Scotland) Act 1995, the extension period for a common law sexual offence cannot exceed ten years, while for a common law violent offence the period is a maximum of five years. We cannot see any justification for such a difference. It has the effect of limiting the discretion of the court in fixing an extension period for a violent offender who may be in need of just as much post-release supervision as someone whose crime was sexual in nature. We note that Scottish Ministers have power, under Section 210A(7) of the 1995 Act, to amend this provision by statutory instrument and we recommend that they do so in order to bring the two provisions into line with each other.

RECOMMENDATION 11

The maximum competent extension period of an extended sentence should be ten years in the case of both a sexual offence and a violent offence prosecuted at common law.

Option four: alter the law on supervised release orders

4.35 Supervised release orders require an offender serving a custodial sentence of less than four years to be under the supervision of a designated authority on release

from custody, for up to twelve months. They are competent only for an offence other than a sexual offence committed after 30 September 1998. The criterion is that the supervision is required to protect the public from serious harm. SACRO (Safeguarding Communities, Reducing Offending) commented to us that supervised release orders may not have been used as widely as might have been hoped, possibly because of difficulties in assessing future risk at time of sentencing. The Association of Directors of Social Work suggested that the low uptake of supervised release orders suggested that they needed to be altered or extended in scope.

4.36 Other suggestions made to the committee included making such Orders mandatory in all cases of sexual and violent crime, and allowing the term of the Order to extend beyond the date by which the entire term of custody specified in the sentence has elapsed, on the basis of an end-of-custody assessment. It was also pointed out that the conditions attached to supervised release orders are less stringent than those which apply to parole or non-parole licences; for example, the commission of a further offence is not in itself a ground for breach.

4.37 Because supervised release orders are only available to those receiving shorter sentences, most of the offenders for whom they might be imposed are not the high risk offenders with which we are primarily concerned. However, some offences may be part of a pattern of more serious offending and we hope that the recommendations we make about improving the quality of information to sentencers will help to address the concern that sentencers are unable to assess risk at the time of sentencing.

Option five: alter the legislation on sex offenders

4.38 The Sex Offenders Act 1997 provides that offenders convicted of certain sexual crimes must register with the police and imposes on the registered offender a range of legal requirements. The Crime and Disorder Act 1998 makes provision for Chief Constables to apply for a Sex Offender Order in respect of persons over 16 years who are sex offenders and who have acted in such a way as to give reasonable cause to believe that an order under the Section is necessary to protect the public from serious harm. To date, few such orders have been sought.

4.39 While our recommendations for the sentences imposed on, and future management or treatment of, high risk offenders go beyond the provisions of the Sex Offenders Act 1997 and the Crime and Disorder Act 1998, we did give consideration to the adequacy of that legislation. The Committee heard of concerns over:

- the range of offences covered;
- the need to notify a settled address;
- proof of identity of sex offenders who were required to register and the period allowed for registration;
- the details of offences of failing to register and the powers to pursue reasonable enquires;
- notification of discharge from hospital;
- cross-border registration;

- non-registered sex offenders; and
- UK nationals convicted abroad and the restrictions on who can apply for a Sex Offender Order.

Our Committee heard that amendments were justified which would give greater powers to the authorities, provide better information and create greater controls over the movement of registered sex offenders.

4.40 Our Committee was also aware of the work of Lady Cosgrove's Expert Panel on Sex Offenders and that the Panel is also pursuing work on the Sex Offenders Act and the Crime and Disorder Act. Members of our Committee and Lady Cosgrove's Panel have met on two occasions and shared common interests. From these meetings it became clear that work on the registration of sex offenders falls squarely within the remit of Lady Cosgrove's Panel and while pertinent to our work, is less central to it. It was agreed therefore that the substantial responsibility for work in this area should lie with the Panel and that any recommendations for legislative change should be advanced by it.

Option six: alter the law on stalking and harassment

4.41 Other orders which can be imposed to control anti-social behaviour in the community include Anti-Social Behaviour Orders and Non-Harassment Orders. The latter, in particular, are intended to deal with 'stalking' and could, in some cases, arise in relation to psychologically disturbed individuals who may present a risk of serious harm. It was not possible for us to consider these orders in detail, but we note that the operation of the stalking and harassment legislation is now the subject of separate consultation by the Scottish Executive Justice Department[14]. In general, we believe that the recommendations we make regarding a more thorough and systematic process of risk assessment and risk management might be of some relevance, in that such techniques may help to inform the question of when such orders should be sought, and the conditions they should contain.

[14] Stalking and Harassment Consultation Paper, Scottish Executive, 23 February 2000

CHAPTER 5: THE NEW SENTENCE

Our Committee's proposals for a new sentence

5.1 In our consultation paper we asked for views on whether courts had available to them an adequate range of custodial disposals to deal with those offenders within our remit. Having considered the responses we have received, we have come to the view that while for many such offenders the present range is satisfactory, for a small number of others the current sentencing provisions are deficient since they do not ***require*** the courts to impose on exceptional individuals an exceptional sentence which both marks the gravity of what they have done and provides an appropriate level of public protection, having regard to the risk that such individuals pose. For this latter group of offenders we believe that new and separate provision requires to be made so that so that they are subject to the control of the State for the remainder of their lives. The risk that they pose should be assessed pre-sentence. State control over them should initially be of a custodial nature, only becoming non-custodial when, following a further comprehensive assessment of risk, it is thought that the offender can be released with safety to live in the community under appropriate measures of supervision. For adult offenders such custodial control will be in prison; henceforth in this report we assume that the majority of the offenders with whom we are concerned will be adult, but the principles behind our recommendations apply irrespective of the age or gender of the offender.

5.2 We have already reviewed in the context of imprisonment the law and practice in relation to the imposition of a mandatory life sentence for murder and a discretionary life sentence for other crimes. Of its very nature, the latter species of life sentence need not be passed in any particular case, depending on the overall view taken by the sentencing judge. We believe there is a need for a lifelong sentence for certain individuals who commit crimes other than murder, which sentence would be passed only if strict legal criteria were met. We suggest that the new sentence should be called: '**An Order for Lifelong Restriction (OLR)**' in order to distinguish it from (1) a sentence of life imprisonment, whether mandatory or discretionary; and (2) an extended sentence.

RECOMMENDATION 12

Legislative provision should he made for a new sentence called 'An Order for Lifelong Restriction (OLR)' for the lifetime control of serious violent and sexual offenders who present a high and continuing risk to the public.

The current information deficit

(i) Inadequate structure

5.3 We discussed at paragraphs 2.46 and 2.47 the general issue of the provision of information as being crucial to proper risk assessment. Nowhere is this more significant than at the sentencing stage and yet, in our view, its importance is not reflected in current legislation or practice. There is no proper structure for bringing forward all the relevant issues of concern to sentencers: and the sources of

information are seriously deficient. There are several factors which contribute to this.

5.4 First, it has not hitherto been regarded as one of the functions of the Crown to address sentencing issues beyond laying before the court a list of any previous convictions recorded against the offender and indicating the length of any pre-trial period of remand in custody. Meanwhile, those acting for the defence will seek to highlight mitigating factors in the case, rather than those indicating continuing risk.

5.5 Second, while for those who appear to have a mental disorder a psychiatric assessment may be obtained, a large number of the most dangerous offenders will not be acutely mentally ill, and so a mental health disposal is unlikely to be recommended. If it is not, any psychiatric opinion may not address other risk issues, based on factors such as the personal characteristics of the offender.

5.6 Third, there is the current legislative provision and practice in relation to Social Enquiry Reports (SERs) prepared by the relevant local authority. The National Objectives and Standards for Social Work Services in the Criminal Justice System provide detailed guidance on the nature and content of SERs and current practice reflects, or ought to reflect, that guidance.

5.7 As matters stand, it is not a requirement of law that an SER must be obtained before imposing a custodial sentence on an offender who has committed a serious violent or sexual offence, other than in cases where a first custodial sentence is being considered or where the accused is under twenty-one years of age.[15] Even in relation to the latter classes of case, it is a feature of sentencing in the High Court (but not in the sheriff court) that a report which is prepared pre-conviction is regarded as adequate compliance with the law. Such a report will disclose nothing about the offender's attitude to the offence, his/her state of remorse (if any) and a host of other relevant information. While it is always open to the High Court to continue a case for a full SER to be prepared, this does not always happen.

5.8 In our view the quality of SERs has improved in recent years but it is still too variable. In particular a report prepared on a pre-trial basis can make little useful contribution to the assessment of future risk. In the context of our other recommendations, the only contribution which may usefully be made by a pre-trial SER would be to provide information which would assist the Court to decide whether a further comprehensive multi-disciplinary risk assessment is required.

5.9 In responding to our Consultation, several local authorities and the Association of Directors of Social Work stressed that the authors of SERs require (and do not currently have) access to all appropriate information. This would include information regarding antecedents and previous offences, as well as the circumstances of the current offence. Particular information which would be relevant includes that obtained from police reports and evaluations from psychiatrists and other experts.

5.10 The final contributory factor to the problem of lack of adequate structure is the time limit for the preparation of an SER. This is typically two weeks if the offender has been remanded in custody and at least three if he/she is on bail, although in some cases these periods can be extended. We believe this is generally inadequate to allow for a comprehensive risk assessment.

[15] See Sections 204 and 207 of the Criminal Procedure (Scotland) Act 1995.

(ii) Details of past offences

5.11 Quite apart from the foregoing considerations, we believe that further steps are necessary to improve the quality of information regarding previous offences. We understand that our concern is shared by the Criminal Courts Rules Council, which has separately set up a working party to look at this issue. Detailed and accurate information about a person's offending behaviour is vital to the process both of risk assessment and risk management. We have already noted that past behaviour is the best predictor of future behaviour. It is essential therefore that those involved in making decisions in relation to risk assessment should be in a position to base those decisions on reliable information about the offender's previous offences.

5.12 If, as we go on to propose, the Crown should have power to apply in certain cases to the Court for a full risk assessment to be carried out with a view to determining whether the offender is a continuing danger to the public, the prosecutor will require to base that application on information about the offender's antecedents and past criminal behaviour. The circumstances of the offence for which the offender is to be sentenced may be sufficiently serious in themselves to justify making such an application. However, in many cases it will be necessary to establish whether there is a pattern of behaviour which justifies ordering a full risk assessment. It is essential therefore that the prosecutor has access to information about previous sexual offences or offences involving the use of violence. This information will also assist the sentencer in deciding whether to order a risk assessment. In turn, the psychiatrist or psychologist who conducts the assessment on behalf of the Court will require all available background information on the offender, including personal and family history, criminal record, and any previous psychiatric or psychological assessment.

5.13 One reason for the paucity of information about previous offences is, no doubt, an assumption that such information is only of limited relevance, in that the punishment imposed by the Court should relate to the current offence. Certainly it would be wrong that a person should be sentenced twice for an earlier crime. That is not our aim.

5.14 As we have said at paragraphs 4.2 to 4.3, minimising risk and protecting public safety should be key sentencing aims when dealing with serious violent and sexual offenders. That being so, the value of information about previous offences, including (in the case of a young person) even that gleaned from reports to a Children's Hearing, is that it tells us much about the risk presented by the offender at the time of being sentenced for the index offence. It is right, then, that as much of this historical information as possible should be available to the Court when it has to deal with an offender within our subject group.

5.15 Some changes can be made without difficulty, in relation to the information which is collected when an offender is convicted. At present, details of the offender's previous convictions will be available from the record of criminal history kept by the Scottish Criminal Record Office. However, that record will only disclose the date of conviction, type of offence and sentence. No record is generally kept of the details of the way in which the crime was committed, for example in relation to the nature, degree and results of the violence used, or to any sexual deviance not apparent from the words of the charge. In a case of assault to severe injury and permanent disfigurement of the victim, those words may not disclose that, for instance, there

was present a degree of ritual or sadistic mutilation. The exception to the general rule that detailed information is not recorded is in cases where the offender is given a determinate sentence of four years or more, or where an extended sentence is passed. In such cases the sentencing judge provides (or ought to provide) a report on the case for the benefit of the Parole Board.

5.16 In order to meet at least some of the foregoing concerns about the lack of accurate information on the details of past offences, we think that a report should be prepared by the sentencing judge or sheriff in *all* cases of a violent or sexual nature (including, where appropriate, cases of breach of the peace) which are prosecuted on indictment, whether or not such a report is later required for parole purposes. Such a report should contain an outline of the circumstances of the commission of the offence and will thus constitute a contemporaneous record of those circumstances as presented to the court when dealing with that case. The report should be produced as soon as possible after sentence has been passed and should remain with the case papers in the custody of the Clerk of Court so that it is available on future occasions when the offender requires to be sentenced.

RECOMMENDATION 13

In all cases of a violent or sexual nature (including, where appropriate, breach of the peace) prosecuted on indictment, the judge should prepare promptly a report setting out the circumstances of the offence as narrated in court, which report should be preserved with the case papers for later use if required.

(iii) Collating information on potential risk

5.17 We are convinced that all the available pointers to the potential risk displayed by an offender should be centrally collated. Our Committee was attracted to the arrangements in British Columbia where the Attorney General's Office has a system of 'flagging' potential candidates for dangerous offender status under the relative provisions of the Canadian Criminal Code. The goal of the 'flagging' system is to provide Crown Counsel with the necessary information to decide whether to make an application to the Court to seek an assessment report to determine whether the offender is a dangerous offender on whom a sentence for an indeterminate period should be imposed. When prosecutors in British Columbia identify an offender who might at some future point be made the subject of a risk assessment, they send information on the circumstances of the offence to an official in the Attorney General's Office.

5.18 We think that a similar 'flagging' system should be introduced in Scotland and that the Crown Office should take on this role. It should do so because of its national role as the prosecuting authority for Scotland and its unique status in our system of public prosecution. Furthermore, since we later recommend that it should normally be the Crown which applies to the court for a risk assessment to be carried out on high risk offenders, that application will be facilitated if it is the Crown which has previously gathered the necessary information on the past offences committed by that group.

5.19 While one of the primary sources of information available to the Crown about past offences would be the contemporaneous report prepared by the sentencing judge or sheriff, the Crown would of course have access to all the additional information contained in the police report and precognitions relating to those past cases and to any other cases proceeded with by way of summary complaint.

RECOMMENDATION 14

The Crown Office should develop a system of recording information about offences which would be relevant in future decision making on the question of ordering risk assessment in serious violent and sexual cases.

5.20 Those whose task it is to assess risk of future offending must have regard to previous problems of behaviour and apply any known predictors of risk. They will require to obtain and consider information about the offender's personal and family relationships, employment history, financial circumstances, personality traits and characteristics, physical and mental health and any history of substance abuse. Much of this information will come from the offender. Information will also have to be gathered from documentary sources, as well as from the family and friends of the offender, employers, health professionals who have had contact with the offender, and others who may possess relevant information.

5.21 However, it may be necessary to go further. We have discussed above the need for more detailed information about the circumstances of the offender's previous convictions. There may also be a need to have regard to allegations of criminality which have not, for one reason or another, resulted in prosecution. This controversial issue gave us great difficulty and we now summarise the arguments on both sides.

Unprosecuted allegations

5.22 On the one hand, it might be thought highly relevant to a risk assessment that the offender has in the past repeatedly placed him/herself in a situation which has led others to feel alarmed or in danger, even although no criminal charges have been brought. This is the approach taken in Canada, where the person assessing the risk of re-offending may have regard to the circumstances of allegations of criminal behaviour for which the offender was not prosecuted. Details of these allegations would be disclosed in the report prepared by the assessor. If the offender denies any part of the report, the prosecutor has to lead evidence in support of the allegation.

5.23 On the other hand, it is obvious that to found on unproved allegations may be to afford them a status which is not supported by the facts surrounding them. There may always be an innocent explanation which the offender cannot be prevented from advancing. There is a risk that sentencing decisions may be taken (at least in part) on the basis of information which is misleading, irrelevant or borne of malice. There is also the practical difficulty of proof to an adequate standard for the purpose required.

5.24 On balance, the relevance of these allegations to the process of risk assessment is such that we have come to the view that it is legitimate for unproven allegations of criminal behaviour to be taken into account, so long as these allegations are admitted by the offender or, if challenged, established by the leading of evidence.

Prior acquittals

5.25 It would be quite wrong, however, in assessing the risk of future danger, to have regard to previous allegations which have been made the subject of prosecution but which have not been established and which have resulted in acquittal. There may, nevertheless, be aspects of the offender's behaviour in relation to the alleged offence which resulted in acquittal, which are matters of legitimate concern to the assessor of risk. The assessor should be entitled to take these into account on the same basis as unprosecuted allegations.

5.26 In reaching this view, we have kept at the forefront of our minds the purpose to which this information is to be put. It is ***solely*** for the purposes of assessing future risk. We stress that the nature of the evidence to be taken into account and the standard of proof to be applied in conducting risk assessment is different from that required to obtain a conviction in a criminal court on a particular charge. But it seems to us that if, for example, an offender is prepared to recognise that his/her past behaviour on particular occasions in fact provided a justification for fears expressed at the time that recognition is significant in assessing future risk.

RECOMMENDATION 15

The sentencing of serious violent and sexual offenders should be informed by a formalised, multi-disciplinary risk assessment based on the circumstances of the current case and much fuller information regarding the antecedents of the offender and the nature of any previous offences, including unproven allegations of criminality.

CHAPTER 6: PROCEDURES FOR IMPOSING THE NEW SENTENCE

Sentencing procedures

(i) The legal test

6.1 It will be necessary for any legislation providing for the imposition of an OLR to define the conditions under which such a sentence can be imposed. In our view, an OLR should only be imposed by the High Court, either following conviction in that Court or following remit by the sheriff after conviction on indictment in the sheriff court. Restricting the imposition of an OLR to cases where the offender has been convicted on indictment is intended to ensure that the OLR is only imposed in cases of serious offending.

6.2 It would be possible to restrict the imposition of the OLR to cases in which the accused has been convicted of a serious offence of violence or a serious sexual offence. However, as indicated above, our concern has been with serious violent or sexual ***offenders*** as opposed to offences of that nature. Clearly, the option of imposing an OLR should be available to the Court where an accused has been convicted of a serious offence of violence or a serious sexual offence, but in our opinion it should also be available where an offender with a history of violent or sexual offending is convicted on indictment of an offence which, while not in itself inferring violence or having a sexual content, is closely related to, or reflects, the offender's previous history of violent or sexual offending. Two examples of this type of case can be envisaged.

6.3 Suppose an accused has previously been convicted of raping a woman in her home. On a subsequent occasion he obtains access to another woman's home by means of fraud. It would be possible, under our proposals, for such an offender in the subsequent case to be made subject to an OLR if he were to be convicted on indictment of obtaining access to a woman's home or place of work by fraud, even in the absence of any evidence of a sexual assault on that occasion.

6.4 In like manner, an offender who has a history of sexual assault or lewd practices with children might find himself subject to an OLR on conviction on indictment on a charge of breach of the peace, which consists in causing alarm or upset to a child by inviting her/him to enter a car, or some other place.

RECOMMENDATION 16

The option of imposing an OLR should be available only in the High Court. The Court should have the power to impose an OLR where the offender has been convicted on indictment of (a) an offence of violence, (b) a sexual offence, or (c) any other offence which is closely related to, or reflects an offender's propensity for violent, sexual or life-endangering offending.

6.5 The fact that an offender has been convicted of such an offence, while necessary for the imposition on an OLR, is not of itself sufficient to allow the Court to impose this form of sentence. The OLR is intended for cases where the offender presents a

serious risk to the public, and the Court should only impose this sentence if it is satisfied that there are reasonable grounds for believing that the offender presents a substantial and continuing risk. We deal later with the situation where this test is not met.

RECOMMENDATION 17

An OLR would be available only in cases where the High Court was satisfied that there are reasonable grounds for believing that the offender presents a substantial and continuing risk to the safety of the public such as requires his lifelong restriction. If the Court is so satisfied, it must make the Order.

(ii) The need for a risk assessment

6.6 Any decision to make an OLR involves a very substantial interference with the liberty of the offender and must therefore be made only where there is clear and convincing evidence that the offender presents a substantial risk to the public. It is therefore necessary that before any such order is imposed the Court should have before it information concerning the offender and the degree of risk which the offender presents to the community. This can only be done following a formal risk assessment, in a secure setting, the purpose of which is to inform the court of the likely risks which the offender may present to the community, and to enable it to determine whether or not the test set out in Recommendation 17 is satisfied.

RECOMMENDATION 18

Before an OLR can be imposed a formal risk assessment must be carried out in accordance with statutory procedures.

(iii) Conditions for ordering a risk assessment

6.7 As indicated above, we think that the Court should only have the power to impose an OLR where there are reasonable grounds for believing that the offender presents a substantial and continuing risk to the public. A similar test should be satisfied before the Court makes an order for a formal risk assessment, but it is clearly not possible for the Court to determine in advance of the assessment whether or not the offender ***does*** present such a risk. It should therefore be open to the Court to order an assessment where, having heard submissions, it is satisfied that there are reasonable grounds for believing that the offender ***may*** present a substantial and continuing risk to the public.

RECOMMENDATION 19

The Court shall make an order for a risk assessment where there are reasonable grounds for believing that the offender may present a substantial and continuing risk to the public.

6.8 In all cases in which it is thought that an OLR might be an appropriate disposal, the normal mode by which the necessary risk assessment should be requested will be by Crown motion to the Court, made immediately upon the conviction of the accused and after the motion for sentence is made. Intimation that the Crown intend to make such a motion must be given to the accused prior to the close of the Crown case, so that the accused has proper notice that, if convicted, the Crown intend to adopt this stance. There may, however, be cases where the evidence at the trial is of such a character to suggest that an assessment should be ordered irrespective of the wishes of the Crown; in such cases the Court should retain the power to order such an assessment of its own accord, after hearing submissions.

6.9 On the assumption that the necessary motion for a risk assessment is made by the Crown, the accused will have the right to oppose the motion by making contrary submissions. The decision of the Court on the motion will be final and not subject to appeal.

RECOMMENDATION 20

A risk assessment should normally be ordered following a Crown motion intimated to the accused prior to the close of the Crown case. Such a motion could be opposed and would be determined after conviction. The decision of the Court thereon would be final. Exceptionally, a risk assessment could be ordered by the Court of its own volition, but only after hearing submissions from both sides.

6.10 We have already referred to the need for all agencies operating in the criminal justice system to ensure that those of their staff who take decisions based on risk are appropriately trained. This is especially important in the case of the prosecution service.

6.11 Decisions relating to the level at which proceedings are taken have always been influenced by assessments of the risk of offending. The decision whether to take proceedings and the nature of any proceedings will be determined by the prosecutor's assessment of the public interest. In deciding whether to take proceedings on indictment, the Crown will have regard to the whole circumstances of the case, including the gravity of the offence, the record of the accused and the penalty considered to be appropriate.

6.12 It is essential that prosecutors have a clear understanding of those factors which have a bearing on risk. In the case of a serious violent or sexual offence, it is almost inevitable that proceedings will be taken on indictment because of the gravity of the offence. There may be other cases, however, involving violent or sexual behaviour where the latest offence is not of itself sufficiently serious to merit solemn proceedings, but the offender's history of criminality and his/her past behaviour indicate that he/she may present a continuing danger to the public. As the new sentencing option which we propose would be available only if the offender is prosecuted on indictment, prosecutors must be in a position to identify those who may present a continuing danger so that this can be taken into account when deciding the form of prosecution.

(iv) Procedure once a risk assessment has been ordered

6.13 If a risk assessment is ordered, a Risk Assessment Order would be pronounced and would constitute authority for the accused to be detained for up to 90 days for the assessment to be carried out. This period, if thought to be insufficient, might be extended by the Court on cause shown for a further period of not more than 90 days. The order would specify the primary location at which the assessment would be carried out, being a centre accredited for the purpose by the Risk Management Authority.

RECOMMENDATION 21

A Risk Assessment Order would be authority for the detention of the accused for up to 90 days, or up to 180 days on cause shown, at a centre accredited by the Risk Management Authority for the purpose of a multi-disciplinary risk assessment.

(v) Procedure on completion of risk assessment

6.14 Once the accredited assessor has completed the task of co-ordinating all the elements of the multi-disciplinary risk assessment, he/she should be required to lodge all written reports with the Clerk of Court so that they are available to the judge and all parties. It is of course essential that the defence should have a proper opportunity to challenge the basis of the assessment and to lead contrary evidence if they wish. Procedural provision will therefore require to be made for these purposes and for the disclosure of any defence reports to the Crown. In cases where the facts and/or conclusions are in dispute, it may be necessary for oral evidence to be led at the sentencing hearing.

RECOMMENDATION 22

The risk assessment and its component parts should be lodged with the Clerk of Justiciary. The accused will have the right to challenge it by obtaining a contrary assessment. Procedural provision will be required for the mutual disclosure of reports, and the names of potential witnesses, and the conduct of the sentencing hearing.

6.15 At the sentencing hearing, it will be for the Crown to satisfy the Court, on a balance of probability, that the statutory criteria for an OLR have been met. In order to discharge this burden of proof the Crown might well elect in the public interest to call evidence, even if there is no defence challenge to the assessment. We see the function of the Crown at this point as actively assisting the court, rather than adopting its traditional passive role in sentence matters. In any event a sentencing hearing may take some time, with obvious implications for Court programming.

RECOMMENDATION 23

It will be for the Crown to establish, on a balance of probability, that the statutory criteria for the imposition of an OLR are met.

6.16 If the Crown discharge the burden of proof, the High Court would pronounce the Order. The Court would also set, at that time, a period of time to be served by the offender in prison to meet the concerns of punishment and deterrence. The formula presently applied to compute the designated part of a discretionary life sentence should likewise apply to an OLR (see ***O'Neill v HM Advocate*** (1999) SCCR 300).

RECOMMENDATION 24

If the High Court was satisfied that the statutory criteria were met, it would impose on the offender an OLR, setting at the same time a designated period of time which the offender would serve in custody to reflect the concerns of punishment and deterrence.

(vi) What if the statutory test for the imposition of an OLR is not met?

6.17 It may of course be that the Crown fail to discharge the necessary burden of proof, in which case the High Court could not impose an OLR. In such a case we think that the Court should generally be free to impose any other competent penalty or make a mental health disposal if the statutory tests relative thereto are met, but it should not be free to impose a discretionary life sentence. We would expect that in many cases the option selected would be an extended sentence, the extension period of which might be lengthy and in some cases the maximum competent for the offence in question; and the risk assessment should be regarded as an adequate substitute for the statutory pre-sentence report required for the imposition of such a sentence. In that way the decision to pass an extended sentence in these cases will be much better informed and the length of the appropriate extension period more accurately assessed.

6.18 It is because of our belief that most offenders who presently receive a discretionary life sentence would 'qualify' for an OLR that we see no place for discretionary life as a competent disposal in the event that the statutory tests for an OLR are not met. We do not, however, recommend the complete abolition of the discretionary life sentence since Parliament has prescribed it as a competent penalty for certain statutory offences of a non- violent or sexual nature.

RECOMMENDATION 25

If the High Court was not satisfied that the statutory criteria for the imposition of an OLR were met, it would be able to adopt any other competent disposal other than to pass a discretionary life sentence.

(vii) Appeals

6.19 The decision on whether or not to make an OLR should be amenable to appeal, both by the accused (if an Order was made) and by the Crown (if an Order was not made). The normal appeal provisions would apply.

RECOMMENDATION 26

The accused should have a right of appeal against the making of an OLR on the ground that to adopt this disposal was excessive; and the Crown should have a right of appeal against a refusal to make such an order, on the ground that the refusal was inappropriate because the statutory test was in fact met.

CHAPTER 7: HIGH RISK OFFENDERS WITH A MENTAL DISORDER

7.1 We have described above our proposals for the procedure and disposals to be adopted in respect of high risk offenders who do not suffer from a mental disorder. The proposed OLR is designed to recognise and address the issue of risk to public safety. Our Committee recognises that there may be some high risk offenders who, in addition, have a mental disorder of a nature or degree that warrants detention in hospital for medical treatment. We do not think that the proportion of high risk offenders who suffer from such a mental disorder is likely to be large. However this small number of potential high risk offenders is likely to pose particular difficulties in terms of safeguarding the public. In this chapter we therefore make recommendations concerning the assessment by the court of potential high risk offenders with a mental disorder, and the appropriate court disposal.

7.2 Mental disorder is a term defined in the Mental Health (Scotland) Act 1984 and subsequently amended by Section 3 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. Mental disorder is now defined as 'mental illness (including personality disorder) or mental handicap however caused or manifested'. This definition and indeed the whole issue of mental health legislation are matters currently under review by the Millan Committee. It would not be appropriate for our Committee to make recommendations on the definition of mental disorder since, although the subject impinges on our area of interest, it also extends much beyond it. We have therefore assumed that the definition of mental disorder is that which appears in current mental health legislation.

7.3 We think that in the case of a high risk offender who has a mental disorder, the disorder is likely to be of a complex nature. It is likely that a personality disorder will form part of that mental disorder but it is not necessarily inevitable that it will do so. In clinical terms high risk offenders with a mental disorder are likely to have combinations of mental illness (of a psychotic or organic type), substance abuse disorder, personality disorder, psychosexual disorder and possibly a learning disability. Indeed it is the complexity of the condition that is likely to contribute to the designation of the offender as a high risk offender with a mental disorder.

7.4 There may however be other circumstances in which an offender with a mental disorder comes into the category of a high risk offender. For example, a person may commit a serious offence of a nature that fulfils the criteria for a high risk offender but suffers from a mental disorder in which there appears to be a tenuous or non-existent relationship between the particular mental disorder and the commission of that offence. In such circumstances treatment of the mental disorder may be readily accomplished. However there would still remain a substantial risk to the public by virtue of other contributory factors to the offending behaviour. These would need to be recognised and addressed by the sentence. In those high risk offenders where the mental disorder is solely one of personality disorder we anticipate that the sentence will normally be an OLR rather than a psychiatric disposal. We consider personality disordered offenders further in Section Three.

Current situation

7.5 The current situation with regard to a high risk offender with a mental disorder is that he or she may be dealt with by the court in various ways. First, the court may impose a sentence of imprisonment, during the course of which transfer to hospital would be possible in terms of Sections 71 and 72 of the Mental Health (Scotland) Act 1984. Where the sentence is a determinate one, and where the prisoner is in hospital at the expiry of that sentence, then his/her status becomes that of an ordinary detained patient and he/she is not subject to the regulation of Scottish Ministers. This may be seen as unsatisfactory and failing to provide sufficient protection for the public. At any time, providing there is still a period of imprisonment remaining in the sentence, the patient can be returned to prison in terms of Section 74(2) and continue his/her sentence. Public protection will continue for as long as he/she remains in prison and following release subject to any existing post-release supervision arrangements.

7.6 Second, the court may impose a hospital order with restrictions on discharge. The effect is that the offender is managed exclusively by health services, receiving mandatory treatment in hospital (normally at the State Hospital initially); decisions concerning absolute discharge, conditional discharge or transfer to another hospital rest with Scottish Ministers. Rarely, the restriction order may be terminated by Scottish Ministers, in which case the patient acquires the status of an ordinary detained patient. In any event there is a disadvantage to this disposal in respect of high risk offenders. Where, during the course of the hospital treatment, it is found that there remains a high risk of re-offending even though the mental disorder has been treated or has remitted, there is no mechanism for continued custody other than within a hospital; the treated but high risk patient cannot be transferred to prison.

7.7 Following treatment at the State Hospital most patients are considered either for transfer to a local psychiatric hospital or, rarely, conditional discharge to the community. Both these options may not provide sufficient safeguard for public protection. In such circumstances it is now mandatory for such patients to remain in hospital by virtue of the provisions recently introduced in Section 1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. The implication of Section 1 is that discharge (whether conditional or absolute) will not be permitted where continued detention in hospital is necessary 'to protect the public from serious harm'. Such detention is irrespective of the need for medical treatment in hospital. From the perspective of clinical practice, this is an unsatisfactory state of affairs. We think that patients who are detained in hospital should only remain in hospital where there is a requirement for medical treatment as defined in the Mental Health (Scotland) Act 1984.

7.8 A third possibility is that the high risk offender with a mental disorder could currently be made the subject of a hospital direction under Section 59A of the Criminal Procedure (Scotland) Act 1995. This has a number of advantages enabling the offender to receive treatment in hospital and at the same time providing protection for the public. The sentencer passes a prison sentence which currently could be a discretionary life sentence, and at the same time imposes a hospital direction, the effect of which is that the 'sentence' begins by admission to hospital.

When treatment is completed, or if the mental disorder is no longer present, then the offender patient is transferred by recommendation of Scottish Ministers to prison to continue his/her sentence. The period of time spent in hospital is recognised as part of the time served. Later in the sentence, should treatment again be required in hospital, then it is possible for the prisoner to be transferred to hospital for further treatment. Protection of the public continues for as long as the offender remains under sentence. Thus only in the case of those offenders who receive a discretionary life sentence together with a hospital direction is lifelong protection of the public provided. In all other cases protection of the public cannot be provided after termination of the prison sentence with the exception of those arrangements that can be made for supervision in the community. At present these may be of limited duration.

Proposal for sentencing

7.9 In the light of the problems described, and in order to maintain public protection, we believe that there is a need for new legislation in respect of the sentencing of high risk offenders who have a mental disorder. The legislation should have certain aims and principles.

7.10 First, the sentencing of high risk offenders with a mental disorder should not be undertaken hastily; early decisions, that are subsequently irreversible, should not be made on the basis of inadequate information. Mental disorders may change in their nature, severity and response to treatment. We think that sentencing procedures should reflect this feature.

7.11 Second, we think that procedure, safeguards and outcome for high risk offenders with a mental disorder should match, as far as is possible, the procedures, safeguards and outcome for high risk offenders who do not have a mental disorder. In particular the measures to safeguard the public should be as stringent as those for ordinary high risk offenders yet medical treatment should be available for the mental disorder in the same way that it is available for other offender patients.

7.12 Third, the essential determinant in ensuring protection of the public should be the assessment, management and containment of risk, rather than the presence of any particular category of mental disorder. It is not possible to make definitive statements that any particular category of mental disorder is one that always carries a high risk while another category invariably does not. There is such a wide variation in this matter that decisions taken with public protection in mind must turn on the issue of risk (and its proper assessment and management) and not on the existence of any particular type of mental disorder.

7.13 We think it is essential that the standards of risk assessment and management should be exactly the same as the standards that we have outlined in relation to non-mentally disordered high risk offenders.

7.14 We have described in Chapters 5 and 6 our new sentencing Order for Lifelong Restriction (OLR) in respect of high risk offenders. This is, in essence, an indefinite sentence imposed on the basis of a substantial risk to the community with regular reviews and a requirement to address the elements that constitute that risk. If such an offender suffers, in addition, from a mental disorder, it seems appropriate that he should also be made the subject of a hospital direction.

RECOMMENDATION 27

A high risk offender who also suffers from a mental disorder that meets the criteria for compulsory detention in hospital should receive an OLR together with a hospital direction. This should be the only sentence permitted in respect of such offenders.

7.15 The sentence would begin with admission to, and treatment in, the State Hospital where treatment would be in accordance with normal clinical practice. Any decision to transfer the offender patient to prison should be based on the grounds that medical treatment in hospital is no longer appropriate. For this particular category of offender, we do not think it is necessary that public safety, as we construe that term, is an appropriate determining factor for continued detention in hospital. The offender patient will not in any case be returning to the public at this stage but will be transferred to prison. The arrangements that are made for the management of that offender patient when transferred to prison are a matter for the prison authorities. One of the principal tasks of the SPS is the protection of the public. The safe custody of high risk offenders who have received treatment for mental disorder is essentially no different from that provided for other high risk offenders. We think it would be inappropriate, in the case of high risk offenders in hospital, for consideration of public safety rather than appropriateness of treatment to determine whether they continue to be detained in hospital when there is no possibility of the offender patient at this stage being in contact with the public.

RECOMMENDATION 28

The provisions of Section 1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 should not apply to offenders subject to an OLR together with a hospital direction.

7.16 With regard to decision making on the matter of transfer from hospital to prison, we believe that this is a matter which the Millan Committee may wish to consider. Currently the decision is one for Scottish Ministers and we do not think there are grounds for changing that arrangement solely in relation to these particular offender patients. We think it is important that the plans for the offender's management should be re-evaluated before transfer to prison in order to determine an appropriate location within prison.

7.17 Having described the mandatory disposal for a high risk offender suffering from a mental disorder, we now consider the nature of the assessment required by the court for making that disposal. It is of course a very restrictive disposal. Indeed the combination of indeterminacy of prison sentence and mandatory committal to hospital is probably the most restrictive type of sentence available to Scottish courts. It is therefore proper that is should be reserved solely for those for whom it is intended, and that it should not be imposed unless there has been the fullest type of pre-sentence assessment.

7.18 We recommend that the procedures previously described, whereby the Crown normally initiates the procedure towards the imposition of an OLR by applying to the court for a risk assessment, should also apply in the case of potential high risk offenders with a mental disorder. Where there is reason to suppose that the potential high risk offender may be suffering from a mental disorder then pre-sentence psychiatric reports should be obtained in the normal way. Where these reports indicate that the offender is suffering from a mental disorder and that it may be appropriate for a hospital order to be made, then we suggest that the appropriate disposal, at this stage, would be by way of an interim hospital order for detention in the State Hospital.

RECOMMENDATION 29

An interim hospital order should be imposed in all cases where the offender is one who would otherwise be assessed to determine whether he/she fits the statutory criteria for the imposition of an OLR, but where there is also evidence that he/she may be suffering from a mental disorder for which treatment is appropriate.

7.19 Currently the maximum duration of an interim hospital order is 12 months. We think this provides sufficient time for a full assessment to be made in accordance with the new standards. We do not think this maximum limit requires modification. Currently, however, renewal of the order is necessary every 28 days and we think this is unnecessarily bureaucratic and burdensome. It should be increased to 90 days.

RECOMMENDATION 30

The time limit for renewal of the interim hospital order, where the assessment is for the purpose of determining whether the offender should ultimately be made the subject of an OLR coupled with a hospital direction, should be increased from 28 to 90 days.

7.20 It has been suggested to us that there may be offenders convicted of a serious violent or sexual offence for whom the high risk offender pre-sentence procedure has not been adopted, and for whom psychiatrists reporting to the court intend to recommend the standard hospital order with restrictions. Where the court follows these recommendations and imposes a hospital and restriction order, the offender, as indicated above, becomes the permanent responsibility of health services, together with social work services in the event of conditional discharge. We have noted (in paragraph 7.7) that in the cases of Reid and Ruddle (both of whom were detained under hospital and restriction orders), the original clinical diagnosis that applied at the time of admission changed during the course of treatment. This had major implications for the appropriateness of continued detention in hospital. We therefore think there needs to be a safeguard whereby reporting psychiatrists who recommend hospital and restriction orders on those convicted of a serious violent or sexual offence should be required first to consider the appropriateness of an interim hospital order (which would enable assessment in a hospital for up to 12 months) before finally making the recommendation of a hospital order with restrictions.

RECOMMENDATION 31

Where a psychiatric report in respect of a person convicted of a serious violent or sexual offence recommends the imposition of a hospital order with restrictions, the psychiatrist shall be required to address in the report the question of why an interim hospital order is not appropriate.

High risk offenders found insane in bar of trial or acquitted on the grounds of insanity

7.21 We recognise that within the small number of mentally disordered offenders who are found insane in bar of trial, or who are acquitted on the ground of insanity, there may be some who may be regarded as high risk offenders. Completely new provisions for the court disposal of people found insane - we use the word in the sense that it appears in legislation but recognise that it has no place in modern psychiatry - were introduced in 1995 and are set out in Sections 54-57 and 62-63 of the Criminal Procedure (Scotland) Act 1995. In essence the court has flexibility in disposal (except where the charge is one of murder) but is precluded from imposing any sentence of punishment including imprisonment. These disposals were widely welcomed in the criminal justice and mental health fields and we do not consider there are any good reasons for making changes.

7.22 The disposal of a person charged with murder but found insane is automatically by way of hospital and restriction orders - whether or not he/she may be regarded as high risk. It is not within our remit to suggest any change in this matter and it is under consideration by the Millan Committee.

7.23 We believe, however, that the issue of risk should be an important factor in disposing of all other people who are found insane under solemn procedure. Currently, by virtue of section 57(2) of the 1995 Act there are five possible disposals for people found insane in bar of trial or acquitted on the grounds of insanity: hospital order, hospital order with restrictions, guardianship, supervision and treatment order and no order of any kind. There is no opportunity for the court to make an interim hospital order in terms of Section 53 of the 1995 Act. As described earlier, such an interim order provides opportunities to assess both the appropriateness of making a hospital order itself and the degree of risk presented by the mentally disordered offender. We consider that this option should be available to a mentally disordered offender to whom Section 57(2) otherwise applies, so that an assessment of risk can be conducted as we propose for other mentally disordered offenders. Where the insane offender is reasonably considered to come within the category of high risk, then we think that the proper disposal should be by way of a hospital order with restrictions, and the other options in Section 57(2) should not be available to the court. If, after assessment under an interim hospital order, the patient is not regarded as high risk then the current options should continue to be available.

RECOMMENDATION 32

Section 57 of the Criminal Procedure (Scotland) Act 1995 should be amended to enable an interim hospital order to be made for mentally disordered offenders who are found insane following proceedings taken on indictment and who may be a high risk to the public.

RECOMMENDATION 33

A hospital order with restrictions should be the mandatory disposal for a mentally disordered offender found insane following proceedings taken on indictment who, after assessment, is considered to be a high risk to the public.

Procedure after an interim hospital order is made

7.24 We now consider procedures following the admission of a high risk offender to the State Hospital under the terms of an interim hospital order. We anticipate that in the period of up to one year in hospital thereafter, assessment of risk will be in accordance with the standards described previously (see Chapters 2 and 3). We recognise that treatment of the mental disorder may be appropriate and that it may be given in accordance with the general approach to consent to treatment and the special provisions of Part X of the Mental Health (Scotland) Act 1984. In any event, at the end of the period of detention under the interim hospital order two decisions should have been reached: first, whether or not the offender fulfils the criteria for a high risk offender, and second, whether or not the offender suffers from a mental disorder such that a hospital order with restrictions is appropriate.

7.25 If neither of the above decisions is positive, then the offender will simply be sentenced by the court in the normal way for that particular offence within the range of sentencing options currently available.

7.26 If the offender is found to be a high risk offender but does not suffer from a mental disorder appropriate for treatment in hospital, then he/she should simply be made the subject of an OLR.

7.27 If the offender is found not to be a high risk offender but he/she has a mental disorder such that he/she should be detained in hospital, then the court may impose a hospital order with restrictions on discharge or a hospital order simpliciter. Where appropriate, the court may impose a hospital direction, or indeed, disregard the medical recommendations and impose a prison or other sentence. These are not matters within our remit. The general requirements for hospital and restriction orders are matters for the consideration of the Millan Committee.

7.28 If the court is satisfied that there are present the criteria for both a high risk offender and mental disorder appropriate for treatment in hospital, then as indicated above the mandatory disposal should be an OLR together with a hospital direction.

7.29 Where a high risk offender is detained in hospital under an OLR with a hospital direction it is likely that a stage will be reached when he/she no longer requires treatment in hospital. Normally we would expect such an offender patient to be transferred, on the authority of Scottish Ministers, to prison. We would expect the Risk Management Authority to have an advisory role in reviewing risk management plans at this stage. If however the offender has served the designated part of his/her sentence, he/she should be entitled to apply to a Designated Life Tribunal for release from custody, as with someone who has received an OLR without a hospital direction.

RECOMMENDATION 34

A person detained in hospital under an OLR with a hospital direction should be entitled to apply to a Designated Life Tribunal for his/her release if, at the time the designated part of his/her sentence has been completed, he/she is still in hospital.

7.30 When offenders are transferred between prison and hospital the sharing of information is an important component of risk assessment both in prison and in hospital. Our Committee was concerned to hear from a prison governor in England that prisoners with severe mental health problems and/or personality disorders may be transferred to special hospitals, and returned to prison some months later, with no information recorded on their file other than the dates of admission and discharge to and from hospital. We understand that working relationships between the relevant agencies in Scotland are of a better quality. Nevertheless, we consider that there would be benefit in more formalised arrangements between agencies with regard to information sharing.

Discharge and release considerations

7.31 There may be some high risk offenders with a mental disorder for whom it becomes apparent that their future management and care should remain within health and/or social services. This, for example, might require a series of decisions concerning the transfer of the offender patient from one level of secure hospital to another and, eventually, conditional discharge from hospital to the community.

RECOMMENDATION 35

Decision making in relation to the management and care of high risk offenders with a mental disorder should be informed by a multi-disciplinary risk assessment and risk management process in accordance with the standards that apply for sentencing and sentence management as outlined in Chapters 6 and 8.

7.32 We anticipate that there may be high risk offenders with mental disorders who achieve conditional discharge from hospital or who are released from prison in accordance with the procedures described above. As with all high risk offenders the standards of supervision and aftercare in the community should be the same as those described in Chapter 9.

RECOMMENDATION 36

We recommend that the standards of supervision and aftercare for high risk offenders with a mental disorder who are discharged from hospital, or released from prison, should be the same as those for other high risk offenders.

CHAPTER 8: THE OPERATION OF THE NEW SENTENCE

Establishing a risk management plan

8.1 The new OLR should be seen as the beginning of the process of risk management, not the end. In particular, we envisage that the formal risk assessment should be used, not simply to inform the sentence, but also as the basis for the subsequent arrangements for the offender. We envisage, therefore, that the risk assessment prepared prior to sentencing would be developed, in the first months of the order, into a detailed risk management plan.

8.2 Jointly with the SPS, the social work department for the area in which the offender normally lives, and any other agencies it considers may have an active role at this stage, the Risk Management Authority would draw up such a risk management plan for the designated period of the offender's sentence. It would 'contract' with each agency that is to play a part in that plan for their delivery of what is intended.

RECOMMENDATION 37

Upon beginning an OLR, a risk management plan should be prepared, drawing on the pre-sentence assessment, and approved by the Risk Management Authority.

8.3 Currently in Scotland, all adult male offenders serving more than ten years begin their sentence at the National Induction Centre (NIC) at Shotts Prison. We were impressed by the arrangements at the NIC for the assessment of the needs of prisoners serving very long sentences, which compared favourably with several of the establishments we visited in other jurisdictions. Their current focus is on the management of the prisoner during his time in prison, but we feel that the arrangements could readily be modified to begin to address longer-term issues of risk management.

8.4 The great majority of the prisoners likely to receive the new order will be adult males, although it is of course possible for a young person or a woman to be so sentenced. In that event, the risk management plan would require to be drawn up at other establishments.

8.5 We explain in Chapter 7 the arrangements for people who receive the new Order and who have a mental disorder appropriate for treatment in hospital. Such offenders will normally have been subject to an interim hospital order for up to a year, and so it can be anticipated that a risk management plan will have already been developed to some extent by the time of sentence, although this may change depending on the offender's response to treatment.

8.6 Our recommendations are confined to those sentenced under our new sentencing proposals. It is the case that some offenders who receive a mandatory life sentence for murder will present similar issues of risk management to those who receive the new sentence. They would not require a formal pre-sentence risk assessment, because the sentence is fixed by the offence, but it may be desirable that a similar approach to developing a comprehensive risk management plan is introduced, once the sentence has commenced.

8.7 The Risk Management Authority will review progress against the plan at intervals as it sees appropriate, and may bring other agencies into play as the period progresses.

Management within prison

8.8 Our Committee heard evidence from SPS about progress that has been made over the last five years in developing needs and risk assessment, and programmes of demonstrated efficacy and independent accreditation.

8.9 Our proposals for high risk offenders build on this approach. In turn it may be that the work with the wider group of prisoners will be influenced by our proposals for a system where risk assessment and risk management drives decisions about, and opportunities afforded to, prisoners.

8.10 Currently, the progress of prisoners through their sentence and their access to programme interventions and opportunities in the community are heavily influenced by decisions taken on their security category. We believe that such decisions about high risk offenders should be based on the risk management plan.

8.11 Similar considerations arise in relation to decisions concerning the establishments wherein offenders are placed. Such decisions should be determined by the individual needs of the offender, and high risk offenders should have the opportunity to progress through the system when this is appropriate for their needs.

RECOMMENDATION 38

The supply of interventions to high risk offenders in prison, and decisions concerning security categorisation and placement should be determined by the risk management plan.

Consideration of release

8.12 In advance of the completion of the designated period set by the sentencing court, the Risk Management Authority will prepare a report to the Parole Board, describing the plan that had been agreed and performance against that plan. It will submit a current risk assessment to the Board, together with proposals for the onward management of the offender on completion of the designated period. It will give its assessment of its capability to deliver the forward plan, as described.

8.13 The formal arrangements for review of the sentence will be similar, in many respects, to those which currently operate in respect to discretionary life prisoners, although the risk management plan will be a mechanism for bringing together the information required in considering questions of movement from prison to the community (and indeed return to prison). As now, the prisoner would retain the right to a review every two years.

RECOMMENDATION 39

Review of the sentence, and any decision to release the offender from, or to recall the offender to prison, should be the responsibility of the Parole Board, operating through a Designated Life Tribunal (DLT).

RECOMMENDATION 40

The risk assessment and risk management plan should be reviewed formally on a regular basis under the supervision of the Risk Management Authority. Procedures for consideration of release by the DLT should operate in the same way as current arrangements for discretionary life prisoners, but any decision as to release should be informed by the risk assessment and risk management plan.

8.14 Following the decision of the DLT, the Risk Management Authority will 'contract' again with the service agencies for delivery of those parts of the plan that have been agreed with them.

Release powers

8.15 While the new sentence replaces the current discretionary life sentence, insofar as that sentence applies to serious violent and sexual offenders, we are anxious to ensure that the current procedure used in determining level of risk in relation to a reduction in level of control (as practised by the Parole Board through the mechanism of the Tribunal) is retained. There is much of value in the Tribunal approach with respect to the requirements of the European Convention on Human Rights, and to the opportunity it presents for individuals to present their case for release from the controls of imprisonment, directly to the Tribunal.

8.16 However, the requirements of the concept of life-time control explained earlier lead us to believe that the Parole Board (operating as a Tribunal) should, in these cases, have increased powers comparable to those of the Parole Board in dealing with cases of mandatory life prisoners. In assessing level of risk in this context, the Tribunal should be able to determine a future release date - linked to levels of progress relevant to the case under review, together with determining any requirements for levels of control, supervision and support in the community. This new power would allow the Tribunal greater flexibility in its decision making and increase the transparency of its decisions both for the prisoner and for the wider public.

8.17 Should the Parole Board set a future date for reconsideration of the case, or should it set conditions on the offender's licence that the Risk Management Authority subsequently considers could be varied, the Authority will prepare further reports to the Parole Board, again setting out its assessment of the effectiveness of the existing plan and its proposals for future management of the offender.

8.18 Decisions of the DLT to refuse release from prison would not be subject to appeal, but would remain subject to judicial review.

RECOMMENDATION 41

The Parole Board operating through a DLT would have similar powers to those it has in relation to discretionary life prisoners, including the power to set and vary licence conditions. In addition, it would have the power to order release from prison, at a specified future date, and with a requirement that provision be made for supervision and risk management in the community.

The role of Ministers

8.19 Ministers and the Executive currently perform an important role in relation to the management of discretionary and mandatory life prisoners, and other prisoners released on licence. For discretionary life prisoners, the power of release rests with the Parole Board, but Ministers may and do make recommendations to the Board as to whether or not the risk of releasing a designated life prisoner is acceptable. The power to recall prisoners is exercised by Scottish Ministers. Ministers exercise no discretion in relation to designated life prisoners who are the subject of a recommendation to recall from the Parole Board, but have power to recall prisoners prior to consultation with the Board when this is judged expedient in the public interest.

8.20 Although the co-ordination of information in relation to offenders serving the new sentence would largely pass to the Risk Management Authority, we envisage that Ministers would continue to be entitled to make representations to Tribunals on issues concerning the release of prisoners subject to the OLR, and to recall prisoners in urgent cases prior to consultation with the Board. It is fundamental to the operation of the system for the management of high risk offenders, and to maintaining public confidence, that decisions about recall are implemented swiftly and effectively.

8.21 If it were to be decided that the Risk Management Authority should take on a wider role in relation to other offenders, there may be a case for some of the responsibilities of Ministers in overseeing review and recall being transferred to the Authority.

Legal Aid

8.22 Increased powers for the Tribunal bring with them increased responsibility to ensure that its procedures are fair. One of the elements of fairness is the opportunity for prisoners to present their case. But opportunity is meaningless in the absence of a right to exercise it fully through legal representation provided (as in most cases it must be) at the expense of the State. At present only Assistance by Way of Representation (ABWOR) is available under the Legal Aid (Scotland) Act 1986 to a prisoner appearing before a Tribunal. This is insufficient in our view; we think that legal aid (rather than ABWOR) should be available.

RECOMMENDATION 42

Legal Aid should be available to a prisoner appearing before a DLT.

CHAPTER 9: SUPERVISION OF HIGH RISK OFFENDERS

Supervision of high risk offenders in the community

9.1 We have advocated a new form of indeterminate sentences for certain 'serious violent and sexual offenders who may present a continuing danger to the public'. The term indeterminate sentence should not be seen as synonymous with indeterminate incarceration. It is central to our Committee's thinking that where the risk assessment indicates that it is appropriate, and where the comprehensive risk management plan is in place, offenders will continue their sentence in the community. Return to the community will be subject to life-long supervision, specified conditions of release appropriate to the individual, and sanctions and restrictions including recall to custody.

9.2 The SPS and local authority social work departments have long experience of preparing offenders for their return to the community and of supervising and assisting them on their release. This work is supported by the contribution of housing agencies and a range of other statutory bodies and voluntary organisations.

9.3 The role envisaged for the Risk Management Authority and the arrangements for considering release have already been outlined. Before addressing the issue of future service arrangements it is important to acknowledge the current arrangements for supervising offenders in the community.

9.4 The evidence received by our Committee suggests that local authorities are developing structured approaches to risk assessment, such as the Level of Service Inventory (Revised) (LSI(R)) and the Risk Assessment and Guidance Framework (RAGF). Growing numbers of offenders have access to specified change programmes delivered either individually or on a group basis. In general, local authorities appear to be delivering within, and even above, the standards expected of them, although there are variations in practice between and even within authorities.

9.5 Our Committee is aware that the Social Work Services Inspectorate has carried out an inspection of the management of sex offender cases in the community. It is hoped that, if and when its report is published, this will provide a clearer picture of the current baseline of services. Such a baseline is required in order to inform the development of new standards.

9.6 However, we are of the view that more needs to be done for the very high risk group with which we are concerned. If such offenders are to be released into the community, this is only likely to be appropriate, and acceptable to the public, if the conditions of supervision are of a different order from those which are currently available.

9.7 The current National Objectives and Standards for Social Work Services in the Criminal Justice System will not be sufficient to meet the needs of this group. New standards require to be developed, which combine a national minimum standard of service with a framework which accommodates highly individualised risk management plans. The Risk Management Authority could be expected, in due course, to contribute to the development of these standards.

9.8 In addition to new standards, resources will require to be made available in order to meet these standards.

RECOMMENDATION 43

National standards for the supervision of high risk offenders should be developed by the Scottish Executive, in consultation with the Risk Management Authority.

9.9 Some local authorities have the benefit of specialist workers or projects who work exclusively with sex offenders (e.g. the Tay Project). The development of such projects significantly enhances the capacity of local authorities to provide detailed and specialised assessment. It also enhances the level and nature of community supervision.

9.10 The current re-organisation of Social Work Services in the Criminal Justice system will form groupings of local authorities.

RECOMMENDATION 44

Each of the proposed local authority groupings should have access to a specialist services for high risk offenders which can supplement and support the work of individual supervising social workers.

9.11 In considering the nature of community supervision of high risk offenders, we have been influenced by the services we visited overseas, particularly the Sexually Violent Predator (SVP) programme in Phoenix, Arizona (see Annex 4). Whilst we do not support the legislative framework in the United States for detaining sexually violent predators, this is an example of a service which appears to have successfully developed mechanisms to allow high risk offenders to move into the community, while maintaining public safety.

9.12 The SVP programmes do have a considerable therapeutic element, but our view is that this is not the only, or even main, basis for success. Significant factors in these programmes appear to be:

- strong incentives for individuals to manage their behaviour and engage with therapy;
- a thorough system of supervision, with regular re-assessment;
- very clear boundaries of acceptable behaviour;
- integrated management of custody, therapy, and community services.

9.13 This approach includes not only supervision, as it is traditionally understood in Scotland, but also an element of surveillance. This is done both through technological means, such as satellite monitoring systems, and by personal checks. This may well involve the development of a new cadre of staff to provide this intensive monitoring, supporting the more traditional case management by social work staff, and other therapeutic input.

9.14 There may require to be primary legislation to ensure that the widest range of options is available for the safe management of high risk offenders in the community. This may apply in particular to electronic monitoring. We see this as potentially useful in a variety of situations, including the periods when offenders are still subject to custodial control, or when they are living in a pre-release hostel, or after release on licence.

9.15 Currently, electronic monitoring (or 'tagging') has been introduced on a pilot basis in three sheriff courts. These arrangements are intended for a different client group, and use more limited technology than we observed in the USA.

9.16 The indiscriminate use of electronic monitoring rightly causes concern. However, as was noted by one respondent to our consultation, 'the civil liberties implications will always be less grim than the alternative of indefinite imprisonment'. Our experience in the USA was that many offenders also take this view, and are quite prepared to accept the inconvenience of electronic monitoring, including devices which are much more cumbersome than the more simple tags used in the UK, if this allows them to remain in the community and to lead a comparatively normal life. We recognise that the technology used to monitor offenders is developing at a fast rate, but public confidence in the methods used is of course paramount.

9.17 Another striking difference between the SVP programme in Phoenix and the Scottish system is that licence conditions are considerably more detailed and stringent than would be expected here. Despite this, it appeared that such conditions were tolerated by offenders. This seemed to be because they were extremely strictly enforced, so there was no scope for offenders to test the system. Undoubtedly, another strong incentive was the considerable hardship for offenders being returned to secure conditions, and particularly to prison.

9.18 The final key element was a staged approach, which allowed people to progress in manageable steps to conditions of greater freedom (and, if necessary, have that freedom restricted).

RECOMMENDATION 45

Community services for high risk offenders should develop techniques for intensive supervision and surveillance. Components of this service would include:

- use of electronic monitoring technology;
- regular unannounced and announced visiting;
- regular drug and alcohol testing;
- strict conditions, including as to place of residence, and participation in treatment;
- a 'halfway house' offering semi-secure facilities and intensive treatment, (comparable to the 'less restrictive alternative' operated by the Arizona Community Protection and Treatment Centre); and
- rapid and predictable return to conditions of greater security in the event of non-compliance.

9.19 The risk management plan would continue to be the basis upon which needs are assessed and co-ordinated. Where the offender is being managed in the community, the Risk Management Authority would require reports to be supplied periodically by all agencies working with the offender and would conduct a formal risk assessment and risk management review with periods determined by the risk management plan.

Accommodation

9.20 Our Committee is aware that a number of pieces of work are currently in progress in relation to the provision of accommodation for offenders in general and sex offenders in particular. The Scottish Executive is currently co-ordinating the development of a national accommodation strategy for offenders. It is understood that this work is still at an early stage but it is of considerable significance in terms of the group of offenders with whom we are concerned. The availability of appropriate accommodation is central to reaching a decision to release prisoners on indeterminate sentences. It is also central to the appropriate supervision of offenders in the community. Unstable or unsuitable accommodation arrangements will have a direct bearing on the capacity to manage risk.

9.21 This point was reinforced by the 1997 Scottish Office Social Work Services Inspectorate publication ***'A Commitment to Protect: Supervising Sex Offenders. Proposals for More Effective Practice'*** which states that 'Homeless and highly mobile offenders are very hard to monitor and supervise effectively. They therefore pose a greater risk and the provision of stable accommodation will assist in minimising the risk of offences'. The availability of appropriate accommodation will be an essential pre-condition for the release of prisoners serving indeterminate sentences.

9.22 The move from custody to the community can involve specialist residential facilities, general hostel provision and community housing. Previous reports have highlighted the dearth of specialist residential facilities. Those which do exist may have specific admission criteria which exclude sex offenders. While the difficulties of establishing such facilities are not underestimated it is clear that the number of hostels or half-way houses available in other countries is substantially greater than is the case in Scotland. The availability of such facilities enhances supervision and monitoring and decreases risk.

9.23 The general hostel provision for homeless men is unfortunately associated with high levels of alcohol and drug use and low levels of supervision and support. As such it is wholly inappropriate for this client group.

9.24 Where consideration is being given to the allocation of an individual tenancy, housing authorities will play a key role in managing risk. The Chartered Institute of Housing in Scotland issued advice in 1999 on the housing of sex offenders.[16] This guidance would apply equally to all of the offenders with whom we are concerned.

RECOMMENDATION 46

The Scottish Executive should ensure that there is an appropriate range of accommodation, including hostels and other forms of supported accommodation, which can facilitate the discharge of high risk offenders from custody and ensure their appropriate supervision in the community.

[16] Housing and Sex Offenders in Scotland. The Chartered Institute of Housing in Scotland, April 1999

Community notification

9.25 In gathering evidence on the practice in other countries our Committee became increasingly aware of the very wide range of practices which have developed for community notification of the release from custody of serious violent and sexual offenders. In North America the clear trend is towards the use of generalised community notification. This can manifest itself in a number of forms including widespread use of the local media, individual leafleting of the neighbourhoods surrounding the proposed address and the calling of community meetings organised by the Police and the authority responsible for post-custodial supervision. In contrast, the approach we observed in relation to release from the TBS clinics in The Netherlands was one of no community notification.

9.26 From the information available, and from the evidence gathered in discussion with practitioners with direct experience of such arrangements, it is not clear that widespread community notification makes any significant additional contribution to public safety. Problems associated with offenders being driven out of one address after another have been experienced in a number of countries and there is a clear danger that such experiences lessen both the capacity of the authorities to exercise appropriate supervision and the willingness of the offender to co-operate.

9.27 The current arrangements in Scotland have largely been developed since the introduction of the Sex Offenders Act 1997. The guidance associated with this legislation places on obligation on the Police to notify the Social Work Department of the details of each registered offender. The current guidance stresses the strictly confidential nature of this exchange of information. A limited amount of information requires to be shared with the housing authorities in order that they can make appropriate decisions about accommodation, but beyond this the guidance emphasises that information should not be given to agencies or individuals outwith the Police and Social Work Department unless it is believed that serious harm might result from not sharing information about the risk the offender poses.

9.28 Following the introduction of the Sex Offenders Act 1997 the Police and local authorities have developed a series of local protocols which outline the arrangements for information sharing, risk assessment and the development of jointly agreed risk management plans. Such protocols have enhanced inter-agency co-operation at both strategic and operational levels and provide a sound basis for future joint work. Our Committee are aware of the current work being undertaken by the Association of Directors of Social Work and the Association of Chief Police Officers of Scotland to develop a Scottish protocol. We see this as a helpful development of the work previously undertaken at a local level.

9.29 In the Scottish context, our Committee considers the current guidance to be appropriate and does not consider that adopting a policy of widespread public notification would enhance public safety.

SECTION 3

OFFENDERS WITH PERSONALITY DISORDER

CHAPTER 10: PERSONALITY DISORDER

10.1 Our terms of reference require us 'to compare practice, diagnosis and treatment with that elsewhere, to build on current expertise and research to inform the development of a medical protocol to respond to the needs of personality disordered offenders'.

10.2 The remit therefore carries the implication that the presence of a personality disorder is a potentially important component in those who commit serious violent or sexual offences. We do not think this implication should be over-stated. Our approach to the problem of serious violent and sexual offenders has consistently been governed by the identification and management of the risk they present to society rather than by the presence or absence of any particular psychological or medical condition. Nonetheless, our remit clearly requires us to address the issue of personality disorder. In this chapter we set out our understanding of the term, discuss its relevance to serious violent and sexual offending in Scotland and make some observations concerning treatment.

What is Personality Disorder?

10.3 The category of mental disorders known as 'personality disorder' is probably the most contentious in psychiatry and associated disciplines. Personality disorders that are manifested by antisocial behaviour patterns (discussed further below) are the chief concern in this chapter. In antisocial types of personality disorder there is, at present, inadequate evidence of a generalised abnormality in the brain, or elsewhere in the central nervous system or in any other body structure. Science has not, so far, found a widely accepted explanation of what abnormality causes the antisocial behaviour in those with this type of personality disorder. Therefore to some extent the personality disorder is defined by antisocial behaviour and the behaviour is explained by the disorder. Not surprisingly, this type of definition has been criticised for being somewhat circular.

10.4 There is a further problem in grading the seriousness or severity of antisocial types of personality disorder. Some workers in this field do not clearly distinguish between a moderate degree of personality disorder and the most severe form of the condition. The latter is sometimes referred to as 'psychopathy' but we think that term may have unwelcome implications and we therefore avoid it. We do however emphasise that our concern is with severe degrees of antisocial types of personality disorder.

10.5 Finally, there are related issues that generate what can only be described as unanswerable questions. For example, if the abnormal behaviour disappears, has the mental condition remitted? Can a person with a personality disorder exercise control over his/her behaviour? Is a person with a personality disorder legally responsible for his/her actions? Is the condition simply a way of describing one extreme in the range of human behaviour? These are all huge questions and their discussion is largely beyond the remit of the Committee. We do however emphasise that

although the subject is contentious, there continues to be a slow accumulation of knowledge based on properly conducted scientific research.

10.6 There are definitions of personality disorder, and its various sub-types, in the standard classifications of mental disorder, namely the ICD-10 Classification of Mental and Behavioural Disorders (World Health Organisation, 1992) and the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition - DSM IV (American Psychiatric Association, 1994). In essence there are four components in the definition of a personality disorder. These are:

i. a pattern of behaviour or emotional response or perception

ii. that is evident in early life, persistent, pervasive and a deviation from the person's cultural norm

iii. that leads to distress to the person or to others or to society and

iv. is not attributable to any other psychiatric or physical disorder.

10.7 A personality disorder is thus characterised by a pattern of qualities that is lifelong, that leads to distress or dysfunction and is not due to other conditions. The ICD-10 contains eight categories of personality disorder within Section F60, while the DSM IV lists ten within three different clusters in Section 301. It cannot however be over emphasised that the various categories of personality disorder are not mutually exclusive, and that overlap between them is common. Indeed it is relatively unusual to find 'pure forms' of any particular type of personality disorder.

Personality disorder in Scotland

10.8 There are no figures available for the prevalence of personality disorder in the Scottish population. Community surveys from elsewhere suggest that up to 11% of the adult population may suffer from any type of personality disorder[17] but the great majority are not related to an increased likelihood of offending. We know that the prevalence of personality disorder is substantially higher in those people who have medical complaints and who consult general practitioners or are admitted to hospitals.

10.9 Personality disorder is thus common, probably five times more common than a serious mental illness such as schizophrenia. Extrapolating from the figures above we can estimate that between 200 000 and 300 000 adults in Scotland have a personality disorder. In striking contrast is the rarity of psychiatric hospital admission for people with a primary diagnosis of personality disorder. Less than one in 300 people with a personality disorder is likely to be admitted to a psychiatric unit in any year. In 1998 personality disorder accounted for only 2% of the 32 000 psychiatric admissions in Scotland[18] there is likely to be an under-recording of the diagnostic category of personality disorders in the statistical returns from which these data are derived. Data are not available for the frequency with which people with a personality disorder come to the attention of medical services or social work agencies.

Antisocial personality disorder

10.10 In relation to offenders, there has been particular interest in the type of personality disorder described as dissocial in ICD-10 and as antisocial in DSM IV. Historically

17 de Girolamo G and Reich JM (1993) Personality Disorders - Geneva:World Health Organisation
18 Information Services Division Edinburgh: Scottish Executive

other words have been used such as psychopathic and sociopathic to describe this type of personality disorder. Unfortunately each new term quickly acquires pejorative overtones that affect its application and have damaging implications. For the purpose of this report we will use the term antisocial personality disorder as this seems to be most widely used in current scientific literature. Our concern is with the disorder in its severe form.

10.11 ICD-10 lists the following six characteristics:

i. Callous unconcern for the feelings of others.

ii. Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations.

iii. Incapacity to maintain enduring relationships, though having no difficulty in establishing them.

iv. Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.

v. Incapacity to experience guilt or to profit from experience, particularly punishment.

vi. Marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society.

10.12 DSM IV lists some similar features but also requires that the person is aged at least 18 years before the diagnosis is made, and that there is evidence of disordered conduct with its onset before the age of 15 years.

10.13 There is evidence that antisocial personality disorder is associated with:

1. Increased risk of physical illness.
2. Frequent use of healthcare services.
3. Other psychiatric disorders, e.g. substance misuse and depression.
4. High rates of mortality, particularly by suicide and by accidents.

Prevalence of antisocial personality disorder in Scotland

10.14 Having provided a brief outline of the definition of antisocial personality disorder, we now turn to the more important questions of the prevalence of the condition among those who commit serious or violent sexual offences in Scotland. Our knowledge is incomplete. Psychiatric or psychological assessments are only carried out on selected offenders and therefore the characteristics of all serious and violent sexual offenders are not known. We do however have some data in relation to sentenced prisoners. In a study of men serving sentences in Scotland, Cooke[19] using a research instrument known as the Psychopathy Check List - Revised version (or PCL-R) - found that approximately 6-8% could be diagnosed as having a severe antisocial personality disorder and 52% had a less severe form of antisocial personality disorder. Research in England and Wales (using a different measuring instrument) found 63% of sentenced men, and 31% of all women in prison had an antisocial personality disorder, but the research did not seek to identify severity of the disorder[20].

[19] Cooke D J & Michie C (1999) Psychopathy across cultures: North America and Scotland compared. Journal of Abnormal Psychology. 108. 58-68: Cooke D J (1999) Psychopathy: Structure and cross-cultural generalisability. Keynote address at the 8th Annual Conference of the German Psychology and law Association. Nurnberg 15-18 September 1999.

[20] Singleton N, Meltzer H and Gatward R (1998) Psychiatric morbidity among prisoners in England and Wales: Government

10.15 There are limited data available concerning people with a personality disorder who are compulsorily detained in hospital and who have a mental disorder manifested only by abnormally aggressive or seriously irresponsible conduct - often considered the Scottish equivalent of the category psychopathic disorder in the Mental Health Act 1983 for England and Wales. In 1998 there were more than 4000 compulsory admissions to psychiatric hospitals in Scotland. These include approximately 3700 non-offenders (i.e. ordinary patients who have not broken the law) admitted under the civil provisions of the Mental Health (Scotland) Act 1984, and approximately 500 offender patients admitted either under the Criminal Procedure (Scotland) Act 1995 or Part VI of the Mental Health (Scotland) Act 1984. These compulsory admissions are in the legal categories of mental illness or mental handicap. Information kindly provided for us by the Mental Welfare Commission for Scotland confirms that in less than 20 cases was detention in hospital applied by reason of a mental illness manifested only by abnormally aggressive or seriously irresponsible conduct. These were all under civil provisions and there were no such detentions ordered by the court in respect of offender patients.

10.16 At the State Hospital, a survey conducted by Thomson ***et al.***[21] found only 13 patients (5.4% of the resident population) in whom the principal diagnosis was a personality disorder. However a further 51 patients had the disorder in combination with other conditions. Indeed an unpublished survey referred to in the Report of the Inquiry into the Care and Treatment of Noel Ruddle (Mental Welfare Commission for Scotland, 2000) suggests that up to 75% of the State Hospital population may have a personality disorder of one type or another.

10.17 Summarising these points we can conclude as follows:

1. It is not known how many serious violent or sexual offenders have a personality disorder.
2. Personality disorder alone is very rarely the diagnostic criterion for compulsory admission either under civil or criminal mental health legislation.
3. Approximately 50% of male sentenced prisoners in Scotland have an antisocial personality disorder, and this is severe in up to 8% as measured by current research instruments.
4. In 1997 there were 13 patients at the State Hospital with a principal clinical diagnosis of personality disorder.

Personality disorder and other conditions

10.18 While personality disorder is in itself an unlikely reason for compulsory detention in hospital, abnormal personality traits are commonly found in patients who are detained under mental health legislation. The figures for personality disorder in combination with other disorders given in paragraph 10.16 (above) are broadly similar to those reported from the English special hospitals[22]. In these populations the psychiatric conditions that are most likely to co-exist with personality disorder include schizophrenia, other types of paranoid psychoses, substance misuse and learning disability.

10.19 Personality disorder may be present in some people who commit serious sexual crimes. In general however sex offenders are a heterogeneous group with few uniform psychiatric features. Thus they may or may not have a personality disorder,

[21] Thomson L, Bogue J, Humphreys N, Owen D and Johnston F (1997) The State Hospital survey: a description of psychiatric patients in conditions of special security in Scotland. Journal of Forensic Psychiatry, 8, 263-284

[22] Taylor P J et al 'Mental disorder and violence: a special (high security) hospital study'. British Journal of Psychiatry 1998

they may or may not be sexually deviant and they may or may not have a recognized psychosexual disorder. The presence or absence of a personality disorder in itself is not a reliable indicator of any propensity for committing sexual offences.

10.20 The discussion outlined in paragraphs 10.1-10.17 indicates why we consider that personality disorder is an inappropriate 'starting point' from which to consider the problem of sentencing serious or violent sexual offenders. In short, it is not sufficiently specific to include the wide range of people who may commit serious violent or sexual offences. Many serious offenders do not have an antisocial personality disorder. We are aware that the UK government has proposed for England and Wales various measures in relation to a condition it has referred to as 'dangerous severe personality disorder'. For reasons stated earlier, we have considered that the more appropriate approach in Scotland is to consider risk assessment and risk management, rather than focus solely on personality disorder.

Treatment for personality disordered offenders

10.21 Although offenders with personality disorder are only part of our terms of reference we have been asked to comment in particular on issues of practice, diagnosis and treatment in relation to this group. The way in which services should deal with offenders with personality disorder is considered in Chapter 11, but it may be helpful to address the general question of treatment before setting out our detailed recommendations.

10.22 The evidence of the effectiveness of various treatment approaches was exhaustively studied by Coid and Dolan in 1993, in a work commissioned by the Reed Working Party[23]. More recent analyses have been carried out by Loesels and Blackburn.[24]

10.23 We also received submissions from a number of organisations and individuals about treatment and 'treatability'.

10.24 Although there was some anecdotal evidence of promising treatments, such as dialectical behaviour therapy and therapeutic communities, the majority of psychiatric responses reflected current 'therapeutic nihilism', and the lack of convincing research evidence to support any particular treatments. However, a number of respondents disputed the perception that personality disorder was 'untreatable'. The National Schizophrenia Fellowship Scotland pointed out that such a view was likely to be a self-fulfilling prophecy - if treatment is assumed to be hopeless, then no treatment will be tried and evaluated.

10.25 The Psychotherapy Section of the Royal College of Psychiatrists said that there was clear evidence that effective treatments (particularly psychosocial interventions such as cognitive and dialectical behaviour therapy and psychodynamically orientated day patient treatment) exist to alleviate the symptoms of personality disorder.

10.26 The consensus view, which we share, is that it is unduly pessimistic to conclude that 'nothing works'. However, we are still some way from being able to say exactly what does work, and for whom. Furthermore, it is generally agreed that interventions are more likely to have a beneficial effect with those who are willing

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[23] Dolan B and Coid J (1993) 'Psychopathic and antisocial personality disorders: treatment and research issues'. Gaskell Publications.

[24] Blackburn R. (2000). Treatment or incapacitation? Implications of research on personality disorder for the management of dangerous offenders. Legal and Criminological Psychology, 5, 1-21
Loesel F. (1998). Treatment and management of psychopaths. In D J Cooke, A Forth and R D Hare (Eds), Psychopathy: theory,

to engage with treatment, and with those who are less severely disordered. Indeed, in relation to severely personality disordered offenders, there is some evidence that recidivism increases after treatment.

10.27 All currently accepted treatments for personality disorder require the co-operation of the person with the disorder. Treatment cannot be successfully imposed against the will of that person. Not only is the research literature on treatment approaches unconvincing but it derives principally from settings where voluntary patients undergo treatment in conditions in which they are not compulsorily detained. The applicability of these treatments for compulsorily detained people in custodial settings has not been established.

10.28 It is also extremely difficult to measure treatment success clinically, since any evaluation of the individual's psychological state depends largely on self reporting. Nor can it be assumed that treatment which may alleviate some of the symptoms of personality disorder will necessarily reduce the risk of serious violent or sexual offending, since the connection between the disorder and risk is often complex.

10.29 It is important, therefore, that any attempt to reduce the risk to society created by offenders with personality disorder is not predicated on the idea that compelling people to receive treatment will necessarily achieve this aim.

10.30 Personality disorder is a mental disorder, but it by no means follows that treatment must only be delivered in a health care setting. Several responses to our consultation from psychiatrists and NHS services contended that psychiatry was not best placed to meet the needs of offenders with personality disorders, and that, insofar as treatment was appropriate, it was principally social and psychological treatments that were indicated. Other responses from social work and prisons suggested that forensic psychiatry did have a role, but in partnership with clinical psychology, social work and others.

10.31 There is no clinical tradition in Scotland for detaining large numbers of serious violent or sexual offenders with personality disorders in secure or other hospitals. Any change in current practice can only be driven by clinical developments and not by a policy decision that lacks a sound theoretical footing. We have not been able to identify any major clinical development in the treatment of personality disorder that would justify a change in Scottish practice. We therefore expect that serious violent or sexual offenders who have a personality disorder will, on conviction, continue to serve sentences in prison. We recognise that the burden of responsibility for providing safe custody and for addressing the problems that gave rise to offending will remain with the SPS. This is a heavy burden and responsibility but we do not think it can be carried out by any public body other than the SPS.

10.32 We have noted the discussion in the Home Office consultation paper[25] on what has been called the 'third way' between hospitals and prisons for personality disordered offenders. Such institutions do not currently exist and the difficulties in establishing them in Scotland would be immense. They would require appropriate location, staffing, policies and regimens. At present we do not consider that the establishment in Scotland of a third way type of institution is either feasible or advantageous. Instead we think that an imaginative approach is necessary within the SPS. Regimens are needed that are driven by risk assessment and its continued management throughout the term of imprisonment and, with the assistance of

[25] Managing Dangerous People with Severe Personality Disorder. Proposals for Policy Development. (Home Office 1999)

other agencies, in the community. We discuss these measures further in Section Two.

10.33 There are some other general issues regarding treatment. Any change in personality disorder takes place over long periods of time. This presents problems in evaluating treatment since it is hard to know whether any beneficial change is the result of treatment or is simply the amelioration of violent behaviour due to the ageing process. More importantly, for our purposes, it means that short 'blasts' of treatment are highly unlikely to be effective. Personality disorder is a 'lifetime condition' and therapeutic interventions may require to be delivered over lengthy periods. Thus a consistent and co-ordinated approach is necessary between agencies and in different service settings. The British Association of Social Workers commented that there are many people who do not 'fit' either the mental health or criminal justice system. A complex package of care and intervention is often required, which in turn necessitates a flexible range of disposals.

10.34 Many experts are sceptical about the extent to which underlying personality can be changed, once a pattern of dysfunctional behaviour has been established. Treatment, if it works at all, will probably help the person better to adjust his/her situational responses to societal norms, rather than "cure" the disorder. When working with personality disordered offenders, the most important aim is to reduce the risk of their committing further antisocial acts. Treatment, therefore, should be seen not as a time-limited intervention but as part of an overall strategy for the management and reduction of risk.

Preventive detention

10.35 We gave careful thought to the matter of the identification of people with personality disorder currently at liberty but who, at some time in the future, might commit a crime of a serious violent or sexual nature. The implication of such identification is that it might be followed by some form of preventive detention, whether or not the personality disorder is a condition for which medical treatment is available, feasible or beneficial. The implications of this type of measure are profound. We did not learn of any jurisdiction where it is currently in practice. In the UK it is possible under existing mental health law for civil detention in hospital to be on the basis of personality disorder that meets appropriate criteria but the disorder must be one for which treatment is appropriate; and there must be a prospect of benefit from treatment. In other words this legislation may not be applied simply to achieve preventive detention.

10.36 No witnesses from whom we heard supported a move towards preventive detention of this type. We did not hear any professional body or agency say they considered it an appropriate task for their particular profession or agency. Practitioners had little confidence in their ability to identify cases; providing, staffing and running an appropriate place of detention would pose difficulties that would probably prove insurmountable; and above all the deprivation of freedom for those detained would not be balanced by a sufficiently measurable gain in terms of public safety. For all these reasons we firmly rejected the proposition of pre-offence preventive detention.

Prevention

10.37 Finally, within the modern national health service it is recognised that health policy should be directed not solely towards treatment but also at prevention. The prevention of personality disorder is not a matter within our remit. However, we noted with interest the comments of the Royal College of Psychiatrists in its report on offenders with personality disorder - 'the preventive approach appears to offer more hope and a stronger basis for the investment of scarce resources and treatment interventions'[26]. In England and Wales, the Home Office and DoH document on managing people with dangerous severe personality disorder contains a section on prevention strategies, focusing particularly on intervention in childhood and adolescence. We commend such an approach to the Scottish Executive.

RECOMMENDATION 47

The Scottish Executive should consider measures that might be taken to include the prevention of personality disorder within its broader strategies, including those on education, social inclusion, public health and substance misuse.

[26] Offenders with Personality Disorder, The Royal College of Psychiatrists, 1999 Council Report CR71

CHAPTER 11: SERVICES FOR OFFENDERS WITH PERSONALITY DISORDER

Introduction

11.1 We have emphasised that the identification and sentencing of high risk offenders should be based on the development of improved methods of risk assessment and management, rather than the identification of a particular type of psychiatric condition or personality disorder. Nonetheless, our terms of reference require us to specify the services required by serious violent or sexual offenders with personality disorder. In our considerations of this complex matter we have heard evidence from experts and practitioners in the field and have visited services within the UK and abroad.

11.2 In this chapter we review the types of service that currently exist both within Scotland and elsewhere, identify the problems inherent in such services, and finally make some recommendations which are intended to help create the basis for developments in treatment and management.

What is currently available?

11.3 Our Committee was unable to identify any service in Scotland with a sole and specific remit for the care or treatment or supervision of offenders with personality disorder. Within certain local authority, penal and health services there are some limited facilities within the general provision for a wider group of clients, prisoners or patients. We visited some of these, and met staff from others (see Annex 4), and were impressed by the dedication of professionals in dealing with a difficult group of people, often with little support.

11.4 Within local authority criminal justice services, we heard evidence that the designation of an offender as 'personality disordered' was regarded as unhelpful, for various reasons. First, it had a discriminatory effect serving to exclude the offender from services because of an implied risk inherent in the designation. Indeed it was even suggested that the term was used by staff in psychiatric services as a means of rejecting the offender from service provision. Second, it carries the implication of untreatability or incorrigibility and makes the offender an unattractive prospect to agencies that are more keen to work with clients who are seen as likely to benefit from the particular intervention.

11.5 The SPS does not have a resource specifically for offenders with personality disorder. There are small units at Shotts and Peterhead prisons for particularly difficult prisoners, many of whom would probably attract a diagnosis of personality disorder. (The unit at Peterhead has since been suspended from operational use). We were impressed by the success that the staff have had in coping with a very difficult group of prisoners. However, even in these units it was clear that there were substantial problems in coping with a small number of highly antisocial prisoners. The aim of these units is primarily to manage difficult prisoners, rather than to offer treatment for personality disorder, and in this task it seemed successful.

State Hospital and other health facilities

11.6 As indicated above (paragraph 10.14) the State Hospital contains mentally disordered offenders of whom a small number have a sole diagnosis of personality

disorder but a larger number have such a disorder in combination with other psychiatric conditions. There is considerable expertise at the State Hospital but it was not suggested to us by staff that the hospital currently had a particular focus of interest in, or treatment for, personality disorder.

11.7 The special hospitals in England (broadly equivalent to the State Hospital in Scotland) accommodate a much higher proportion of patients with a primary diagnosis of personality disorder than does the State Hospital. This reflects both differences in mental health law (the Mental Health Act 1983 in England has a specific category of psychopathic disorder) and a different tradition within the English special hospitals. The evidence base for the effectiveness of the special hospitals in managing personality disorder is limited. The Ashworth inquiry[27] found that the decision as to whether a serious offender with personality disorder was sent to prison or to hospital was (in their words) 'a lottery'.

11.8 We found no other in-patient services specifically for personality disordered offenders in Scotland. The situation regarding community NHS facilities was little different. Some day hospitals or community-based services attempted to deal with personality disordered offenders but there were no designated services for such people. We were advised that even specialist services for offenders, such as that at the Douglas Inch Centre in Glasgow which deals with many offenders who would be categorised as personality disordered, lack appropriate staffing to offer comprehensive psychologically based programmes designed to address offending behaviour for this group.

<u>Why is the service base low?</u>

11.9 A comprehensive evidence base for the successful management of personality disordered offenders within the criminal justice system does not exist. In its absence it is not surprising that specific services for personality disordered offenders have not developed. This is an area where failure is common and may sometimes have grave consequences. Professional staff naturally wish to be associated with success rather than failure, and there have been few initiatives. We are not surprised. There are also well recognised pitfalls in the provision, functioning and management of any such service and these too are likely to be powerful deterrents.

11.10 Striking a balance between treatment and control of serious offenders with personality disorder is a challenging task given the behavioural manifestations of the disorder and the vagueness of definition in certain treatment approaches. A recurring theme apparent from the visits to the facilities and services, and from presentations made to our Committee, was the difficulty arising from failures to manage the relationship between the offender with personality disorder, whether or not in combination with any other psychiatric condition, and the service in question. Many of the facilities visited had experienced problems at some time arising from a breakdown in the boundaries between staff and patients/prisoners; these had often led to situations of potential or actual danger.

11.11 Key features of personality disorder are the behavioural and interpersonal manifestations of the individual's personality traits. These present particular challenges in treatment and can easily lead to the 'splitting' of staff. That is, staff members, individually or collectively, become the focus of the patient/prisoner's

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[27] The Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, Cm 4194-11

distorted relationships and behaviour; some staff are 'favoured' by the client while others are not. Generally such 'favour' comes at a price for the staff member unless he/she is aware of it, and is able to receive proper professional supervision to deal with it. Indeed for all staff working with such personality disordered people the importance of proper supervision is essential for maintaining appropriate professional boundaries.

11.12 Our Committee recognised that the legislative framework, the treatment goals of the service and the possible outcomes for the prisoner/patient must be integrated in a way that is clear to staff and their clients. Where services had a less clear framework there appeared to be a danger that containment and treatment issues could become confused. Such confusion provides opportunities for the manipulation of the rules and regulations of the service concerned, and possibly of the actual treatment programmes.

11.13 It was clear to our Committee that mental health models of care with the modern emphasis on patients' rights and user empowerment can sit uneasily in a service dealing with serious offenders with personality disorder. People with severe personality disorder can be very challenging and litigious; they can identify and exploit 'fault lines' in the organisation of any treatment setting. Services should have clear philosophies of treatment and management; these should protect the clients' rights but also provide an organisationally robust environment that supports consistent treatment interventions to promote positive change in clients.

11.14 We found a variety of approaches in the services visited. Some placed a greater emphasis on containment with specific treatment interventions, others provided a living environment (or milieu) that in itself was seen as the major part of the therapy, as in therapeutic communities. Other facilities combined features common to both these approaches within a structured therapeutic environment. Many of the facilities visited provide a range of environments allowing for movement between differing levels of security. These arrangements reflect the fact that any service must allow for change and progression in its client group.

11.15 Our Committee is not in a position to identify the 'best' approach but we think it important to recognise some of the key features that we, and others, consider essential in the provision of services for serious offenders with personality disorder, whether such services are in a prison, health service, local authority or other facility. Some of these key features are in accordance with evidence submitted to the Ashworth Inquiry[28]. These include:

- a coherent treatment approach/philosophy;
- a treatment philosophy with which all staff agree;
- a structured therapeutic environment;
- the opportunity for the psychosocial development of clients;
- a team approach which minimises the burden on individual staff members;
- staff who have a full understanding of the interpersonal aspects of personality disorder and a capacity for self examination;
- staff provided with sufficient support and supervision in working with personality disordered clients.

[28] Written evidence of B Dolan in Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital. Vol II Cm 4195. 1999

11.16 There exists a serious shortage of properly qualified and experienced practitioners with the appropriate expertise to initiate and maintain services with the features we have outlined above. We discuss below the possibility of piloting new services. We emphasise that there are unlikely to be any such developments until there is a sufficiency of skilled professionals to offer specialist input and provide appropriate leadership.

A medical protocol for personality disordered offenders

11.17 Included in our terms of reference is a requirement for 'the development of a medical protocol to respond to the needs of personality disordered offenders" based on "current expertise and research'. We therefore gave the task much consideration.

11.18 In this context, a medical protocol usually refers to a set of guidelines providing a basis for good medical care. The Scottish Intercollegiate Guidelines Network (SIGN) has published more than 40 clinical guidelines covering a range of medical disorders, all based on current evidence. To date, only two SIGN publications deal with mental disorders, namely management interventions in dementia (February 1998) and psychosocial interventions in the management of schizophrenia (October 1998). The other conditions covered by SIGN are physical conditions such as coronary artery disease, asthma and epilepsy.

11.19 We do not think that the problem of personality disordered offenders lends itself to the development of guidelines or a medical protocol of this type. The term, personality disordered offenders, does not describe a medical condition. The great majority of personality disordered offenders will not routinely have contact with doctors or with other medical agencies, though they might consult them with various health problems. The starting point for any medical protocol must be a clearly defined medical condition or medical symptom, rather than a group of offenders within the criminal justice system.

11.20 Further, the majority of people with personality disorders do not break the law, and only a small number commit serious violent or sexual offences. We do not think that a medical protocol for personality disordered offenders can usefully be developed. We think there may be a case for an organisation such as SIGN to address the more general issue of personality disorder with a view to establishing national clinical guidelines on the basis of current evidence.

RECOMMENDATION 48

The Scottish Executive should consider whether or not the condition of personality disorder generally should be referred to SIGN with a view to the development of national clinical guidelines.

New Services

11.21 We have concluded above that the service base in Scotland for serious offenders with personality disorder is minimal. We have also emphasised that little evidence exists that any specific treatment approach has a measurable effect on recidivism in this group of offenders. Our Committee is thus faced with a dilemma in

considering recommendations for new services. An apparent need for services is not matched by proven benefit of any particular type of service, yet to make no recommendation implies that no attempt should be made to improve the current situation.

11.22 It is our view that there is no single treatment approach which, were it to be adopted, would solve the problem of serious offenders with personality disorders. Over the years, there have been many false dawns. Therefore our recommendations focus on the more general task of long-term management rather than on a time-limited delivery of treatment. We think the aim of the task is the better protection of the public.

11.23 We found little support for the notion that a new specialist service for serious offenders with personality disorders should be developed outwith existing agencies. Our Committee agrees that such a service is not appropriate for Scotland for a number of reasons. First, no professional group from which we heard considered it had the knowledge, skills or professional enthusiasm to take on such a task. Second, there is no clear definition of the appropriate clients for such a service, nor of the treatment approach it might reasonably adopt. Third, we think that a new service, even if it were feasible, would serve to increase rather than diminish organisational boundaries.

11.24 It therefore seems clear that the needs of serious offenders with personality disorders, and those of society, must be met by the efforts of existing agencies. We recognise that at present serious offenders with personality disorders are an issue for many agencies but may easily become the responsibility of none. There is also an understandable tendency to avoid responsibility for such offenders because of the criticism that is directed at staff if there is serious re-offending (see paragraph 2.17).

11.25 Given the lack of demonstrable benefit from any single treatment approach, we think there is scope to develop and improve the task of long-term management of these offenders in the context of a risk management strategy. We think professional staff of all disciplines would feel more confident, and less vulnerable to public criticism, if the supervision and surveillance of these offenders, in institutions and in the community, was determined by an approach based on sound risk management. We have described in Section One the elements of modern risk assessment based on methods of structured clinical judgement. We would like to see a similar approach govern the management of personality disordered offenders whether in custody or in the community. Risk management is a multi-professional task and we expect that the Risk Management Authority would be a crucial source of guidance on the type and quality of management to be applied.

RECOMMENDATION 49

Services for serious offenders with a personality disorder should focus on long-term risk management according to standards promulgated by the Risk Management Authority.

11.26 In respect of treatment interventions we think these will be necessary particularly to deal with co-morbid conditions, such as alcohol or substance misuse. They will also be required to assist the offender to make necessary adjustments in his/her social functioning and behaviour. Although we are unable to recommend the wholesale introduction of a new treatment approach, we strongly support properly planned pilot developments that can be evaluated for their benefits. Since the numbers in any pilot services in Scotland are likely to be small, we also support arrangements to share experience with those elsewhere in the UK and beyond.

11.27 We do not consider that we are in a position to recommend specific types of pilot services. We anticipate that these are likely to be based on currently accepted psychotherapies, including cognitive and psychodynamic models, and therapeutic community approaches. Of equal importance as an agreed treatment philosophy is the need for any service to be co-ordinated between relevant agencies, including those in the community. We hope that the Risk Management Authority could play a useful role in gathering and disseminating evidence of useful treatment approaches, and in supporting trials of new methods. We also anticipate that much can be gained by sharing experience with England and Wales. Although our remit is distinct from the work of the Home Office in relation to 'dangerous severely personality disordered' individuals, and our recommendations differ from their approach, it would appear that there are likely to be new service developments in England and Wales from which Scotland can learn.

RECOMMENDATION 50

Pilot services should be developed, with the support of the Risk Management Authority, in relation to the long-term management and, where appropriate, treatment of personality disordered offenders. These should be co-ordinated between relevant agencies, draw on the experience of similar pilot projects elsewhere, and should be subject to rigorous evaluation over a period of years.

Chapter 12 HIGH RISK OFFENDERS WITH PERSONALITY DISORDER

12.1 Our Committee began its work after the decision by the House of Lords in Reid v Secretary of State for Scotland[29] and in the wake of public concern about a number of cases in which the detention of serious offenders designated as 'personality disordered' was an issue. Some months after we began our work the sheriff's decision in Ruddle v Secretary of State for Scotland[30] was delivered. This was followed by the Scottish Parliament's enactment of emergency legislation in the form of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.

Mental Health (Public Safety and Appeals) (Scotland) Act 1999

12.2 When the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 was debated in the Scottish Parliament, Scottish Ministers stated their intention to review the legislation in light of our recommendations and those of the Millan Committee. We have therefore given particular consideration to restricted patients now at the State Hospital who might reasonably be regarded as high risk offenders with a mental disorder.

12.3 We recognise that there may be some patients (no specific number or details have been established) at the State Hospital who, as a result of the 1999 Act, remain detained even though the mental disorder from which they suffer may not be one that is appropriate for treatment in a hospital. Their situation, as a consequence of the 1999 Act, is that they are detained on the basis of the need to protect the public from serious harm. After lengthy consideration, we do not feel there is any recommendation we can reasonably make that would alter the existing situation for these patients. The compulsory transfer of this group of patients to prison is not permissible by law nor would it be proper on civil rights grounds; we discuss this further below. Some, if not all, of the patients to whom we refer may have a personality disorder. Our Committee hopes that effective treatments will develop for such patients but we cannot make any recommendation in this regard.

12.4 We recognise that the key factor preventing the transfer of these patients to less secure facilities within health services, or their conditional discharge to the community, is the perceived level of risk they present for management in less secure settings. While we are unable to make recommendation with regard to the situation of these patients, we note that the assessment of risk and its management are the crucial factors in determining their continued detention and in assessing their suitability for transfer to less secure facilities. It is therefore essential that the assessment of that risk is carried out to the highest standards.

RECOMMENDATION 51

For patients whose continued detention at the State Hospital arises solely from the need to protect the public from serious harm, the procedures for assessing the risk they present should be consistent with those recommended elsewhere in this report for the assessment and management of risk.

[29] Reid v Secretary of State for Scotland 1999 SC(HL) 17
[30] Ruddle v Secretary of State for Scotland, Lanark Sheriff Court, August 1999, unreported

Detainees with personality disorder: alternative approaches

12.5 We considered suggestions put to us, and examples from other jurisdictions, of alternative approaches to the problems presented by detainees with personality disorders deemed untreatable (or no longer requiring treatment) yet who are considered to present a serious risk to public safety. The issue was at the heart of the cases of Reid and Ruddle (cited above). Somewhat similar issues arise in relation to the release from prison of prisoners at the expiry of their sentence, who are, commonly described as having personality disorders, and who are considered to present a serious risk to public safety.

12.6 In relation to State Hospital patients it was suggested to us by some agencies that the provisions of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 be replaced by a procedure that would enable patients who had originally received a hospital order, later found to be inappropriate, to be returned to court in order that a prison sentence may be imposed. The perceived advantage of this approach is that it would remove the element of non-judicial preventive detention that some critics have argued is contained within the 'public safety' test introduced by the 1999 Act.

12.7 We are unable to support this proposal. The retrospective imposition of a prison sentence appears to us to present formidable human rights objections, especially where the offender has already spent what may be a substantial period in hospital. Furthermore, it would be highly undesirable if all those mentally disordered offenders who, quite appropriately, receive a hospital order were to face the prospect of re-sentencing should their mental disorder no longer require hospital treatment. We do not think we can make any legislative recommendation that would alter the situation for any current patients detained at the State Hospital solely on public safety grounds by virtue of the 1999 Act. Our recommendations in Section 2 are framed, in part, to prevent this insoluble conflict between public protection and inappropriate hospitalisation arising in the future.

12.8 On the matter of the release of prisoners who remain a risk to public safety, our Committee considered some major legislative developments in North America and elsewhere. These are the introduction of a new form of detention applied at some stage - in practice many years - after sentence has been passed. In essence this is civil detention imposed prior to the end of sentence on the grounds of a mental condition. Presence of an identifiable mental condition is crucial in order to satisfy requirements for civil detention in North America, as it would be in the UK were it to be introduced. To be compatible with Article 5.1(e) of the European Convention on Human Rights, detention is only permitted where the detainee is of 'unsound mind'. In other words, a mental condition is identified in order to legitimise civil detention beyond the date when the original sentence of the court would terminate. In our view, and that of many others in the field, detention is driven by the goal of public protection and not really by the expectation of treatment for a mental condition. The latter however is presented as the means of achieving the former.

12.9 This is the approach that has been adopted by several states in the US, in their 'sexually violent predator' or 'sexually violent person' legislation and representatives of our Committee visited such States. A detailed account of the basis of this legislation can be found in the literature review commissioned by us

(See Annex 3). In essence, the legislation empowers the State to seek to commit an individual to indefinite detention (with the possibility of supervised release), at the expiry of a determinate prison sentence. This detention is on the basis of the presence of mental disorder and risk to the public. Detention must be in a health facility and treatment must be offered. The detainee, now a 'patient', acquires all the legal rights of a detained mental patient; these are significantly more liberal than those of prisoners - a factor that was causing significant problems for management in one facility visited by our Committee

12.10 Despite these requirements, our clear impression was that this legislation amounted to preventive detention under the guise of mental health treatment. The mental condition that formed the basis of the detention included (indeed almost always consisted of) personality disorder, often in association with a disorder of sexual preference. The assessment of risk is usually based on actuarial methods that rely heavily on evidence of past offences. One psychologist confirmed that it was effectively possible to establish both mental disorder and high risk purely on the basis of the individual having committed certain types of offence, particularly those of a paedophilic type.

12.11 Were such a system to be introduced in Scotland, it would be necessary either to send such individuals to existing mental health services, such as the State Hospital, or to develop completely new specialised services. It was clear from the services we visited that placement of this highly dangerous group alongside individuals with conventional mental illnesses was unsafe. In the States we visited, new specialist services had been hastily developed and more were under development. These had usually been improvised in response to hastily passed legislation, following an individual and often high profile case.

12.12 The essence of this legislation was, in our view, an attempt to 'put right' mistakes made during the original sentencing process, when sentences were passed which did not properly reflect the risk posed by the offenders. We saw no evidence that the decision to designate someone as a 'sexually violent predator' was based on information that could not have been considered at the time of the original sentencing.

12.13 Our Committee also visited The Netherlands (see Annex 4). The Dutch TBS system provides for a period of detention in special clinics for those offenders deemed to be of 'partial responsibility'. After serving a period of imprisonment sufficient to reflect the 'punishment' part of the sentence, the prisoner is transferred to a special mental health facility for treatment. This differs from the US system in that the disposal is imposed at the time of the original sentence. Although the disposal is potentially indefinite, and includes treatment, it is separate from the conventional mental health system.

12.14 Our Committee believes that the Dutch system, which is long-established, and based on different psychiatric and legal traditions from those of the UK, has a number of positive features . Nevertheless, the model of disposal is not one that we would recommend. Where treatment is felt to be appropriate, it seems to us wrong that the offender should spend a number of years in prison before such treatment is started. As with other specialist services for personality disorder, the evidence of treatment benefit remains equivocal. It could not be adopted in Scotland without a wholesale revision of the criminal law with regard to the pivotal

issue of responsibility. This option does not seem feasible for use in Scotland, and does not seem to offer any significant advantages, as a sentencing disposal, over our proposals for sentencing high risk offenders described in Section Two.

High risk offenders with personality disorder: sentencing

12.15 We have sought throughout this report to emphasise that protection of the public through the sentencing of serious violent or sexual offenders should be driven by the careful and considered assessment and management of risk. We regard this as more logical and more likely to be effective than seeking to identify any particular form of personality disorder. Our specific recommendations for sentencing high risk serious violent or sexual offenders are set out in Section Two of this report. We have made, also in Section Two, separate recommendations for offenders in this category who have a mental disorder (see Chapter 7).

12.16 We have considered whether we should make recommendations in those cases where the mental disorder is in clinical terms a personality disorder and in legal terms a persistent disorder manifested only by abnormally aggressive or seriously irresponsible conduct.

12.17 The current situation is that where a personality disorder satisfies the legal criteria for detention and the 'treatability' test[31] , the reporting psychiatrist has the option of recommending a mental health disposal. This recommendation can be accepted or rejected by the sentencer. Thus it is currently possible for the court to make a hospital order, restriction order or hospital direction if all the necessary criteria are satisfied. These matters are all discretionary. Under our proposals, however, we suggest new mandatory arrangements for the post-conviction assessment and disposal of those high risk offenders who have a mental disorder, namely an interim hospital order followed by an OLR and hospital direction (see para 7.14). Should any specific and mandatory arrangement beyond this be included if the mental disorder is a personality disorder? We do not think it should, for the following reasons.

12.18 First, the general principle of mandatory measures on the basis of a specific category of mental disorder runs counter to our general approach to the problem. We have consistently emphasised that the degree of risk, and not any particular type of mental condition, should be the crucial determinant in sentencing. Second, we have doubts that the assessment of personality disorder is a task that can be accomplished with sufficient robustness to form the basis for a sentencing decision. Third, there is the matter of clinical judgement of individual cases in an area that contains so much variability. The human condition, and individual circumstances, are so diverse that it does not seem right to us that the diagnosis of a personality disorder (with all the variability of that condition) should require one particular sentencing path - and no other - to be followed. Some high risk offenders with personality disorder may appropriately receive the OLR; for others the OLR combined with a hospital direction would be proper. We do not think a statutory requirement for the same disposal in every case is either feasible or advisable. Finally, this is an area in which diagnostic and therapeutic developments are anticipated and it would therefore be imprudent to tie the hands of sentencers and psychiatrists at this stage.

[31] Section 17(1)(a) and 17(1)(a)(i) of the Mental Health (Scotland) Act 1984

RECOMMENDATION 52

The sentencing options for a high risk offender who suffers from a personality disorder should be either an OLR (recommendation 24) or such an order combined with a hospital direction (recommendation 27) according to the individual circumstances of the case.

LIST OF RECOMMENDATIONS

Chapter 1: Definitions and Context

1. Special sentencing considerations are necessary for persons convicted on indictment of a violent or sexual offence, or exceptionally another category of crime, whose offence(s) or antecedents or personal characteristics indicate that they are likely to present particularly high risks to the safety of the public. We refer to them henceforward, in the context of this report, as 'high risk offenders'.

Chapter 2: Risk

2. Systems of risk assessment should be based on the best available research. Current evidence suggests that the structured clinical approach to risk assessment should be seen as the most helpful approach in relation to risk assessment for forensic purposes, and this should be reflected in guidance and training.

3. There is a need for research on risk assessment issues relating to serious violent and sexual offenders, and in particular research on:

   - the numbers of such offenders who may present a continuing risk to public safety;
   - the application of risk assessment instruments and techniques in a Scottish context; and
   - recidivism, including factors which may predict recidivism.

   The Committee recommend that national grant-giving bodies are encouraged to include such aims in their research agendas.

4. All agencies operating in the criminal justice system should ensure that professionals who evaluate risk, or make decisions based on risk, are appropriately trained.

Chapter 3: A Risk Management Authority

5. A new authority, to be called the Risk Management Authority, should be created with a view to securing the protection of the public from seriously violent and sexual offenders while restricting their freedoms no more than is necessary in the public interest.

6. The Risk Management Authority should:

   - be headed by a board that reports to Ministers;
   - produce strategic and annual management plans;
   - have an operating budget for the purposes of securing the continuing development of services to high risk offenders, and for commissioning specific services that are required for the management of individual offenders;
   - produce an annual report on its work to Parliament.

7. The Risk Management Authority's policy work should fall into three main areas:

   - monitoring international research and practice in risk management and commissioning Scottish developments;

- disseminating best practice and developing guidelines and protocols;
- reviewing current practice and making proposals to Government for change.

8. The Authority's standard setting work should fall into three main areas:
   - accrediting risk assessment systems;
   - accrediting risk management processes;
   - the training and competence assessment of practitioners.

9. The operational role of the Risk Management Authority is to manage the risks presented by serious violent and sexual offenders, by agreeing a risk management plan for each and by commissioning appropriate risk management services from the agencies it considers give best value for money in protecting the public.

Chapter 4: Sentencing Options

10. Section 1 of the Crime and Punishment (Scotland) Act 1997 should be repealed.

11. The maximum competent extension period of an extended sentence should be ten years in the case of both a sexual offence and a violent offence prosecuted at common law.

Chapter 5: The New Sentence

12. Legislative provision should he made for a new sentence called 'An Order for Lifelong Restriction (OLR)' for the lifetime control of serious violent and sexual offenders who present a high and continuing risk to the public.

13. In all cases of a violent or sexual nature (including, where appropriate, breach of the peace) prosecuted on indictment, the judge should prepare promptly a report setting out the circumstances of the offence as narrated in court, which report should be preserved with the case papers for later use if required.

14. The Crown Office should develop a system of recording information about offences committed which would be relevant in future decision making on the question of ordering risk assessment in serious violent and sexual cases.

15. The sentencing of serious violent and sexual offenders should be informed by a formalised, multi-disciplinary risk assessment based on the circumstances of the current case and much fuller information regarding the antecedents of the offender and the nature of any previous offences, including unproven allegations of criminality.

Chapter 6: Procedures for Imposing the New Sentence

16. The option of imposing an OLR should be available only in the High Court. The Court should have the power to impose an OLR where the offender has been convicted on indictment of (a) an offence of violence, (b) a sexual offence, or (c) any other offence which is closely related to, or reflects an offender's propensity for violent, sexual or life-endangering offending.

17. An OLR would be available only in cases where the High Court was satisfied that there are reasonable grounds for believing that the offender presents a substantial and continuing risk to the safety of the public such as requires his lifelong restriction. If the Court is so satisfied, it must make the Order.

18. Before an OLR can be imposed a formal risk assessment must be carried out in accordance with statutory procedures.

19. The Court shall make an order for a risk assessment where there are reasonable grounds for believing that the offender may present a substantial and continuing risk to the public.

20. A risk assessment should normally be ordered following a Crown motion intimated to the accused prior to the close of the Crown case. Such a motion could be opposed and would be determined after conviction. The decision of the Court thereon would be final. Exceptionally, a risk assessment could be ordered by the Court of its own volition, but only after hearing submissions from both sides.

21. A Risk Assessment Order would be authority for the detention of the accused for up to 90 days, or up to 180 days on cause shown, at a centre accredited by the Risk Management Authority for the purpose of a multi-disciplinary risk assessment.

22. The risk assessment and its component parts should be lodged with the Clerk of Justiciary. The accused will have the right to challenge it by obtaining a contrary assessment. Procedural provision will be required for the mutual disclosure of reports and the names of potential witnesses, and the conduct of the sentencing hearing.

23. It will be for the Crown to establish, on a balance of probability, that the statutory criteria for the imposition of an OLR are met.

24. If the High Court was satisfied that the statutory criteria were met, it would impose on the offender an OLR, setting at the same time a designated period of time which the offender would serve in custody to reflect the concerns of punishment and deterrence

25. If the High Court was not satisfied that the statutory criteria for the imposition of an Order for Lifelong Restriction were met, it would be able to adopt any other competent disposal other than to pass a discretionary life sentence.

26. The accused should have a right of appeal against the making of an OLR on the ground that to adopt this disposal was excessive; and the Crown should have a right of appeal against a refusal to make such an order, on the ground that the refusal was inappropriate because the statutory test was in fact met.

Chapter 7: High Risk Offenders with a Mental Disorder

27. A high risk offender who also suffers from a mental disorder that meets the criteria for compulsory detention in hospital should receive an OLR together with a hospital direction. This should be the only sentence permitted in respect of such offenders

28. The provisions of Section 1 of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 should not apply to offenders subject to an OLR together with a hospital direction.

29. An interim hospital order should be imposed in all cases where the offender is one who would otherwise be assessed to determine whether he/she fits the statutory criteria for the imposition of an OLR, but where there is also evidence that he/she may be suffering from a mental disorder for which treatment is appropriate.

30. The time limit for renewal of the interim hospital order, where the assessment is for the purpose of determining whether the offender should ultimately be made the subject of an OLR coupled with a hospital direction, should be increased from 28 to 90 days.

31. Where a psychiatric report in respect of a person convicted of a serious violent or sexual offence recommends the imposition of a hospital order with restrictions, the psychiatrist shall be required to address in the report the question of why an interim hospital order is not appropriate.

32. Section 57 of the Criminal Procedure (Scotland) Act 1995 should be amended to enable an interim hospital order to be made for mentally disordered offenders who are found insane following proceedings taken on indictment and who may be a high risk to the public.

33. A hospital order with restrictions should be the mandatory disposal for a mentally disordered offender found insane following proceedings taken on indictment who, after assessment, is considered to be a high risk to the public.

34. A person detained in hospital under an OLR with a hospital direction should be entitled to apply to a Designated Life Tribunal for his/her release if, at the time the designated part of his/her sentence has been completed, he/she is still in hospital

35. Decision making in relation to the management and care of high risk offenders with a mental disorder should be informed by a multi-disciplinary risk assessment and risk management process in accordance with the standards that apply for sentencing and sentence management as outlined in Chapters 6 and 8.

36. We recommend that the standards of supervision and aftercare for high risk offenders with a mental disorder who are discharged from hospital, or released from prison, should be the same as those for other high risk offenders.

Chapter 8: The Operation of the New Sentence

37. Upon beginning an OLR, a risk management plan should be prepared, drawing on the pre-sentence assessment, and approved by the Risk Management Authority.

38. The supply of interventions to high risk offenders in prison, and decisions concerning security categorisation and placement, should be determined by the risk management plan.

39. Review of the sentence, and any decision to release the offender from, or to recall the offender to prison, should be the responsibility of the Parole Board, operating through a Designated Life Tribunal (DLT).

40. The risk assessment and management plan should be reviewed formally on a regular basis under the supervision of the Risk Management Authority. Procedures for consideration of release by the DLT should operate in the same way as current arrangements for discretionary life prisoners, but any decision as to release should be informed by the risk assessment and risk management plan.

41. The Parole Board operating through a DLT would have similar powers to those it has in relation to discretionary life prisoners, including the power to set and vary licence conditions. In addition, it would have the power to order release from prison, at a specified future date, and with a requirement that provision be made for supervision and risk management in the community.

42. Legal Aid should be available to a prisoner appearing before a DLT.

Chapter 9: Supervision of High Risk Offenders

43. National standards for the supervision of high risk offenders should be developed by the Scottish Executive, in consultation with the Risk Management Authority

44. Each of the proposed local authority groupings should have access to a specialist services for high risk offenders which can supplement and support the work of individual supervising social workers.

45. Community services for high risk offenders should develop techniques for intensive supervision and surveillance. Components of this service would include:
    - use of electronic monitoring technology;
    - regular unannounced and announced visiting;
    - regular drug and alcohol testing;
    - strict conditions, including as to place of residence, and participation in treatment;
    - a 'halfway house' offering semi-secure facilities and intensive treatment, (comparable to the 'less restrictive alternative' operated by the Arizona Community Protection and Treatment Centre); and
    - rapid and predictable return to conditions of greater security in the event of non-compliance.

46. The Scottish Executive should ensure that there is an appropriate range of accommodation, including hostels and other forms of supported accommodation, which can facilitate the discharge of high risk offenders from custody and ensure their appropriate supervision in the community.

Chapter 10: Personality Disorder

47. The Scottish Executive should consider measures that might be taken to include the prevention of personality disorder within its broader strategies, including those on education, social inclusion, public health and substance misuse.

Chapter 11: Services for Offenders with Personality Disorder

48. The Scottish Executive should consider whether or not the condition of personality disorder generally should be referred to SIGN with a view to the development of national clinical guidelines.

49. Services for serious offenders with a personality disorder should focus on long-term risk management according to standards promulgated by the Risk Management Authority.

50. Pilot services should be developed, with the support of the Risk Management Authority, in relation to the long-term management and, where appropriate, treatment of personality disordered offenders. These should be co-ordinated between relevant agencies, draw on the experience of similar pilot projects elsewhere, and should be subject to rigorous evaluation over a period of years.

Chapter 12: High Risk Offenders with Personality Disorder

51. For patients whose continued detention at the State Hospital arises solely from the need to protect the public from serious harm, the procedures for assessing the risk they present should be consistent with those recommended elsewhere in this report for the assessment and management of risk.

52. The sentencing options for a high risk offender who suffers from a personality disorder should be either an OLR simpliciter (recommendation 24) or such an order combined with a hospital direction (recommendation 27) according to the individual circumstances of the case.

ANNEX 1

MEMBERSHIP OF THE COMMITTEE

CHAIRMAN

The Hon Lord MacLean, Senator of the College of Justice

COMMITTEE MEMBERS

Mr Andrew Brown, Chief Constable, Grampian

Mr David Burns QC

Dr Derek Chiswick, Consultant Forensic Psychiatrist, Lothian Primary Care NHS Trust

Professor David Cooke, Professor of Forensic Psychology, Glasgow Caledonian University, Douglas Inch Centre

Mr David Crawford, Head of Operations, Renfrewshire Council Social Work Department

Ms Jeane Freeman, Vice Chair, Parole Board, Director APEX

Professor Christopher Gane, Professor of Scots Law, Aberdeen University

Mr William Gilchrist, Regional Procurator Fiscal, North Strathclyde

Mr Roger Houchin, Governor, HM Prison, Barlinnie

Mr Murray Macara, Solicitor Advocate, Beltrami & Co

Mr Jamie Malcolm, Nursing Officer for the Mental Welfare Commission for Scotland

Sheriff Charles Stoddart, Sheriff of Lothian and Borders of Edinburgh and Director of Judicial Studies

Dr Linda Treliving, Consultant Psychotherapist, Roseangle Day Hospital, Tayside Primary Care NHS Trust

ANNEX 2

SENTENCING OF SERIOUS VIOLENT AND SEXUAL OFFENDERS

Frazer McCallum Research Consultant

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- Long determinate sentences

Summary

1. Chapter 1 presents the background to the research and an outline of the research methodology. The research was commissioned to look at the sentencing of serious violent and sexual offenders, with the aim of determining how offenders who are given discretionary life sentences differ from those who receive lengthy determinate sentences for similar offences. The main element of the research involved the examination of the prisoner files and court papers relating to: (a) 19 offenders who received discretionary life sentences; and (b) 19 offenders who received long determinate sentences (10 or more years).

2. Chapter 2 is mainly concerned with reasons for imposing a discretionary life sentence and, in particular, the importance attached to the question of whether there is a serious risk that an offender will commit a similar crime in the future. The significance of the length of the designated part in a discretionary life sentence is also discussed.

3. Chapter 3 looks at the reasons for imposing a long determinate sentence. This includes consideration of the reasons for imposing a long custodial sentence and the reasons for not imposing an indeterminate sentence. Again, much of the chapter focuses on the question of whether there is a serious risk that an offender will commit a similar crime in the future.

4. Chapter 4 draws together some of the main differences between the sample of offenders who received discretionary life sentences and the sample who received long determinate sentences.

Chapter 1: Introduction

Background

1.1 The MacLean Committee on Serious Violent and Sexual Offenders was established in March 1999. It was asked to make proposals for the sentencing, and future management and treatment, of serious violent and sexual offenders who may present a continuing danger to the public. The present research was commissioned by the Scottish Executive Justice Department to inform the MacLean Committee in its deliberations. The remit was to look at the sentencing of serious violent and sexual offenders with the aim of determining how offenders who are given discretionary life sentences differ from those who receive lengthy determinate sentences for similar offences.

Main legal provisions

1.2 A sentence of life imprisonment is the only available sentence for adult offenders convicted of murder. However, in relation to certain other offences a judge dealing with a case at the High Court of Justiciary has the power, but is not obliged, to impose a life sentence. A life sentence imposed in such circumstances is, in this report, referred to as a 'discretionary life sentence'. (This report is not concerned with mandatory life sentences.)

1.3 The Prisoners and Criminal Proceedings (Scotland) Act 1993 (the '1993 Act') placed an obligation on trial judges, when imposing discretionary life sentences, either to stipulate the period that the prisoner must serve in the interests of punishment (the 'designated part') or to state reasons for not stipulating such a period. The Appeal Court in the case of ***O'Neill v. H.M. Advocate***[1] pointed out that a prisoner has the right to have his/her case considered by the Parole Board once this punitive period expires, and that it is for the Parole Board, having regard to any danger which the prisoner may continue to pose to the public, to determine the actual date of release.

1.4 The 1993 Act also changed the rules governing the early release of determinate sentence prisoners so that all prisoners serving sentences of four years or more became eligible for parole at half sentence.

Research design

1.5 The main elements of the research design were determined by the Criminological Research Branch of the Scottish Executive Justice Department. It was decided that it should take the form of a comparative study of all (adult) discretionary life sentence prisoners sentenced between 1994 and 1998 and a similar number of determinate sentence prisoners convicted of serious violent and sexual offences who received sentences of 10 years or more during the same period. The starting point of 1994 was chosen to ensure that all of the prisoners were sentenced under the regime set up by the 1993 Act.

1.6 The Criminological Research Branch identified all discretionary life sentence prisoners sentenced during this period (a total of 19 offenders)[2], together with a further 19 offenders sentenced, during the same period, to determinate sentences

[1] 1999 SCCR300

[2] In fact, it was subsequently discovered that two of the discretionary life sentence prisoners were sentenced in January of 1999. It is possible that the computer records, used by the Criminological Research Branch to identify relevant discretionary life sentence prisoners, gave the impression that they were sentenced in 1998 since both sentences were back-dated to 1998. Whatever the reason, the cases of both offenders were included in the analysis of the discretionary

of at least 10 years. The second group of offenders represented only a partial sample of all offenders receiving such a sentence during that period, and was weighted in favour of offenders sentenced for serious sexual offences so as to reflect the fact that a high proportion of the 19 discretionary life sentence prisoners were sentenced for such offences.

1.7 The main task during the research was to examine any information, which might be relevant to the sentencing of the two samples of offenders, which was contained in the relevant prisoner files (held by the Scottish Executive Justice Department and the Scottish Prison Service (SPS)) or court papers (held by the High Court of Justiciary). It was not possible (during the time available) to trace the court papers for five of the offenders who received determinate sentences, but the court papers were examined in relation to the remaining offenders and prisoner files were examined in relation to all of the offenders. There was an element of duplication in the two sets of files and it was not felt that the inability to trace some of the court papers detracted significantly from the quality of information available for consideration.

1.8 The judge sentencing an offender should, both in relation to discretionary life sentences and long determinate sentences, prepare a report setting out the factors which led to the selection of the particular sentence. This report (the 'trial judge report') is generally prepared shortly after the offender is sentenced and is intended to inform the deliberations of the Parole Board when they come to consider the case. These reports formed a vital element of the research since it was decided that the consideration of reasons for imposing a particular sentence should focus on those factors which the various judges themselves put forward as being important. The relevant trial judge report was examined in relation to each of the 38 offenders.

1.9 Information was also gathered from any other relevant papers contained in the prisoner files and court papers (e.g. schedules of previous convictions, psychiatric reports and social enquiry reports). This allowed some of the information outlined in trial judge reports to be checked against the original source (e.g. where the trial judge stated that certain factors set out in a psychiatric report were important in determining sentence). It also enabled the research to investigate whether or not there were any factors which might have been thought relevant to sentencing but which were not highlighted by the trial judges.

Chapter 2: Discretionary life sentences

Offender sample

2.1 The 19 offenders receiving discretionary life sentences (all offenders receiving such sentences during the relevant period - see paragraphs 1.5 to 1.6 above) were all male. Fourteen of the offenders were sentenced for offences of a sexual nature, the other five being sentenced for serious violent offences (not involving a sexual element).

Reasons for imposing a discretionary life sentence

2.2 The following information, on reasons for imposing a sentence of life imprisonment, was taken from the reasons advanced by the trial judges themselves in the relevant trial judge reports (i.e. those prepared in relation to the 19 offenders receiving a discretionary life sentence). The trial judge should have considered both whether or not a life sentence was required and, if so, the appropriate length for the designated part. It is only those reasons which were advanced as justification for imposing a life sentence which are considered at this point.

Nature of the offence

2.3 The nature of the offence was highlighted in most cases. This included consideration of the nature of the act(s) committed by the offender and of the impact on the victim(s). It was apparent that the nature of the offence was considered relevant in more than one way. The serious nature of the offence was sometimes discussed in punitive terms (i.e. relating to the need for severe punishment). However, the nature of the offence was also highlighted as an indicator that the offender was likely to re-offend in a similar way in the future. Both approaches were used in a number of cases (sometimes both in the same case) although it was not always easy to determine the exact significance which the trial judge had placed on the nature of the offence.

2.4 The connection between the nature or seriousness of an offence and the question of punishment is probably clear enough. The connection between the nature of the offence and the risk of re-offending requires further clarification. The trial judge reports suggest at least two ways in which judges considered that it could be relevant to an assessment of the risk of re-offending. First, where an offenders was convicted of a series of analogous crimes (on the same indictment) spanning a number of years, the fact that he had continued to offend in the same way for a prolonged period was sometimes seen as evidence that there was an established pattern of offending which would be difficult to break. This tended to be highlighted in relation to offenders convicted of sexual offences. Second, an offender whose crime(s) appeared to be indiscriminate was sometimes thought to be at greater risk of re-offending. The latter point was illustrated where a trial judge stated:

> *'This was plainly a motiveless, random, mindless stabbing. That alone indicated the accused presented a significant threat to the public in general'*

Previous convictions

2.5 Analogous previous convictions were highlighted by the trial judge in relation to nearly all of the offenders receiving discretionary life sentences. Such convictions were generally referred to in terms suggesting that they were seen as an indicator that the offender was more likely to re-offend in a similar way in the future. This fear was likely to be heightened if previous long determinate custodial sentences for similar crimes had not stopped him re-offending, particularly if he had re-offended shortly after release from a custodial sentence.

2.6 Previous convictions (particularly if they relate to analogous matters) may also be seen as relevant to the question of punishment. This is, for instance, apparent in the legislation relating to the determination of the appropriate length for the designated part in a discretionary life sentence (see paragraph 2.20 below). However, although the precise significance attached to previous convictions was not always wholly clear, they were generally referred to as an indicator of the risk of re-offending when the judge was giving reasons for imposing a life sentence.

Assessment of other professionals

2.7 Trial judges also referred to the views of other professionals in most cases where an offender was sentenced to life imprisonment. Psychiatric reports (normally prepared with a view to sentencing) were by far the most commonly referred to source, although the opinions of clinical psychologists and social workers were also considered.

2.8 Although psychiatric reports generally dealt with the question of whether the offender was (either at the time of the offence or at the time of the trial) suffering from a mental disorder amounting to legal insanity, the main focus of these psychiatric reports was an assessment of the reasons contributing towards the offending and the risk of re-offending. This was found to be the case when looking at both the psychiatric reports themselves and the discussion of those reports contained in the trial judge reports. (Most of the following points made in relation to psychiatric reports are also applicable to reports from clinical psychologists and social workers.)

2.9 The main factors which were discussed in relation to the risk of re-offending were: (a) any connection between alcohol abuse and offending; and (b) sexually aggressive or deviant attitudes and behaviour. Thus, the fact that an offender was an alcoholic coupled with the fact that his offending behaviour (generally involving crimes of violence) was associated with his being intoxicated was sometimes characterised as a factor suggesting that he might be more likely to re-offend in the future. Equally, an assessment that sexual offences were connected with well established sexually deviant attitudes was often seen as an indicator that an offender might re-offend in a similar way in the future. A serious risk of re-offending was generally said to exist where it was thought that the offender either could not, or would not, successfully tackle the problem (i.e. alcohol abuse or sexually aggressive attitudes or behaviour) within the foreseeable future. Psychiatric reports generally dealt with the possibility of change by considering factors such as the response of an offender to previous treatment or the willingness of an offender to recognise and deal with the problem. Psychiatric opinions on this point were normally (but not always) accepted in the trial judge reports.

2.10 It may be noted that consideration of the nature of the offence and, in particular, the existence of previous analogous convictions, frequently formed part of the assessment of the risk of re-offending contained in psychiatric reports. Thus, there was often some overlapping between the independent reasoning of a trial judge in relation to these factors and the assessment of a psychiatrist. However, the psychiatric assessment would (of course) take into account other factors (e.g. the views expressed by the offender during interview).

Mental illness

2.11 Only one of 19 offenders sentenced to life imprisonment was said to suffer from a treatable mental illness (only amounting to diminished responsibility at the time of the offence). The judge formed the view (mainly on the basis of psychiatric reports) that the offender presented a serious risk of re-offending when his illness was not being controlled by medication. The judge went on to state that a hospital order was not appropriate given that the offender's illness was being successfully controlled by medication. He was not, however, willing to rely on community-based medical support for the offender, given the risk he considered the offender would present should his mental health again deteriorate. He stated that a supervised release order would be inappropriate (too restricted in its application according to the judge's stated opinion) and that an indeterminate sentence was required to deal with the risk posed by the offender and to ensure the proper supervision of his medical needs.

Interests of the offender

2.12 The view that an indeterminate sentence would be in the best interests of the offender himself was advanced in relation to a few of the 19 offenders receiving a discretionary life sentence. There was generally little explanation of why this might be the case although there was some indication that a life sentence was sometimes seen as the best way of ensuring that the offender received long-term treatment and/or support.

The risk of re-offending

2.13 The decision to impose a life sentence was nearly always supported in the relevant trial judge report by more than one reason. However, it was clear that it was the risk of the offender committing a similar (and possibly more serious) offence in the future which was at the heart of the judges' decisions to impose discretionary life sentences (as opposed to long determinate sentences). The fact that a serious offence was committed was certainly a vital element in raising the possibility of imposing a life sentence (any lengthy sentence can only be justified if a serious crime has been committed and it is the risk of re-offending in a similar ***serious*** manner which is of concern), but it was this factor of risk which was emphasised when considering the choice between a long determinate sentence or a sentence of life imprisonment.

2.14 Trial judge reports generally contained little discussion of exactly why a life sentence was thought to be more appropriate than a long determinate sentence in relation to offenders who presented a high risk of re-offending. However, two factors were mentioned: (a) a life sentence meant that there was no fixed date on or before which the offender had to be released irrespective of assessments of the likelihood of him re-offending; and (b) a life sentence meant that, after release from custody,

he would remain on a life licence, and thus liable to recall for the rest of his life, should his future behaviour justify such action.

2.15 It was noted above that 14 out of the 19 offenders sentenced to life imprisonment had committed crimes of a sexual nature. The fact that there was such a high representation of offenders sentenced for sexual offences probably reflected a view that such offenders are, due to the nature of sexual offending, more likely to re-offend in a similar manner in the future than is the case for offenders convicted of other crimes.

2.16 In relation to the offenders sentenced for serious crimes of violence (not involving a sexual element), it was notable that, in relation to four of those offenders, a link between offending behaviour and chronic alcohol abuse was a factor in the assessment that there was a serious risk of re-offending. Mental health problems were a factor in this assessment of risk for the remaining offender sentenced for serious crimes of violence.

Influence of the judge

2.17 Although it seems reasonable to suppose that different trial judges will have different views on exactly when a discretionary life sentence should be imposed, the information available to this research did not disclose significant differences in the approach to the question of whether a life sentence should be imposed. Concerns about the risk of re-offending appeared to be central to the reasoning of all of the trial judges. This does not, of course, mean that different judges could not reach different conclusions (the sometimes complex process of determining the level of risk and then balancing that risk against other relevant factors may certainly result in different judgements), but the general approach appeared to be similar.

2.18 It was discovered that one judge had sentenced three of the offenders receiving a discretionary life sentence and that another had sentenced two of them. It is not, however, possible to comment on whether these facts say anything about the likelihood of the judges concerned imposing a discretionary life sentence since information on the numbers and types of cases dealt with by those judges (as compared with the 'average workload' of a High Court judge - if there is such a thing) was not available.

Appeals against the imposition of a life sentence

2.19 Five of the offenders sentenced to life imprisonment appealed against the imposition of a life sentence[3]. The sample was originally selected (by the Criminological Research Branch of the Scottish Executive Justice Department) so as to exclude any offenders who had successfully appealed against a life sentence and thus all of the appeals, at least in so far as they concerned the life element of the sentence, were unsuccessful. However, it is worth noting that the Appeal Court gave clear support for the view that a discretionary life sentence was justified where there was an assessment that an indeterminate sentence was required to protect the general public (or particular groups of people such as women or children) from similar offending behaviour in the future. Thus, the Appeal Court decisions supported the view that the assessment that an offender presents a serious risk of re-offending in the future is central to the decision to impose a life sentence.

[3] In one of these cases it was not wholly clear (from available information) whether or not his appeal was restricted to the length of the designated part.

The designated part

2.20 It was noted in Chapter 1 (at paragraph 1.3) that the 1993 Act placed an obligation on trial judges, when imposing discretionary life sentences, either to stipulate the period that the prisoner must serve in the interests of punishment (the 'designated part') or to state reasons for not stipulating such a period. The significance of the designated part is that a prisoner has the right to have his/her case considered by the Parole Board once this punitive period expires. In relation to the length of the designated part, Section 2(2) of the 1993 Act states that it should be:

'such part as the court considers appropriate taking into account -
(a) the seriousness of the offence, or of the offence combined with other offences associated with it;
(b) any previous convictions of the designated life prisoner.'

2.21 Given the above, one might, by looking at the length of the designated part, hope to gain some further insight into how a trial judge sentencing an offender to life imprisonment viewed the seriousness of the factors set out in Section 2(2). A wide range in the lengths of the designated part set for each of the 19 life sentence offenders might support the view that factors, other than those set out in Section 2(2), can be more important in relation to the decision to impose a discretionary life sentence. This view might receive further support if it was also found that the length of the designated part was sometimes significantly shorter than the length of long determinate sentences.

2.22 Unfortunately, comparisons between the length of the designated part imposed in relation to one offender with either: (a) the length of the designated part imposed in relation to another offender; or (b) the length of a determinate sentence imposed in relation to another offender, are not as straightforward as one may have anticipated. This is due to the fact that a number of the offenders in the sample successfully appealed against the length of the designated part. The relevant Appeal Court judgements did help to clarify the factors which should be taken into account in determining the length of the designated part. In particular, the Appeal Court in ***O'Neill v. H.M. Advocate***[4] stated that the length of the designated part should bear a fair and reasonable relationship to the minimum period which an offender would actually have served in custody had a determinate sentence been imposed in similar circumstances. The Appeal Court pointed out that, under the terms of the 1993 Act, an offender serving a determinate sentence of four or more years may, on the recommendation of the Parole Board, be released on licence after serving one half of his sentence. This does suggest that it should be possible to compare the lengths of the designated part, in the discretionary life sentence sample, with one half of the lengths of the determinate sentences in the long determinate sentence sample. However, difficulties arise due to the fact that it was not possible to determine to what extent, if any, the length of the designated part for other offenders in the discretionary life sentence sample reflected a similar approach. Trial judge reports generally contained little explanation as to exactly how the length of the designated part had been determined.

2.23 Bearing in mind the need for caution when drawing comparisons, it is still worth noting that: (a) there was a wide variation in the lengths of the designated part set in relation to the 19 offenders receiving discretionary life sentences (between 3 and 15 years); and (b) there were some examples of offenders receiving a life sentence with a designated part which was less than one half of the length of some of the long determinate sentences.

[4] 1999 SCCR300

Chapter 3: Long determinate sentences

Offender sample

3.1 The 19 offenders receiving long determinate sentences (defined, for the purposes of this research, as prison sentences of 10 or more years - see paragraph 1.5 above) were all male. Ten of the offenders were sentenced for offences of a sexual nature, the other nine being sentenced for serious violent offences.

Reasons for imposing a long determinate sentence

3.2 The following information on reasons for imposing a long determinate sentence of imprisonment was taken from the reasons advanced by the trial judges themselves in the relevant trial judge reports (i.e. those prepared in relation to the 19 offenders receiving a long determinate sentence).

Decision to impose a long custodial sentence

3.3 The very serious nature of the offences involved was, not surprisingly, generally cited among the reasons for imposing a long custodial sentence. The other factor which was referred to in relation to most of the offenders was the existence of previous analogous convictions. These factors were more frequently discussed in terms relating to the appropriate level of punishment for what had happened (rather than as indicators of the likelihood of re-offending) than was the case in relation to the offenders who were given discretionary life sentences.

Decision not to impose a sentence of life imprisonment

3.4 Although a few of the trial judge reports, prepared in relation to offenders receiving long determinate sentences, did include some discussion (and rejection) of the possibility of imposing a life sentence, the majority did not. This does not necessarily mean that a discretionary life sentence was not considered. It does, however, make the task of identifying any reasons for not opting for a life sentence more difficult.

3.5 It is possible that some of the offenders who received long determinate sentences might have received discretionary life sentences if their crimes had been even more serious. However, it has already been suggested (e.g. see the points made in relation to the length of the designated part at paragraphs 2.21 to 2.23 above) that any distinction between the life sentence and determinate sentence samples does not appear to centre on the seriousness of the offences involved.

3.6 Different opinions on the likelihood of the offender committing similar crimes in the future would appear to be a more promising basis for distinguishing the samples. It was noted in Chapter 2 (at paragraph 2.13) that the assessment that there was a serious risk of an offender committing a similar offence in the future appeared to be central to judges' decisions to impose discretionary life sentences in preference to long determinate sentences. However, this does not mean that the risk of re-offending was always thought to be low where the decision was taken not to impose a life sentence. This point was clearly illustrated by the following statement from a trial judge dealing with an accused convicted of the indecent assault of a young child:

'It is plain, from a consideration of his record and the reports before me and his behaviour during the preparation of these reports, that he has an aggressive violent streak in him which, combined with his inability to distinguish right from wrong and his lack of regard for the law, makes him a public danger. He is clearly capable of being violent in the most incredibly depraved ways. The offence itself was an extremely serious one. As punishment for that alone he required to be imprisoned for a significant number of years. In addition, I had to consider the need to protect the public from him. I considered whether it was necessary to impose a sentence of life imprisonment to provide that protection, but decided that was not necessary.'

3.7 Nevertheless, concerns about the likelihood of the offenders, who received long determinate sentences, committing further similar offences in the future were not expressed with the same regularity as was found in the trial judge reports relating to the offenders who received life sentences. Most frequently (in relation to approximately one half of the offenders) the relevant trial judge report made little or no mention of the risk of re-offending where a determinate sentence was imposed. This does not, however, mean that there was no such risk. It has already been noted (at paragraph 3.3) that one of the factors which was referred to in relation to most of the offenders receiving long determinate sentences was that they did have previous analogous convictions. In fact, it would be very difficult to say that one of the sample of offenders (i.e. either those receiving life sentences or those receiving long determinate sentences) generally exhibited a worse record of previous convictions than that found in relation to the other. Given that fact, it seems fair to say that many of the offenders who were given long determinate sentences did, even where the issue was not highlighted in the relevant trial judge report, present some risk of re-offending in a similarly serious manner. It was not possible, in these cases, to determine whether the judge: (a) decided not to mention the risk of re-offending because the future risk (following a long determinate sentence) was considered to be reasonably low; or (b) considered that there was no need to address the issue because he had not imposed a life sentence.

3.8 Psychiatric reports, obtained to assist the trial judge in sentencing, were found with the papers relating to approximately one third of the sample of offenders receiving long determinate sentences. This is in contrast to the sample of offenders receiving a discretionary life sentence, where a psychiatric report (or similar) was found in most cases. However, both samples were similar in that the main focus of such reports was an assessment of the reasons contributing towards the offending and the risk of re-offending. It is possible that psychiatric reports were obtained less frequently in relation to offenders receiving determinate sentences precisely because they were less likely to be thought of as posing a serious future risk and thus an additional assessment of that risk was thought to be unnecessary. There was, however, no way in which this could be confirmed during the research. It was also impossible to say whether or not the existence of a psychiatric report might have altered any assessment of the risk of re-offending.

3.9 Although it was not always clear whether or not an offender receiving a long determinate sentence was considered likely to re-offend in a similar way in the future, there were some cases where the trial judge did express a view on this point. It has already been noted that some offenders receiving long determinate sentences were thought to present a serious risk of re-offending (see paragraph 3.6 above). Such an assessment was expressed in relation to approximately one third of the 19

offenders. However, unlike the sample of offenders receiving discretionary life sentences, there were also a few cases where the trial judge clearly stated that he did not believe that the offender posed such a risk. The most clear statement of this was in relation to an offender sentenced for the culpable homicide of his common law wife. The judge clearly formed the view that the offence had arisen from circumstances which were not likely to occur again and that the offender did not present a danger to the public. A long determinate sentence was, however, considered necessary in view of the serious nature of the offence.

3.10 The determinate sentence sample also included one case (involving an offender sentenced for various sexual offences) where the trial judge report suggested that the judge accepted views expressed in a psychiatric report to the effect that there was a reasonable chance that treatment and supervision could prevent future analogous offending. In contrast, it was notable that the psychiatric reports obtained in relation to the offenders who subsequently received discretionary life sentences tended to be less optimistic about the chances of treatment/support dealing with problems (e.g. alcohol abuse or sexually deviant attitudes) which were contributing towards the offending behaviour.

Chapter 4: Overview and conclusions

4.1 The research looked at the sentencing of serious violent and sexual offenders, with the aim of determining how offenders who are given discretionary life sentences differ from those who receive lengthy determinate sentences for similar offences.

Discretionary life sentences

4.2 The nature of the offence; the existence of analogous previous convictions; and the opinions of other professionals (primarily contained in psychiatric reports), were generally highlighted by trial judges when giving reasons for imposing life sentences.

4.3 The common factor, underlying the various reasons advanced by trial judges for imposing life sentences, was that they were primarily considered with a view to assessing the likelihood of the offender committing a similar crime in the future.

4.4 Of the 19 offenders sentenced to life imprisonment, 14 had committed crimes of a sexual nature. The fact that there was such a high representation of offenders sentenced for sexual offences probably reflected a view that such offenders are, due to the nature of sexual offending, more likely to re-offend in a similar manner in the future than is the case for offenders convicted of other crimes. In relation to the remaining five offenders, all sentenced for serious crimes of violence (not involving a sexual element), it was notable that a link between the offending behaviour and either chronic alcohol abuse or mental health problems was a factor in the assessment that there was a serious risk of re-offending.

Long determinate sentences

4.5 The serious nature of the offences involved and the existence of analogous previous convictions were the main reasons advanced by trial judges when imposing long determinate sentences. However, trial judge reports tended to contain much less discussion about the risk of the offenders involved committing similar offences in the future. Instead, a judge was more likely to highlight the seriousness of an offence or a bad record of previous analogous convictions as support for imposing a sentence with a long punitive element.

4.6 The fact that trial judge reports tended to contain less discussion of the risk of re-offending did not mean that the issue was never highlighted in relation to offenders who received a determinate sentence. Indeed, there were several instances where a trial judge stated that an offender did present a danger to the public but nevertheless decided not to imposed a life sentence. It was clear that the decision to impose a determinate sentence, rather than an indeterminate one, was sometimes a difficult one.

4.7 In contrast to the sample of offenders who received discretionary life sentences, there were a few cases where the trial judges clearly stated that they did not believe that the offender in question was likely to re-offend in a similar way in the future.

4.8 Psychiatric reports were less likely to be obtained in relation to offenders who subsequently received determinate sentences.

ANNEX 3

REVIEW OF THE RESEARCH LITERATURE ON SERIOUS VIOLENT AND SEXUAL OFFENDERS: A SUMMARY

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The full review is being published by the Scottish Executive Central Research Unit at the same time as this Report

This review was undertaken to assist the work of the MacLean Committee on Serious Violent and Sexual Offenders, by providing a review of current literature on how serious violent and sexual offenders and severe personality disordered offenders are treated and managed.

MAIN FINDINGS

- Provisions specifically designed to deal with offenders designated serious violent and/or sexual offenders exist in a number of countries.

- These provisions provide for longer than normal, indeterminate or renewable sentences.

- Although similar provisions are available across countries it is possible to divide jurisdictions into two models. Those that have adopted a more therapeutic and treatment orientated approach are grouped under the heading 'clinical model'. Many countries which did, historically, adopt such a model now prioritise public safety and are grouped under the heading 'community protection model'. Within these headings there are variations, and some countries, e.g. England and Wales, bridge both models.

- To comply with the applicable constitutional or human rights protections these provisions normally have appeal and review of detention provisions included.

- Challenges in terms of breaches of constitutional or human rights have clarified that detention of this type is 'lawful' even if the offender is not being 'treated' and its only purpose is public safety.

- Offenders sentenced under these provisions are detained either in prison or hospital.

- The place of detention tends to depend on whether the jurisdiction prioritises treatment or public protection.

- In addition to detention some jurisdictions use castration as a form of 'treatment' for sexual offenders.

- There is limited research and information that evaluates the effectiveness of these disposals and 'treatment'. This is in part due to the fact that many of these provisions are too new for any evaluations to have been carried out. The information that is available generally measures success in relation to the recidivism of offenders and provides mixed conclusions.

INTRODUCTION

1. The main aim of the research was to provide a summary of current and recent UK and international literature on the sentencing of dangerous offenders and the subsequent management of these offenders in hospital or prison settings and upon release into the community. The key objectives of the research were to:

   - review UK and international literature on dangerous offender legislation;
   - review any literature on reviewable and/or renewable sentences;
   - review any available literature on the ***effectiveness*** of dangerous offender legislation or reviewable sentences;
   - review the current and recent UK and international literature on the management of severe personality disordered offenders and offenders sentenced under dangerous offender legislation.

2. This research was conducted from 5 July until 30 September 1999. A literature search was conducted using available electronic, CD-ROM, and on-line databases. The literature search was conducted for references published in the English language or for those with an abstract in the English language. Literature published in languages other than English is excluded from the present review. Although this does not seriously affect the quality of the review, it does present a bias towards English speaking countries in the review of literature. Web sites of countries identified as having relevant legislation were consulted, and individuals with a local knowledge of their jurisdiction were contacted where possible.

Serious violent and sexual offender legislation

3. The literature revealed a substantial amount of information on both the current and prior legislative provisions to deal with this group of offenders. Established and operational provisions were identified in the USA, Canada, Australia, New Zealand, The Netherlands, Germany, Switzerland, Denmark and England and Wales. Additional but limited information was collated on Belgium, Norway, Italy, Spain, Iceland, Finland, France, Hungary and Poland.

4. Shared approaches to dealing with serious violent and sexual offenders exist within and between jurisdictions. In those countries where sentencing laws are determined at State level, e.g. USA and Australia, variations between some States are evident alongside a movement towards a unified approach that prioritises public safety. To help examine different countries, a model approach is used and two models are considered (see below).

The community protection model

5. This model is found in the USA, Canada, Australia and New Zealand. The USA can be distinguished from the other jurisdictions as the indeterminate sentencing takes the form of civil commitment, which is applied after the completion of a prison sentence. It only applies to sexual offenders and the legislation of this type which exists in different States take the form of sexual predator statutes. For non-sexual violent offenders the normal sentencing provisions (e.g. 'three-strikes') are available.

In Canada, Australia and New Zealand indeterminate sentencing, similar to the USA, is available. Although this legislation also prioritises public protection and incorporates review mechanisms in respect of detention, there are some notable differences. The legislation in these countries does not make the same distinction between sexual and non-sexual violent offenders. Also, the decision on indeterminate sentencing is made at the point of disposal for the index offence and not at the completion of the prison sentence, as in the USA. Constitutional and human rights challenges to this legislation have highlighted that a system of regular review of detention is essential.

The clinical or therapeutic model

6. The Netherlands, Germany, Switzerland and England and Wales have been described as having a more clinical approach to dangerous offenders, which is orientated more towards treatment than punishment and public protection. The TBS order in The Netherlands allows post-trial detention in a forensic mental hospital for offenders with partial responsibility and those deemed wholly without legal responsibility. Treatment is provided in this setting. An offender can elect not to be assessed to receive such an order, which is made at the point of sentencing. If the offender chooses not to participate, he/she will receive a normal prison disposal. Review procedures in respect of these orders are stringent and allow for regular review.

7. Like The Netherlands, Germany provides hospital detention for the partially responsible offender. The decision to include an offender in such a regime, however, focuses on considerations of dangerousness and previous convictions rather than illness. Surgical castration is available in respect of sexual offenders and indeterminate civil commitment can be used for offenders who are dangerous and insane, but this is rarely used.

8. In Switzerland preventative detention is available for offenders who have a deep-seated personality disorder and have committed a serious violent offence. Detention is aimed at preventing future similar offending. Regular review provisions are incorporated.

9. Those offenders committing the most serious offences in Denmark will receive a dangerous offender order if a risk of future offending is evident. The order, which is initially for a fixed period, is renewable. Serious sexual offenders are castrated in Denmark. Surgical castration has now been replaced by chemical castration combined with psychotherapy.

10. Due to the existence of disposals, such as the hospital order and hospital and limitation direction, which are available to convicted offenders with mental disorder, England and Wales may be considered as belonging to the clinical model. However, recent legislation in the form of longer than normal sentences, and current proposals for further change, evidence a distinct shift towards the public protection model.

Shared characteristics

11. While having individual legislative provisions, all of these jurisdictions also have shared characteristics. A large number of countries have introduced legislation following a high profile crime committed by a recently released offender with some history of serious offending.

12. The largest category of offenders in receipt of indeterminate sentencing or detention is sex offenders. The treatment of this group appears to be problematic and various approaches have been adopted with limited success. A very large number of offenders in every jurisdiction have been described as suffering from personality disorders and, often, severe personality disorders. It is not always clear from the literature, however, how the author defines this category.

13. Internationally, there appears to continue to be a growth in the creation of new forms of indeterminate sentencing. A movement away from an emphasis on treatment and rehabilitation towards prioritising public safety is obvious not only in the legislation which is already in force, but that which is currently in the process of becoming law.

Evaluation of effectiveness

14. There is limited literature available which is concerned with the effectiveness of these legislative provisions. That which does exist presents a mixture of results. The common trait in this literature is the approach adopted. The legislative provisions are either evaluated on the basis of how successful they are at reducing recidivism or, alternatively, whether they comply with human rights or constitutional provisions.

15. The current public protection legislation has not been in existence for long enough to allow evaluations to have been conducted. The USA provisions, which are some of the earliest, only came into force for the first time in 1990. The majority of offenders detained under these provisions have, therefore, not yet been released.

Compliance with human rights provisions

16. Each of the jurisdictions outlined is required to comply with the protections contained within their national equivalent of the European Convention on Human Rights. Scotland is no exception to this.

17. The position in the USA in this regard is outlined in the case Kansas v Hendricks. In this case, in 1997, the United States Supreme Court approved the constitutionality of Kansas' sexual predator statute. The Supreme Court's disposal of the constitutional issues raised can only be interpreted as providing approval for the viability of a model of community protection within a country and legal system strongly founded on the principles of liberty and due process.

18. In this decision and in those of the European Court of Human Rights the essential compliance criteria appear to be an absence of inhuman treatment or punishment, which may in Europe affect the lawfulness of compulsory castration, particularly if this was to be surgical. Access to a review process by the offender is also essential. The lawfulness of the USA model, whereby indeterminate sentencing is not passed until after the prison sentence has been served, is unique to this jurisdiction. It is possible that if such a system existed in Europe it would be deemed to be in breach of the European Convention on Human Rights.

Further research

19. Additional evaluation on recidivism of offenders in receipt of provisions for serious violent and sexual offenders would contribute to knowledge of the effectiveness of these provisions. Further evaluation of treatment approaches using comparable methodology would also be beneficial.

ANNEX 4

PLACES VISITED

Introduction

1. The terms of reference of our Committee require us to compare practice, diagnosis and treatment with that elsewhere. It was therefore necessary for us to have a working knowledge of current practice in dealing with serious offenders if we were to make informed recommendations about developing their sentencing and management in Scotland.

2. There are many interesting projects developing in prison and health systems in the UK, some of which we were pleased to be able to visit. We were also anxious to be informed by practice and thinking further afield, and so undertook visits to the USA, Canada and The Netherlands, each of which takes a different set of approaches to our target group. The legislative basis of these approaches is described in the literature review commissioned by our Committee, which is summarised at Annex 3.

3. Because of the broad range of the facilities we wished to visit, our visiting programme was extensive, consisting of visits to 16 facilities in the UK and 14 facilities overseas.

4. We would like to register our gratitude to all those who helped with the organisation of these visits, without whom we would not have been able to gather a great deal of fundamental information about current practice at home and abroad. In particular, thanks go to those, at the Foreign and Commonwealth Office and elsewhere, who helped us to organise our overseas visits, amongst whom were Richard Homer, David Belgrove, Yvonne Rideout, Diane Foran, Olivia Moore, Dr Stephen Hart, Andre Batenburg, Roxanne Leib and several other very well-informed and helpful people. Without their help and advice it is doubtful that our visits would have been as smooth-running, informative and interesting as they were.

5. Our thanks also go to the people, too numerous to mention by name, who agreed to take the time to meet with us on our visits and with whom we had many valuable and wide-ranging discussions which greatly informed our thinking.

Part One: Domestic visits

6. Our visits to facilities in the UK were as follows:

Prisons:

HM Prison Durham (CSCs and Women's Wing)

HM Prison Grendon

HM Prison Peterhead (STOP Programme and Small Unit)

HM Prison Shotts (National Induction Centre and Small Unit)

Parole Board and Designated Life Tribunal:

Parole Board for Scotland

Designated Life Tribunal

Secure and medium-secure hospitals:

Ashworth Special Hospital, Merseyside

Broadmoor Special Hospital, Berkshire

Crozier Terrace Regional Secure Unit, London

State Hospital, Carstairs

Other health facilities, including those specialising in personality disorder:

Argyll and Bute Hospital, Lochgilpead

Cassel Hospital, Surrey

Douglas Inch Centre, Glasgow

Henderson Hospital, Surrey

Portman Clinic, London

Royal Cornhill Hospital, Aberdeen

Prisons

HM Prison Durham

Visited 29 October 1999

7. Durham prison is a large prison of around 800 inmates which acts both as a local prison and a Category A prison, including for lifers at the beginning of their sentence.

8. Within the prison are two Close Supervision Centres (CSCs) (Wings I and G), which are part of a specialist national resource for those prisoners who are the most difficult to manage, alongside the other CSC at Woodhill prison, in Milton Keynes. The total CSC service accommodates, at present, 45 out of 68 000 prisoners in the English prison service (12 of whom are in Durham).

CSC: I Wing

9. I Wing is a small unit for prisoners who are difficult to manage, who may have a history of psychiatric or personality disturbance. The wing has a capacity to house nine prisoners, and was full at the time of visiting.

10. The wing has a high ratio of staff to prisoners (almost 1-1 on daytime shifts), and aims to have a high level of staff interaction with prisoners. The day is also fairly structured. The aim is to encourage prisoners to act responsibly and develop their ability to cope with other people.

11. The unit does not aim to address prisoners' offending behaviour outside prison, but manage and improve their behaviour within prison. For many of the inmates, the aim is long-term containment, and it is expected that many will spend several years on the Wing.

CSC: G Wing

12. G Wing opened in May 1999. At the time of visiting, it was still coming up to full complement and was holding three prisoners. Eventually, it will house up to nine prisoners, with a ratio of staff on duty to prisoners of almost 1-1.

13. Prisoners will have caused serious problems in the system. They will all have worked through all the levels at Woodhill. G Wing's brief is to help them develop interpersonal skills and learn to interact in an acceptable way with others.

14. Compared with I Wing, prisoners would have less of a psychiatric history, and the aim is for a fairly rapid reintegration in the prison system: normally between six months and a year.

Women's wing

15. The women's wing houses around 100 women prisoners serving from four years to life, including four Category A prisoners.

HM Prison Grendon

Visited 19 October 1999

16. Grendon is a Category B prison in Buckinghamshire. It is established on a therapeutic community model and has been running for around 35 years. The prisoners are long-term prisoners, nearly all with convictions for sexual or violent offences.

17. There are five wings with around 40 prisoners each, and an assessment wing with 20 prisoners. Each wing of the prison is a self-contained therapeutic community with around 14 prison officers and a psychologist, probation officer and therapist.

18. The regime at Grendon involves intensive group therapy and interaction as well as cognitive and psychodynamic programmes. The prisoners at Grendon have all volunteered to take part in the programme. The average length of stay is 14 months, although the hope is that people who will benefit from the regime will stay for at least two years.

19. Recent research against a control group of people who were selected as suitable for Grendon suggested a reduction in reconviction rate of 20 to 25%[1].

HM Prison Peterhead

Visited 8 November 1999

Prison, including sex offender treatment (STOP) programme

20. The bulk of the prison population at Peterhead consists of sex offenders serving sentences of more than four years, up to and including life imprisonment. Although there has been resistance from some prisoners, most now participate in the group work done as part of the regime.

21. The STOP adopts a group-work-based approach to addressing offending behaviour and is delivered over a period of approximately one year.

Small Unit

22. The Small Unit accommodates a small number of offenders, all with a history of violence and some with borderline mental illness or low IQ. All are serving very long sentences. At the time of visiting, the Small Unit was housing seven prisoners; the maximum is ten. The seven prisoners had all volunteered to go to the Unit. No-one stays for more than three years and there was a waiting list to get in.

23. The regime is centred on regular meetings of staff and prisoners.

24. There is great emphasis on forensic psychology with a view to promoting behaviour changes.

25. At the time of visiting, members of our Committee were informed that a review of the prison estate was underway and the Small Unit at Peterhead was vulnerable to closure. We have since been given to understand that, following completion of the review, the operation of the Unit was suspended.

[1] Home Office Research Findings No. 53 - a reconviction study of HMP Grendon theraputic community: Peter Marshall

HM Prison Shotts

Visited on 17 September 1999

National Induction Centre (NIC)

26. The NIC opened at HM Prison Shotts in May 1995. The aims of the Unit are to provide a placement for adult male prisoners serving 10 years or more where they are sent at the time of or shortly after sentencing to come to terms with their imprisonment and where a long-term sentence plan can be developed.

27. There are 52 places in the Unit and, at the time of visiting, 50 prisoners. There are 32 staff.

28. Prisoners serve between six and twelve months in the NIC, before transferring, normally to mainstream settings (although a few have transferred to small units).

29. The NIC carries out Risk and Needs assessments on prisoners which inform the type of programme work and intervention that is required in the mainstream prisons. It also runs some short of induction programmes designed to assist prisoners to come to terms with their sentence.

Small Unit

30. Prisoners admitted to the Unit present serious management difficulties within mainstream prison settings. Admission is voluntary, and partly depends on a prisoner's acceptance that his behaviour must change. The Unit does not accept prisoners who are showing signs of psychosis or receiving psychotropic medication. Nor does it accept those designated as sex offenders.

31. The Unit is not specifically designed for inmates with severe antisocial personality disorder or psychopathy, although it will receive such prisoners from time to time. At the time of visiting, the Unit held ten prisoners, nearly all of whom were serving life or long sentences. Ages ranged from 29-45.

32. The Unit works on a community model. Prisoners undertake a variety of activities in and for the Unit, which are based on contracts agreed with members of staff. There is a deliberately closer working relationship between prisoners and staff than in other parts of the prison service (however, there are defined limits upon this).

Issues raised in prison visits

Exclusion from health services

33. The general comment was made that communication and joint working between health and prison services could sometimes be improved.

34. It was noted that the prison service operates under an obligation to accept whoever they are sent, whereas health services have scope to refuse to admit someone. There were concerns raised at prison visits that there is no overall authority which can say that a particular setting is the most appropriate available for the prisoner.

Female prisoners

35. Many of the women at Durham prison exhibit high degrees of self-harming behaviour (mutilation, serious cutting etc.), and it is generally difficult for the prison service to effect any positive change. The prison system is more geared to dealing

with male violence and self-harm (e.g. more typically suicide by hanging than self-cutting). In particular, there is a lack of a resource, similar to I Wing at Durham, for women in a really chronic and chaotic state.

36. The point was made that much of the evidence about personality disorder suggests that borderline personality disorder (which is more common among women and more related to issues of self-harm than antisocial personality disorder) was more likely to be 'treatable', yet this group were receiving little or no concentrated input, compared with men in (for example) CSCs. Part of the explanation could be that the extra expenditure on men was felt to be justified because it is economic for the prison service to minimise the damage caused by such men.

Small Unit model

37. At Durham the CSCs were said to be greatly preferable to the segregation units, where prisoners have to be moved around frequently, and where it was impossible to have any kind of sentence planning.

38. The literature provided by Shotts Small Unit identified two possible unfulfilled service requirements: services for people who cannot cope with the challenges of a therapeutic community model and require a more structured regime with less personal responsibility, and services for other people who do not present as violent or extremely disruptive but need help to cope with exceptionally long sentences without foreseeable parole.

Therapeutic communities in prison

39. In Grendon prison it was clear that there is a delicate balance in maintaining the democratic structure of a therapeutic community in a secure prison environment. This can break down unless people who are manipulative or unwilling to engage are screened out or drop out.

Sex offending

40. The Shotts NIC does not take sex offenders, because of problems of integration (although it is likely that a number of the crimes will have had a sexual element which was not highlighted at the time of conviction). It was commented that the rigid separation of sex offenders may be an issue to be addressed at some point.

Psychological input

41. The importance of psychological input was highlighted during several visits, but some prisons were facing difficulties in ensuring access to psychological services. Some of this was linked to problems of recruitment and retention of trained psychologists.

Risk assessment

42. The Shotts NIC currently assesses risk only insofar as it relates to behaviour in the prison system. It makes no attempt to assess long-term 'dangerousness' or risk to the community. Because the current assessment is directed at prison issues rather than dangerousness, it could not be translated directly into a pre-sentencing assessment. However, it was felt by staff that such an assessment would be feasible and might be useful.

43. In general, the view from many prison staff with whom we talked was that an assessment of risk should be linked to decisions on release.

Information sharing

44. Frustrations were voiced by several people with whom we talked in the prison system about the difficulties in obtaining relevant information relating to previous offences and psychiatric histories.

45. In addition, it was commented that there were sometimes difficulties, in trying to address and affect a person's behaviour, if the offence for which a person had actually been tried and convicted did not include any sexual element of their crime.

Indeterminate sentences

46. Although indeterminate sentences were generally welcomed on public safety grounds, some people were concerned about the short tariffs attached to some indeterminate sentences, which did not seem to bear any relation to when the person could realistically expect to be released. It was said that this causes difficulties in sentence planning and unrealistic expectations by the prisoner.

47. It was commented by one group that it might be a good idea to relate the length of the sentence and the discharge decision to clear outcomes which the prisoner can understand and work towards.

48. The power to recall was seen as a benefit of discretionary life sentences. However, this could have unpredictable consequences for the size of the future prison population.

Release from prison

49. Post release, there can be considerable problems with accommodation. Even if it can be found, offenders who are not on licence sometimes disappear from the system.

50. At Grendon there was some anxiety that follow-up care was not always being provided when people moved on from the therapeutic community. The group who seem to have done best are those who have had a 'full dose' of treatment followed up by parole and aftercare.

Treatability of personality disorder

51. Many prisoners at Grendon have a label of personality disorder, but this term is not one that Grendon employs to distinguish between those who are amenable to treatment and those who are not. Instead, they look at elements of a prisoner's personality and behaviour which might be amenable to change.

Accreditation of programmes

52. Durham was beginning to develop accredited programmes. There was concern that pressure to deliver positive outcomes could mean that staff would feel that they had to put forward the 'best' prisoners for the programmes, not necessarily those in most need.

53. There have been some tensions in integrating the therapeutic community model at Grendon into the approach of accreditation of programmes. Grendon feel this is partly due to the density and complexity of the work undertaken within the institution. However, they feel that these difficulties are being overcome, and that promising results have been obtained when the cognitive programmes run by the prison service have been combined with the context of the therapeutic community.

Parole Board for Scotland and Designated Life Tribunal (DLT)

54. Members of our Committee undertook visits to a meeting of the Parole Board for Scotland, which considers questions of release on license and recall of adult prisoners serving determinate and mandatory life sentences, and to a meeting of the Parole Board sitting as a DLT, in which capacity it considers the cases of adult prisoners serving discretionary life sentences, and young offenders who are serving indeterminate sentences.

Parole Board for Scotland

Visited 20 July 1999

55. The Parole Board considers a dossier of reports on a prisoner's case. Prisoners are permitted to make representations. In the event that the information in the reports and the representations made by the prisoner are contradictory, it is for the Parole Board to decide how much weight to give to the different versions of events.

56. Questions of what weight it is appropriate to give to unsubstantiated allegations when considering questions of recall were raised at the visit.

57. There was a discussion of whether, in the case of certain recalled prisoners, public safety is better served by re-releasing them on strict licence conditions or keeping them in custody until their release date and then releasing them without licence supervision.

58. Information flow through the criminal justice system was a matter of great concern to the Board, and the view was taken that information flow between agencies was a key area to be improved.

Designated Life Tribunal

Visited 23 August 1999

59. In the relatively formal setting of the DLT the prisoner might be at a significant disadvantage without representation. At present only advice by way of representation (ABWOR) is available to prisoners before DLTs. There might be a case for the provision of full Legal Aid in all cases.

60. It was observed at the visit that although the DLT has no remit relating to the management of prisoners, its decision on release can be made more complex by service concerns. For example, a prisoner's lack of progress in the prison system might be more closely related to difficulties in finding programmes for him to undertake than to his own behaviour. However, there are clearly difficulties around

making meaningful sentence planning provision for people undertaking very long sentences.

Secure and medium-secure hospitals

Broadmoor Special Hospital

Visited 4 November 1999

61. Broadmoor, in Berkshire, is one of three Special Hospitals in England, the other two being Ashworth (Merseyside) and Rampton (Nottinghamshire).

62. At the time of visiting, Broadmoor was caring for some 430 patients, 80 of whom were female. About 50 patients are admitted per year. There are generally around 30 patients from Broadmoor on 'trial leave' in lower security hospitals at any one time. The average stay at Broadmoor is around eight years, although there are some high-profile and/or elderly patients who are likely to remain in the hospital indefinitely.

63. Approximately two thirds of the patients at Broadmoor have mental illness; approximately one quarter of the patients have a sole diagnosis of personality disorder; and approximately one eighth of the patient population has dual diagnosis of mental illness and personality disorder.

64. Over half of the patients at Broadmoor are restricted patients, for the management of whom the Home Secretary has ultimate responsibility. Around one eighth of Broadmoor's patients are transferred to the hospital from prison on becoming mentally ill.

Ashworth Special Hospital

Visited 7 October 1999

65. As at publication of the 1998/99 Annual Report, the Mental Health Service at Ashworth Special Hospital had 264 patients and 565 staff. The Personality Disorder Service had 110 patients and 177 staff. The Women's Service (which was not visited) had 49 patients and 119 staff. There is also a separate rehabilitation service with 167 staff which services all three patient groups.

66. The Personality Disorder Service is not currently receiving new patients. The patients who are currently at the Ashworth Personality Disorder Service are a highly selected group, in the sense of being particularly disordered even compared with the other English Secure Hospitals. The people in this service are cared for in separate wards, which is a different model from Broadmoor and Rampton where people with personality disorders are, in the main, dispersed throughout the hospitals. The Personality Disorder Service has, in the last three years, reorganised around a containment model with psychological interventions, which draws heavily on the experience of Dutch TBS services. The treatment goal of the Service could be loosely described as helping the patients to manage themselves better in relation to the world.

67. The Sex Offender Treatment Programme is based on the prison 'SOTP' programme, with some adaptations - mainly that it is delivered at a slower pace. There are usually two sessions a week of 1.5 to 2 hours each.

Crozier Terrace Regional Secure Unit, Hackney, London

Visited 17 November 1999

68. Regional secure units (or medium secure units) accommodate mentally disordered offenders, whose level of risk is too high to maintain them in general psychiatric services, but who do not require to be placed in high security hospitals.

69. At the time of visiting, the total number of patients in the Crozier Terrace Unit was 48, but this was likely to increase to 100.

70. There is a multidisciplinary team, headed by consultant psychiatrists, with social workers, psychologists, nurses, occupational therapists and (on referral) creative therapists. There is also educational input.

71. Ninety per cent of the patients come through the courts and prisons, but admission to the service can come from both the lower and upper levels of security in psychiatric services, as well as from prisons, the police, and probation services.

72. There are four wards - an admission ward, an intensive care ward, and two ongoing assessment wards. There is currently no women's ward, but the Unit is developing a business case for 60 new beds, including a women's ward. The service is developing a 24-hour nursing care facility and rehabilitation wards with a lower level of security. The unit also has a flat with four beds, where staff can assess daily living skills such as managing cash for shopping etc.

The State Hospital, Carstairs

Visited 28 October 1999

73. The patient population of the State Hospital at the time of the visit was approximately 250 patients, 18 of whom were female. Seventy per cent of the patient population have schizophrenia. Only 5% have a sole diagnosis of personality disorder. There are also several patients with learning disabilities. The average stay in the Hospital is four and a half years (although it varies from around ten weeks to up to 25 or 30 years)

74. Patients arrived at the hospital's Admissions Ward from court, from other hospitals and from prisons. Approximately one third of the total population has been referred from court, one third transferred from prisons, and one third referred from general psychiatric hospitals.

75. Patients undergo an assessment process usually taking eight to ten weeks, after which they are either moved to an appropriate Ward or returned to court or the referring facility.

76. It is rare for a patient at the State Hospital to be discharged direct to the community. It is more usual for patients to be discharged to mainstream psychiatric hospitals.

Issues raised at secure and medium secure hospital visits

Relationships with prison system

77. At the secure hospitals, concerns were raised about patients who become mentally ill in prison and are transferred to secure hospital services. Such patients will be

returned to prison on recovery from their mental illness. In practice, many of these patients spend many consecutive periods in prison and in hospital, on 'cycles' of mental illness and recovery.

78. In addition, the point was also raised that if prisoners are transferred to secure hospital accommodation and their sentence expires during that time, they are eventually discharged from in-patient care. It was suggested that there is a pressing need in such cases for the mental health and criminal justice systems to work more closely with each other, so as to avoid such individuals losing touch with the services which they may need.

79. Several clinicians took the view that better mental health facilities are required in prisons, in order to help prisoners avoid becoming mentally ill or to recover from mental illness if they do become ill. However, no consensus was reached on whether there should be a development of prison mental health services to the extent that they would be in a position to give, for example, compulsory medication (currently not lawful under the Mental Health Acts).

The care of ethnic minorities and other groups

80. Several comments were made at various visits relating to the apparently high level of compulsory detention of people from ethnic minorities, particularly young black men.

81. At Broadmoor some 30% of the patients are of non-white ethnic groups but the local population, from which much of the unqualified staff complement is drawn, is 99% white (although 9% of the ***qualified*** staff are of non-white ethic backgrounds). In order to address questions of culture, gender, sexual orientation etc, Broadmoor runs a therapy programme which is specifically aimed at women and patients from minority groups. The management at Broadmoor stresses the importance of understanding a patient's culture before addressing their mental illness.

Entrapment

82. At the English Special Hospitals we were given to understand that there is a major shortage of beds to which patients can be transferred on progression. Some long-term medium-secure units have closed, and those which are still open have tended not to wish to take patients who could be expected to remain in their care for much longer than two years. Some patients could in theory go from high security hospitals straight to lower levels of security, but the mainstream services are not keen to take them unless they have been through the intermediate medium-secure stage.

83. This was echoed at the Crozier Unit, where it was indicated that, because of pressure of beds, people currently in prison tend to be given priority over people being referred from high security hospitals (on the basis that the latter group are at least receiving some treatment). This can lead to entrapment in secure hospital accommodation.

Personality disorder - policy towards admission

84. On our visits we asked whether people with a primary diagnosis of personality disorder should be admitted to hospital. We were told that personality disorder can

be a ground for admission to an English Special Hospital, but it was pointed out that individuals with this diagnosis tend to have certain characteristics - most have committed serious offences and score highly on measurements of personality disorder.

85. However, there appears to be an increasing reluctance by regional/medium-secure units to accept this group. At the Crozier it was seen as a bad, and very expensive, way of dealing with people with personality disorder. The expense is partly because the service is individually based, which may not be appropriate for personality disorder. There are some independent services springing up, but there was anxiety amongst some people we talked to about whether these services have the necessary skills to offer anything meaningful to this group of patients.

86. One view given to us at an English secure hospital was that many of the current patients could well be held in prison, but there was a group of what were termed 'inadequate psychopaths' who were appropriately admitted to hospital. It was also suggested that the difference between the personality disordered population and the mentally ill population in the English secure hospitals may be less marked than one would expect. Personality disorder was often a feature contributing to the offending behaviour of patients with episodes of mental illness.

87. At the State Hospital it was pointed out that many sexual offenders with personality disorder and some form of mental illness are sent to prison on conviction, but in the prison service there is relatively little in the way of therapy to help them recover from their illness and/or to address their offending behaviour and their personality disorder.

88. Many staff at the State Hospital took the view that, if a person is mentally ill, and required to be detained, they should be detained in hospital, whereas, if the person had a diagnosis of personality disorder only, they should be accommodated in prison or in some other type of service (whether located within the prison system or not).

'Treatability' of personality disorder

89. At Broadmoor it was suggested to us that prisons and hospitals should agree on assessment and therapy methods for people with personality disorder so that both systems were carrying out assessment procedures and therapy programmes which were consistent with and complementary to each other. In both environments, the aim would be to find aspects of the person's personality characteristics which can be tackled and improved in order to deal with a person's 'dangerousness'. Likewise, at the State Hospital, the clinical approach is that many patients may have personality difficulties and that these are targeted for specific clinical treatments. This approach is therefore concerned with risk management and minimisation of risk as well as the patient's own welfare.

90. At Ashworth, in the past, attempts were made to 'treat' personality disorder. Now the staff see themselves more as trying to reduce and minimise ***risk***, and so look more than before at the index offences. It was accepted, though, that there is a group of people who are very hard to engage in any form of therapy, and who did not fit in well with a model based on progression. They are not a homogenous group, and only a few cause major management problems. For some, choosing to engage is a matter of timing, and their degree of motivation may change.

91. Most people to whom we talked indicated that a psychological input was key to the management or 'treatment' of personality disorders.

Risk assessment

92. It was continually stressed to us that assessment of risk must be multi-disciplinary, it must also take account of historical and collateral evidence (i.e. not simply rely on the word/testimony of the patients themselves), and should take place over a reasonable period of time.

93. The importance was also stressed of examining in a very broad way the evidence of what an individual's risk might be in different contexts - i.e. the risk when outside a secure hospital, the risk to whom, the risk if using which substances/materials/weapons etc.

94. However, the problem that many identified with actuarial risk assessment is that it can assess the risk to groups, but has less predictive value in relation to individual people.

Discharge and follow-up

95. The provision of secondary mental health services in the community was discussed. It was commented in England that mainstream adult mental health services would probably wish forensic services to follow people up for a period after release, but that there are resource issues in duplicating services already available through local mental health teams. At Ashworth it was also commented that there is a clear lack of available community forensic personality disorder services.

96. At several services it was considered to be unfortunate that a patient might be absolutely discharged after a couple of years, and lost to the system thereafter. It was suggested more than once that some type of conditional discharge should always be used if a person might still be dangerous or had a personality disorder.

97. There was also concern expressed that, in the community, there is a lack of services for the treatment of sex offenders. Community projects should be set up for those who need treatment but do not need to be kept in a custodial environment.

Hospital orders and hospital directions

98. Interim hospital orders were felt by the staff of the State Hospital to be useful, as they allow time for assessment of a person's mental disorder and for it to be treated. Many staff at the State Hospital had been pleased when the maximum length of an interim hospital order had been extended from six months to twelve months, because many individuals can successfully complete their treatment within the first twelve months after sentencing and then be transferred on to prison, if appropriate, to complete their sentence.

99. Hospital directions were also cautiously welcomed, particularly their use for people with both a treatable mental illness and a personality disorder. However, it was clearly the view that a hospital direction should not be used for someone whose mental illness was the sole cause of their offending behaviour.

Other health facilities

Argyll and Bute Hospital, Lochgilphead

Visited 5 October 1999

100. Our Committee visited a programme where dialectical behavioural therapy (DBT) is in use for people with borderline personality disorder.

101. There are 10 people on the DBT team at Argyll and Bute Hospital, from a variety of disciplines.

102. There are at present nine out-patients undertaking the programme. There had previously been an intensive four-week course in operation, but funding constraints and a perceived lack of support from the hospital had led to it being shelved indefinitely.

103. The DBT programme involves the application of learned skills to give a person with borderline personality disorder the ability to cope with various situations. A particularly important part of this is 'mindfulness', which is a skill that can be applied in crisis situations. It involves paying close attention to the immediate environment and regulating the impact of impulsiveness, affective instability and suicidal behaviour.

Cassel Hospital, Richmond, Surrey

Visited 14 October 1999

104. Cassel Hospital has three units: the family unit (31 beds); the adult unit (17 beds) and the adolescent unit (12 beds).

105. Of the patients in the adult unit 90% have a personality disorder and 70% have a diagnosis of borderline personality disorder. Not many of this group have had contact with the criminal justice system and most are referred from general psychiatry services. The adolescent unit contains youngsters from similar sources as the adult patients. Very few have any contact with the criminal justice system.

106. Adult patients undergo an outpatient consultation, the main purpose of which is to assess the patient's understanding of his/her condition and motivation for treatment. There is also an assessment of risk to others: the unit is anxious to avoid violent patients or those with any psychosis.

107. Adult patients remain in the unit for between six and 12 months and families for 21 months. This is a fairly strictly applied time span. Discharge is likely to be by return to the referring agency. Unacceptable behaviour is dealt with by discharging patients to their referring source.

108. The inpatient programme consists mainly of psychodynamic and psychoanalytical therapies.

Douglas Inch Centre, Glasgow

Visited 2 November 1999

109. The Douglas Inch Centre is a multi-disciplinary forensic mental health service, serving Greater Glasgow. It has been running since the 1960s. Historically, the service was outpatient based, but there are now also allocated beds at Woodilee and Leverndale, as well as nine learning disability beds at Lennox Castle.

110. Half of the Centre's referrals come from the courts, and they do many court reports. Half come from the NHS and other services (e.g. social work).

111. The inpatient population is mostly mentally ill, but the outpatient population has many people with related problems such as substance abuse or personality disorder.

112. The psychology service has a full-time equivalent of 2.3 psychologists (six people). They have a long waiting list for the service (around eight months).

Henderson Hospital, Surrey

Visited 14 October 1999

113. This hospital works on a therapeutic community model. At the time of meeting with staff the patient mix was as follows: 50% had convictions, 10% had set fires and 10% of the population were on probation. With the latter exception all patients were informal.

114. The maximum length of stay is one year, at which point patients are discharged. No detention is used under the Mental Health Act 1983. They very rarely deal with known sex offenders though sometimes a history of sex offending is revealed during treatment.

115. Selection for admission is by a group of staff and patients, by a democratic process.

116. There are no individual-focused treatment approaches. All treatment is via the therapeutic community. Non-compliance or breaches of rules may lead to patients being 'voted out' of the unit before to the end of their 12-month stay.

Portman Clinic, London

Visited 17 November 1999

117. The Portman Clinic is an NHS outpatient clinic offering assessment, treatment and management for children, adolescents and adults who engage in criminal or violent behaviour or have sexual 'perversions'. It is unique in the UK.

118. People from a variety of disciplines work at the Clinic, all of whom have training as psychoanalysts or child psychotherapists. There are 15 senior staff and five honorary consultants.

119. The Clinic works on a psycho-analytical developmental model, and places considerable emphasis on the early years of life. It typically works with people over several years.

120. The average adult patient received by the Clinic will be guilty of a number of offences. Typically, the defence solicitor will ask for a report on suitability for psychotherapy. The Clinic would not normally accept actively psychotic adults, although it does treat people with high levels of neurosis such as depression and anxiety.

121. The Clinic also offers a range of outreach and consultancy services.

Royal Cornhill Hospital, Aberdeen

Visited 1 November 1999

122. The day therapeutic community at the Royal Cornhill Hospital had been operating for a few months at the time of visiting and had been established following the closure of the former Social Learning Unit.

123. The day unit had eight or nine clients in two small groups when visited. The planned maximum was 20 clients in two groups. Treatment was envisaged as lasting for around 12 to 15 months with extensive follow-up.

124. Patients attend five days per week. There are group meetings which have various tasks including meetings of the community. The therapy offered includes thrice weekly analytic groups, plus art therapy and psychodrama, which are offered once weekly.

125. The client group does not include people with severe personality disorder who have offended but does deal with people who have 'serious disturbances' (described as various personality disorders including borderline).

Issues raised in visits to non-secure hospital facilities

Personality disorder and treatability

126. What was notable from many of these visits was the optimism shown by some, for example the Henderson, Argyll and Bute and Cassell Hospitals, about the treatability of personality disorder generally, especially borderline personality disorder, and their contrasting pessimism about the treatment of those with severe antisocial personality disorder. At Argyll and Bute we were informed that DBT cannot be used to treat predatory/psychopathic people, because for the therapy to work the person must be suffering distress as a result of their personality disorder, which such people tend not to manifest.

127. In addition, these facilities tended to take people on a voluntary basis only (except the Douglas Inch Centre) which would tend to 'deselect' those who are not amenable to the types of treatments they provide.

Treatment in a prison setting

128. We asked about whether the treatments for personality disorder provided by these services could be imported in any way into a prison setting. On the whole the response was in favour of the use of a therapeutic community model of some type in a prison setting, although clearly such a model is based upon a voluntary commitment to it and so cannot be used for many recalcitrant prisoners. Many people that we spoke to referred to HM Prison Grendon as a positive role model for future services in prisons.

Information sharing

129. Frustrations were again voiced by some regarding access to information. The experience of several people to whom we talked was that there were widely variable practices regarding allowing access to records and sharing information.

Research needs

130. At the Portman it was commented that psychotherapy has been bedevilled by the lack of randomised control trials.

131. It was also commented that further research was needed into what services might be of use to people with severe antisocial personality disorder.

Part Two: Overseas visits

Our Committee's overseas visits were as follows:

Visits in Canada

Correctional Service of Canada Headquarters, Ottawa ***(Visited 26 November 1999)***

Kingston Penitentiary ***(Visited 25 November 1999)***

Queen's University, Kingston ***(Visited 25 November 1999)***

Simon Fraser University, Vancouver ***(Visited 24 November 1999)***

Conference: 'Risk Assessment and Risk Management: Implications for the Prevention of Violence' ***(17-19 November 1999, Vancouver)***

Visits in The Netherlands

Henri Van Der Hoeven Clinic, Utrecht ***(Visited 2 December 1999)***

Ministry of Justice, The Hague ***(Visited 3 December 1999)***

Pieter Baan Centre, Utrecht ***(Visited 1 December 1999)***

Veldzicht Clinic, Ommen ***(Visited 30 November 1999)***

Visits in the USA

Sexually Violent Predator Programmes:

Arizona Community Protection and Treatment Centre, Phoenix, Arizona
(Visited 12 November 1999)

Mendota Mental Health Institue, Madison, Wisconsin ***(Visited 10 November 1999)***

Oshkosh Correctional Facility, Madison, Wisonsin ***(Visited 11 November 1999)***

Special Commitment Centre, McNeil Island, Washington ***(Visited 23 November 1999)***

Non-SVP prison:

Patuxent Institution, Maryland ***(Visited 8 November 1999)***

Discussion:

Virginia Law School ***(Visited 9 November 1999)***

CANADA

1. In Canada we met with a number of people in the criminal justice system to talk about the Dangerous Offender Order. We also spoke to Dr Stephen Hart and Dr Vernon Quinsey about their risk assessment tools (HCR-20 and VRAG respectively).

Sentencing

2. The range of available sentences for serious offences in Canada is as follows:
   - first degree murder - mandatory life (parole eligibility at 25 years after arrest)
   - discretionary life (parole eligibility at seven years after arrest)
   - dangerous offender order (indeterminate sentence, parole eligibility at seven years after arrest)
   - long-term offender order (determinate sentence, with community supervision element)

Dangerous offender and long-term offender orders

Dangerous offender order (DOO)

3. DOOs are indeterminate sentences imposed on convicted offenders who pose a serious future risk to the public.

4. This type of legislation has existed in Canada for many years. The DOO in its current form was introduced in 1977.

5. In 1997 the law was changed so that, if the offender fulfils the criteria for a dangerous offender order, the judge cannot impose anything other than an indeterminate sentence. However, the option is still open to the judge to rule that the person does not fulfil the criteria and impose a long-term offender order (LTO) or another determinate sentence.

6. After parole eligibility is reached at seven years, there are biennial reviews of detention. Release from a DOO is rare and most such offenders can expect to end their lives in custody.

Long-term offender order

7. LTO orders (determinate sentences with a fixed period of up to 10 years community supervision) were introduced in 1997 as a disposal for paedophiles with multiple past offences who could be controlled with appropriate community supervision. To give a LTO sentence the courts have to apply the 'confidence test': that they are 'confident that community supervision at the end of the sentence will protect the public'.

Flagging and information-gathering (British Columbia)

8. British Columbia has begun a system of flagging potential candidates for DO status on their computer system. The goal of the flagging system is to provide Crown Counsel with the necessary information it needs to proceed with a DO application.

9. There are at present 780 provincially flagged individuals. Of these, there are 200 to 400 who, when they commit their next offence, will seriously be considered for DO applications. 320 of the provincially flagged individuals are also flagged ***nationally***: on the basis either that DO proceedings are being seriously considered; the offender is geographically mobile, or the offender is a violent Warrant Expiry Date candidate.

10. For all 780 provincially flagged offenders the following information is kept: current criminal records; a photograph; information on the circumstances of previous serious personal injury offences; court transcripts; parole information; psychiatric assessments and any other available information from Police and prison records. If a DO application is being considered, the complete file is made available to the Crown.

<u>Definition of serious offence</u>

11. In both the DO and LTO provisions a 'serious offence' is defined as being a violent or sexual offence that is punishable by 10 years or more. The offences themselves are not listed. The Courts have interpreted this to mean that all sexual offences are included, as are all offences of personal violence, particularly where a weapon has been used.

12. Doubts have recently been aired over whether, for a DO sentence to be passed, the index offence itself must be 'serious', or whether a past serious offence or an escalation of offences could suffice.

<u>Assessment for DO and LTO orders</u>

13. If an offence is 'serious' as defined in Section 752 of the Criminal Code, and the offender might prove to be a serious repeat offender, the Crown can request the court to order an assessment of the offender to be undertaken.

14. On the order for assessment being made, there is a 60-day period within which the Court-Ordered Assessor must complete his/her report. Practice has been to ***file*** the report within 75 days.

15. The report should be a clear opinion in non-legal language on two questions:

    1. What is the person's risk of re-offending based on their past conduct?

    2. What is the likelihood of successful treatment or control over the period of an appropriate definite sentence or other measurable period?

16. In about half of the cases that go to assessment, the Crown decides to pursue DO proceedings. The Attorney-General has to give consent to this application.

<u>The sentencing stage</u>

17. The sentencing judge is always the original trial Judge.

18. In the sentencing stage, hearsay evidence is admissible and the strict rules of proof do not apply, unless the prisoner denies any part of the Court Ordered Assessor's report, in which case these parts must be proven.

19. The prosecution has to prove the following:
    - The fact of the conviction and previous convictions.
    - The circumstances of previous cases. If the circumstances are disputed, former victims are sometimes called to give evidence. However, police reports can sometimes suffice, or transcripts of evidence from previous trials can be used.
    - The circumstances of any past offences for which the offender has ***not*** been convicted but which have affected the assessment of his/her risk. These have to be prosecuted as part of the sentencing hearing.
    - Any psychiatric history.

20. Anything in the Assessor's report that is not proven must be subtracted from his/her report. It is after this part of the sentencing hearing that the Court-Ordered Assessor takes the stand.

21. The defence or prosecution are at liberty to call counter-experts.

The prison system

Correctional Service of Canada

22. The Correctional Service of Canada is the integrated custodial and community agency for Federal offenders (those serving more than two years). It is responsible for a total of 14 000 prisoners in custody and 8 000 in the community.

Post-conviction assessment

23. If offenders are convicted of a Schedule 1 (violent or sexual) offence (which accounts for approximately 70% of the Federal population) they are given an Offender Intake Assessment (a comprehensive assessment done by the intake parole officer) and a psychological assessment. The outcome of these assessments can also lead to the application of other specialised assessments. A detailed plan for the prisoner's time in custody, including details of programmes to be supplied, is then formulated, and seems to be subject to relatively little change as the sentence progresses.

Aboriginal offenders

24. A major problem in Canada is the serious over-representation of Aboriginal men and women in the correctional services. Aboriginal people constitute 2% of the Canadian population, but 19-20% of the federally incarcerated population.

25. Aboriginal villages are now working with the CSC to re-integrate offenders into their communities by using traditional healing processes in prison and community settings.

Mentally disordered offenders

26. There are very few secure psychiatric facilities in Canada except in prisons, which means that mentally disordered offenders are frequently given determinate prison sentences. We visited one psychiatric facility within a prison, the regional treatment centre (RTC) at Kingston Penitentiary. It treats a mixture of vulnerable prisoners,

those who have developed mental illnesses in prison and some with long-standing major mental illnesses who would have been very unlikely to have been given a prison sentence in this country.

27. The RTC occasionally takes people with a primary diagnosis of personality disorder, but only temporarily, only if they have been causing problems in the mainstream prison system and not with any real expectation of being able to offer them treatment.

28. It was argued at the CSC HQ that a personality disordered person with a psychosis has a better chance of having ***both*** his/her criminality and his/her mental illness addressed by being held in a psychiatric hospital within a prison than if he/she was shuttling between a secure hospital and a prison.

Treatment of sex offenders

29. In 1994 there was an overall review of provisions for sex offenders in Canada, and general standards for programmes were set. These give guidance for the length and intensity of programmes, and their aims and design. Within these guidelines each institution is free to design its own programmes.

30. A tripartite system is in operation: the three levels vary in length and intensity. The high intensity programmes attract the most resource input. The people in the high intensity programmes are serious sex offenders who are personality disordered, very recidivistic or have overlying psychiatric issues. National standards suggest that there should be six to eight month programmes in maximum security conditions, with about 15 hours per week of therapy (normally cognitive-behavioural in nature). A study in the Pacific Region has shown that, at the serious end of the scale, untreated offenders had a recidivism rate of 60 to 70% over seven years, while the treated offenders recidivated at a rate of about 30%.

Release into the community

Voluntary sector partnerships

31. The aim is that programmes should be organised so that they take the prisoner seamlessly from the institution into the community. There is a new focus on community programming: in the last three years the prison population in Canada has gone down by 1000 and the number of offenders in the community has risen by the same amount.

32. The CSC works in partnership with voluntary agencies in the community. A major advantage of this type of inter-agency work is that the agencies can carry on with their work past the Warrant Expiry Date.

Warrant Expiry prisoners

33. Federal prisoners are released after two thirds of their sentence unless they are specifically thought to be dangerous, in which case they are kept in for the full length of their sentence (until Warrant Expiry Date) and then released without any supervision. This was designed as a last resort measure, but more and more prisoners are now being kept in until the end of their sentence. Staff feel that they are under pressure not to release people before the end of their sentence because they have to defend their decision in court if the prisoner seriously re-offends.

Recognizance

34. Section 810 of the Criminal Code is a good behaviour bond for those at risk of offending that is applied for to the courts by the police. It is time-limited and specifies certain prohibited behaviours. The maximum length of the bond is one year but it can be renewed. The bond acts in a similar manner to a probation order, and is particularly used for policing Warrant Expiry Date offenders.

35. Theoretically, if a person refused to sign their behaviour bond, they could be sent back to prison, but this has not yet been tested in a challenge under the Canadian Charter of Rights and Freedoms.

Notification

36. Community notification of an offender's release is normally to particular individuals, groups, or schools etc. In rare cases, notification is community-wide. Notification is being used less as the use of recognizances has increased.

Circles of Support Movement

37. The Circles of Support Movement, started in Toronto but now nationwide, consists of a small group of church and community members who provide active individualised support to an offender on release. It appears to have been very successful in minimising recidivism.

Conference:
'Risk Assessment and Risk Management: Implications for the Prevention of Violence'

17-19 November 1999, Vancouver

38. This conference was addressed by Professor John Monahan, Dr Marnie Rice, Dr Stephen Hart and others, and attended by many of those working at the leading edge of risk assessment and risk management. It had as its main focus the relative accuracy of various approaches to risk assessment, although several of the smaller lectures and workshops leant towards more practical questions of risk management.

Main plenary lectures

Professor John Monahan

39. The opening plenary lecture of this conference was by Professor John Monahan, Professor of Law and Psychology at the University of Virginia. Our Committee also met with him at Virginia Law School (see later section on the USA). Professor Monahan addressed the conference on the subject of the relationship between mental disorder and violence.

40. Professor Monahan observed that the assumption in law that clinicians can measure dangerousness and predict violence does not appear to be backed up by the research evidence. The question is therefore not whether clinical judgement should be used instead of actuarial assessment, but whether actuarial evidence should be used alone or in combination with clinical judgement.

41. He made the following observations about violence and mental disorder:

- Substance abuse has a strong impact on the likelihood of violent recidivism. Substance abuse increases violence in the general population too, but it does so more markedly in people with a mental disorder. It also appeared that a greater percentage of patients had symptoms of substance abuse than in the general population.
- The relative levels of violence committed by psychopathic people compared to non-psychopathic people are the same across all social groups, but in disadvantaged areas the absolute levels are twice as high.

42. Professor Monahan noted that questions of the generalisability of screening instruments to different patient groups had not yet been fully addressed by researchers.

Dr Marnie Rice

43. Dr Marnie Rice was one of the authors of the Violence Risk Appraisal Guide (VRAG). Our Committee met with another of its authors, Dr Vernon Quinsey, at Queen's University in Kingston. Dr Rice is a proponent of the use of actuarial risk assessment tools to the exclusion of clinical judgement in making such assessments and she addressed the conference on the development of the VRAG.

44. The VRAG is a tool which was based on studies carried out by Dr Rice and colleagues on 618 mentally disordered offenders, all male, from a mixed correctional and mental health institution (Penetanguishene in Canada). The variables most predictive of violence were:

- PCL-R score
- School maladjustment
- Age
- A DSM-III diagnosis of schizophrenia (a negative correlation)

Professor Robert Hare

45. Professor Robert Hare, author of the Psychopathy Checklist (PCL), addressed the conference on psychopathy and its implications for the criminal justice system.

46. He observed that knowledge of the determinants of human behaviour and violence is relatively scanty because of the fearsome complexity of this area, and because until recently there was a lack of powerful research tools with which to investigate them.

47. He said that he thought it unlikely that there would ever be a single unified theory on human violence. However, he indicated that there was now the beginnings of a 'mini theory' of ***human predatory violence***. Such violence can be defined as being instrumental, cold-blooded, predatory and owing more to the individual than to the context.

48. Psychopathy is a specific personality disorder (although Marnie Rice and others with a socio-biological perspective would argue that it is an adaptive strategy to aid reproduction). It is a clinical construct made up of clusters of traits.

49. The PCL was not designed as a measurement of risk, but instead measures the construct of psychopathy, which is only one factor in violence but may be the most important factor in ***predatory*** violence.

50. Psychopathy is a very important part of much sexual offending. Psychopathic sex offenders tend to be versatile in their range of offences. The combination of sexual deviance and psychopathy is a particularly powerful predictor of sexual recidivism.

Other lectures

Barbara Hart

51. Ms Hart, who works with the victims of domestic violence, made the case for practical risk management strategies as opposed to theoretical constructs and actuarial tools.

52. She observed that much of risk assessment, when applied to domestic violence, is stating the obvious: 'that batterers recidivate'. The important issues are therefore the identification of men who are violent against their families and the design of strategies to avoid the re-occurrence of the violence.

Deborah Ross, Rudiger Muller-Isbermer, Henrik Belfrage on HCR-20

53. These three presenters had investigated the use of HCR-20 in three different groups (mentally disordered offenders in British Colombia; mentally disordered offenders in Haina, Germany; offenders in maximum security prisons in Sweden). All of their results had shown that the HCR-20 had good predictive power for violent and sexual recidivism.

Martien W.G. Philipse (The Netherlands) and Caroline Logan (Ashworth and Liverpool University)

54. Both these speakers raised concerns about the generalisability of many risk assessment tools (actuarial tools specifically) outside North America on the following grounds:

55. Something may be a good predictor everywhere, but may be more common in one country than elsewhere. For example, it appears from Professor Cooke's research that only 3% of the Scottish prison population are psychopathic, which is a significantly lower percentage than in North American prisons.

56. Something may be a good predictor in one culture but not in another. It appears from studies that some Belgian instruments may not even generalise to The Netherlands.

57. Cultures vary widely in their tolerance of and attitude to drugs, weapons, mental disorder, deviancy, the influence of religion, the acceptability of discussing emotions and particular personality disorders. This can affect the outcome of tests which are based on the norms of one culture.

58. Dr Logan said that there was a pressing need for a risk assessment tool to be developed specifically for Britain based upon British cultural norms.

THE NETHERLANDS

The TBS system

59. The Dutch TBS[2] system serves a dual purpose: protection of the public from dangerous offenders, and care/treatment/rehabilitation of such offenders with a view to returning them to society.

60. In essence, TBS candidates are people who have been accused of committing very serious crimes which would receive prison sentences of four years or more (murder, rape, arson and other serious violent offences) but who may have some element of reduced responsibility in relation to the offence because of a mental disorder (a diagnosis which includes personality disorder).

61. Some 30% of TBS patients suffer from some form of psychotic illness, and some 60% of patients have drug and alcohol addiction problems. Most have a personality disorder of some sort. About 25% of TBS patients are sex offenders, 5% of the totality of convicted sex offenders.

62. TBS patients are given a prison sentence which consists of a punishment term in jail (appropriate to their level of culpability) and a TBS order. After serving their prison term they are transferred to a TBS clinic for treatment.

63. The average TBS population in recent times has been approximately 1100-1200.

64. Due to the high staffing levels required in order to manage TBS patients, the cost of the TBS system is some £250 per day per patient. By way of comparison, it costs around £80 per prisoner per day to run a mainstream prison in The Netherlands.

65. In the first five years after release from the TBS system, the recidivism rate for offences generally is 50-60%, but the rate for serious offences only around 20%. About one in six or seven TBS patients relapses into some sort of serious predatory behaviour following release.

Decision to assess

66. The Forensic Psychiatric Service carries out an initial assessment on a remanded prisoner and its report, based on a standardised list of TBS criteria, informs the Examining Magistrate's decision as to whether to have the individual assessed for TBS.

67. If a clinical assessment is undertaken, this is either at a psychiatric hospital or, for people suspected of having personality disorder, the Pieter Baan Centre.

Assessment

68. We visited the Pieter Baan Centre, one of the main facilities where pre-conviction assessments are carried out. Around 225-250 patients per annum are assessed at the Centre: patients undergo a residential assessment programme of approximately seven weeks' duration. The assessment aims to establish whether the patient has a personality disorder and whether or not he/she presents a danger to the public.

69. Twenty-five per cent of admissions to the Centre are found to be suffering from psychotic illness and 75% are found to have personality disorder. Around 60 to 80%

[2] Terbesschikkingstelling: literally. 'placing at the disposal'. Previously known as TBR, terbeschikkingstelling van de regering, 'placing at the disposal of the government'.

have drug or alcohol abuse problems. A small number of cases also have learning disability. Ten per cent of admissions are female. Around 50% of referrals to the Centre are recommended for the TBS system.

Time spent in the prison service

70. The Dutch prison system has not traditionally provided any 'treatment' programmes at all to prisoners (although this approach is now being softened). The general effect for TBS prisoners is that the 'punishment' element of their sentence has to be served before their referral to a TBS clinic, yet for the duration of their time in prison (usually a number of years), they have not received any treatment of the sort provided in TBS clinics. This seems to make the job of rehabilitating them at the TBS clinics rather harder than would otherwise be the case.

71. There is currently an experimental programme in which a TBS programme is being operated in one wing of a prison in Amsterdam. However, it appears that the treatment is not working as well as in TBS clinics, at least partially because the prison is not physically appropriate for TBS treatment.

72. Staff from the Van der Hoeven Clinic also carry out some limited 'pre-therapy' treatment in prisons with people who are preparing for release to the community. However, this does not usually apply to patients who are due to move from prison to a TBS clinic.

Supervision of TBS offenders on release

73. TBS patients are monitored by the TBS system during their phased stages of release as they are gradually allowed more freedom in the community. Once they are fully released by the TBS system, the social work/probation service carry out monitoring for three years.

74. Conditions which could be attached to conditional release might include a requirement to reside in a particular place, or to continue attending for therapy at an outpatient facility.

Outpatient clinics

75. There are six outpatient clinics linked to TBS clinics in The Netherlands. We visited one, the Van der Hoeven clinic day treatment centre. Offenders can be referred to the Centre when they have committed an offence which is not serious enough to justify referral to the TBS system (for example serious assault but not murder). Most of the outpatients at the Centre are on probation, and if they fail to keep their appointments they can be returned to prison.

76. The Centre also undertakes work to avoid offence escalation with those who have committed mild sex offences . The Clinic works with the police to identify such individuals and to bring them into the Centre.

TBS and ECHR

77. The TBS system has not, to date, encountered any challenges in relation to ECHR. A key element of its compliance is the judicial review available to offenders in the TBS system every two years.

Length of stay in TBS

78. The average length of stay in the TBS system is increasing (it is now seven years). There may be two reasons why this is happening. The first relates to the increasingly serious types of offences which offenders in the TBS system have committed. The second is that diagnoses of patients in the TBS system are now more complex than hitherto.

'Treatability' of personality disorder

79. The general view amongst those we met was that personality disorder cannot be cured, but that the inclination of personality disordered offenders to offend can be treated, by addressing the particular internal conflicts within the individual patient, which cause the inappropriate/offending behaviour.

80. Twenty to 30 TBS patients have proven extremely resistant to any treatment and are unlikely ever to be released - most of this latter group are resident at the Veldzicht Clinic.

UNITED STATES OF AMERICA

81. In the USA, we visited a number of States in which Sexually Violent Predator (SVP) Legislation operates. We also visited the Patuxent Institution in Maryland, which is a prison with an emphasis on treatment programmes, and had a discussion with Professor John Monahan and others at Virginia Law School.

States operating Sexually Violent Predator programmes

82. SVP legislation of one sort or another is currently in force in 14 States. It is a civil commitment (i.e. the person is detained under mental health law) because the process is theoretically patterned on the mental health model (treatment must be provided and there is an attempt to get away from the punitive element of a custodial sentence) and, more importantly, because this avoids the legal challenges of double jeopardy and ex post facto detention.

83. Thirteen of the States operate this legislation post-incarceration (a person is considered for a SVP order towards the end of their punitive sentence). The exception is North Dakota, where the legislation allows the person to be committed from the community.

84. Washington was the first state to introduce civil commitment of sex offenders. The order was created in response to specific public demand within the State. Legislators we talked to in Washington State seemed rather surprised by the enthusiastic uptake of this idea across the States.

85. We visited Washington, Arizona and Wisconsin to discuss their various SVP programmes.

<u>Procedure for commitment</u>

86. In Arizona, a person who is due to be released within three months can be referred to the County Attorney. On the basis of an assessment of the records (and an interview, if the person consents), the Attorney decides whether to petition for commitment of the individual as a SVP. This is then reviewed by a Superior Court judge, to determine if probable cause exists to believe that the individual is a SVP. If a finding of probable cause is made, the individual is detained for an evaluation by an expert appointed by the court. (The State and the defendant can also appoint their own experts.)

87. Washington State's procedure is similar. Actuarial risk assessment tools are used to give a probability of re-offending. The results given by the actuarial tools are never clinically over-ridden (although it is not technically prohibited, and clinical judgement is used in addition to actuarial tools to make decisions on release). There is then a Probable Cause hearing where the offender's risk of re-offending must be judged to be in excess of 50% for them to be detained.

88. In Madison, the first stage is a paper screening using an assessment tool which is evaluated by a committee within the Department of Correctional Services. If the person is considered 'likely' to qualify as an SVP, a clinical evaluator does a more complete assessment. This then leads to a Probable Cause hearing. If 'probable cause' is found, the person is sent for detention at Mendota, where an evaluation

for trial is done. This then goes to court and the judge decides if the person is to be committed. Ninety-five per cent of the time, the evaluation by Mendota is decisive. The process is not totally actuarial. They do look at whether people participated in treatment and, where they received any benefit, what people said about their situation. They also look at idiosyncratic factors (such as one recent referral who was aged 95 and so felt to be of lower risk).

89. The North Dakota power of civil commitment without having to be in prison apparently means (we did not visit North Dakota) that a person with previous sexual convictions can be sent to the SVP programme on ***arrest*** for any sexual offence. In effect, the prosecutor who has a strong case would prosecute under the criminal law, but if he/she has a weaker case, he/she has the facility to use the SVP legislation to detain the person civilly for an indefinite term.

Criteria for commitment

90. The criteria for commitment were relatively similar amongst those States that we visited, although phrased in slightly different ways. All States (except North Dakota) require that the person be within a few months of release from his/her determinate prison sentence, and they also require that the person be a danger and be suffering from a mental disorder of some sort (usually broadly defined).

91. Arizona's law provides for the civil commitment of individuals convicted or found guilty except insane of a sexually violent offence, who have a mental disorder that makes the person likely to engage in acts of sexual violence. Mental disorder includes paraphilia or personality disorders predisposing the person to commit sexual acts to such a degree as to render the person dangerous.

92. Candidates for commitment under Washington's SVP legislation are those who have been convicted of a serious sexual offence, have an Axis 1 or 2 disorder and are within six months of the end of their prison sentence. The legislation was deliberately drafted so that the decision on whether to commit an offender as an SVP would be based on the likelihood of re-offending rather than the diagnostic label. Non-sexual offenders are not covered by Washington's legislation, but are instead given fixed periods of supervision.

93. There are four criteria which need to be fulfilled for someone to be committed as an SVP in Wisconsin:

1. A relevant offence.
2. A mental disorder.
3. A high risk of re-offending. The statute uses the term 'substantial probability'. There has been considerable argument over the meaning of this. Judicial authority now says that it means 'much more likely than not' - in other words, the threshold is more than 51%. Other States use 'likely', which could be a 51% probability of committing an offence. Some States would take account of 'seriousness', so that a person might be detained on, for example, a 30% probability of committing a very violent crime.
4. Being within 90 days of release from prison.

Facilities

94. The Arizona Community Treatment and Protection facility has two sets of buildings. One is a secure facility. The other is the Alamo complex, which is the 'halfway house' - the first stage in the 'less restrictive alternative' programme of graduated release into the community, which is an important part of the treatment in Arizona.

95. The SVP service in Wisconsin appears to have been developed at speed from scratch, following the passing of the SVP legislation. It was developed from the programme at the Minnesota Psychopathic Personality Treatment Centre at Moose Lake, Minnesota. Wisconsin has two State hospitals, of which Mendota is one, and, at Oshkosh, a State prison which is administered by the Division of Care and Treatment for Mentally Ill Offenders. Mendota and Oshkosh manage the programmes for sexually violent persons, under Wisconsin's SVP legislation.

96. In Washington, the SVP facility is the Special Commitment Centre (SCC), a Department of Social Health Service's Mental Health treatment facility. It is situated just offshore, on McNeil Island, and is within the walls of a different prison.

Patient profile

97. The age range of people in the Arizona facility is 18-78, with an average age of 45. Around three quarters of the residents are diagnosed as paedophiles.

98. In Wisconsin, the most common diagnosis of the inmates is also paedophilia (over 50%), followed by one third with general personality disorder and 10% with paraphilia. Ninety-five per cent of Wisconsin's SVPs come from prison, and 5% from State hospitals.

99. The SCC in Washington is split evenly between residents who have committed paedophile offences and those who have committed rape against adults.

Numbers of patients

100. All of the places that we visited indicated that numbers of inmates are rising significantly faster than predicted, which is causing problems with accommodation, programme provision and staffing. It was notable that they were all undertaking building programmes for new, larger facilities when we visited them in November.

101. However, it was commented in Arizona and Washington that, in the longer term, it is likely that fewer people will come into the SVP programme than at present, because sentences for sex offences have lengthened dramatically in recent years. In some States, there is also the effect of the 'two strikes' law to be considered, which means that a person will automatically receive a 'natural life' sentence for their second sexually violent offence.

Treatment programmes

102. All of the States we visited based their treatment programmes on a thorough intake assessment and regular assessments throughout the treatment programmes. There was plentiful use of techniques such as penile plethysmography and polygraphy throughout. An individualised treatment programme is then drawn up.

103. Treatment in Phoenix is a six-stage programme based on research which suggests that there is no 'cure' for sex offending, but that there is effective treatment for many, if not all, offenders. The programme uses a relapse prevention model, using a cognitive behavioural therapy approach, and with the lead taken by psychologists.

104. The Washington SCC's standard programme is an extremely detailed four-year treatment programme, essentially cognitive behavioural in nature, with detailed attainment goals for promotion towards release. No-one has yet completed it, and, in fact, only about 30% of the total population is actually participating in the full programme.

105. Wisconsin's programme appeared to consist of a number of education modules, including sex education and some cognitive skills, and some therapy models such as victim empathy, conflict resolution etc. The programme is evolving, as the numbers of patients is rising almost exponentially.

Discharge and community supervision

106. The States are all subject to the principle of the least restrictive alternative, which means that if, on appeal, the judge agrees that an offender could be held in lesser security, this must be done.

107. In Wisconsin 11 people had left the programme, all on supervised release. They were all released by judges against the recommendation of the Mendota Institute. On release from Wisconsin's facilities, there is an extremely long list of conditions with which the person has to comply indefinitely.

108. In Washington the first people approved by the SCC for release were to leave within six months of our visit. However, four offenders have already been released, all contrary to the SCC's recommendation. People who are released from the SCC are also subject to stringent controls in the community, although this community supervision is time limited.

109. Phoenix appeared to have the most co-ordinated release programme. The three levels of custody, a halfway house and discharge into the community were operated by a single agency. No-one had yet progressed to the community, but residents of the halfway house had an active community presence. Most had jobs or college placements, but were subject to intensive monitoring and continued participation in treatment programmes.

Community notification

110. Arizona has a version of 'Megan's Law', which means that sex offenders being released into the community are notified to the State police, who then notify the neighbourhood. The police hold public hearings, and these are often run on local TV. There are also Internet sites identifying sex offenders.

111. Wisconsin and Washington also have strict community notification laws which must be met. Washington claims to be a leader in the field of controlled community notification - their notification takes place by way of public meetings but the aim is to explain the controls that surround SVPs on release. However, doubt was cast on the effectiveness of this approach at the meeting with State prosecutors in British Columbia.

Other issues raised at SVP facilities

Patients' rights

112. One particular problem faced by staff in Wisconsin and Washington is that of the rights of people held under SVP legislation. As SVPs they are technically detained under the States' respective Mental Health Codes, which ensures them certain privileges not given to those in prison. They are therefore permitted unrestricted access to mail and phone calls, which has proven extremely problematic.

113. Wisconsin is looking at ways to restrict patients' rights to a level more appropriate to sexual offenders with personality disorders rather than to mentally ill people. This would involve having two different mental health classifications, one being people with 'victim dependent disorders', and another being the 'vulnerable mentally ill'.

Treatment refusers

114. Non-compliance with treatment is a serious problem in all facilities, as treatment refusers tend to be the most psychopathic of patients and disrupt the facility and other patients.

115. In Wisconsin they have separated out what they call 'behaviourally problematic treatment refusers' from the rest of the people on the SVP programme. They are looking at trying to provide incentives for treatment, by scaling down the privileges of treatment refusers.

116. In Washington, 40% of residents are not in treatment. They are offered some other, educational, activities but recently had to be separated off from the rest of the residents because of concerted group attempts to sabotage the programme.

117. In Arizona, inmates are entitled to refuse treatment, but those who are in treatments get the best facilities and more privileges. Inmates who refuse are asked again every 60 days. About 20 or 30% refuse treatment or drop out.

Qualification as SVP

118. In Wisconsin it was notable that people who have committed paedophile offences will almost automatically qualify as SVPs since this offence is taken to be ***in and of itself*** conclusive of three of the four necessary factors that diagnose someone as an SVP -namely, it is a relevent index offence, it indicates the presence of mental disorder (since they are prepared to diagnose paedophilia as a mental disorder), and there will normally be a high score for risk.

Mental health

119. One problem faced by the SCC in Washington is that, because it is technically a psychiatric hospital (although a prison to all intents and purposes), people who genuinely have mental illnesses are not permitted to go to a more appropriate psychiatric facility for treatment. There are therefore three patients who are floridly psychotic and 24 other people on psychotropic medication at the SCC. This is cause for some concern amongst staff. Some 33% of residents have been removed from the mainstream treatment programme and are now in the Special Needs Programme because they have learning or emotional deficits or mental health problems.

Problems on release

120. There are at least three agencies involved in every case of release from Wisconsin's facilities, and there are considerable issues of co-ordination and accountability. There are also severe problems in finding accommodation and employment for these individuals.

Maryland - Patuxent Institution

121. The Patuxent Institution is a prison, but it operates at one remove from other prison and mental health institutions in Maryland. It has its own legislative base and its own parole procedure. The model appears to be unique in the US (other treatment-based forensic services are either in mental health institutions or based around the sexual predator legislation). The 750 people in Patuxent (of whom 90 are women) are part of a total prisoner population of 23 000 in Maryland. Eighty-five per cent of the inmates in the institution have been sentenced for violent crime, with others in for crimes such as large-scale drug dealing.

122. The population served by the Institution is highly selective. Apart from young people, who can be sent there against their will, prisoners must volunteer to come. It would appear that there is considerable demand for places, at least partly because the facilities are somewhat better than in other prisons.

123. To be eligible for the Institution, prisoners must have an intellectual impairment or 'emotional imbalance'. This appears to be a slightly broader term than personality disorder, but it was said that most of the prisoners would have severe personality disorders, mostly ASPD. Because the programme at Patuxent lasts a long time (normally 7 to 12 years), prisoners must be serving a long sentence and have a significant part of this remaining.

<u>Treatment</u>

124. Patuxent follows a multi-disciplinary team approach involving Remediation Management Teams (RMTs), comprising one psychologist, a social worker, a prison officer and a psychiatrist for each prisoner. Each prisoner has an individually based programme, with an annual review. Essentially, the programme would seem to be a mixture of some psycho-dynamic group work and a selection from a range of individual treatment programmes.

125. The assessment process is directed towards screening out people with high psychopathy scores, who are viewed as likely to get worse through treatment and also as dangerous to the system.

126. There is an annual review of each case by a Board, which consists of four staff from the facility and five lay members. There is a Conditional Release Programme which works on a series of levels. The last stage is parole to the community, which is also decided upon by the Board.

<u>Information availability</u>

127. Staff at Patuxent claim to have access to a fairly full range of information about offenders' backgrounds. It is acknowledged that the crime for which a person is convicted may often be reduced as a result of plea-bargaining. However, staff have access to police reports and other information, and staff tend to assume that the

person did what they were charged with, not what they were convicted of. Also, through participation in the programmes, other information about past behaviour often emerges.

Recidivism

128. No-one has been re-arrested in the last three years who has been released into the community. There is a 7% return for parole violations, mostly drug related. This compares with a 42% re-arrest rate for the mainstream services. This is unlikely to be due solely to the efficacy of treatment, but due also to the long time served, the close level of supervision and perhaps the self-selecting nature of the group.

129. Maryland State has a community-based Sex Offender Programme, which involves weekly group work, which seems to be quite successful in maintaining people in the community. This has been going for 25 years and recidivism is 8% for any offence and 3% for sexual offences.

Sex Offenders' Register

130. The Sex Offenders' Register has been in operation since 1994. It is held by the police, and is public, thus vigilante behaviour and victimisation cause considerable problems for offenders and the parole system.

SVP in Maryland

131. There was an attempt to introduce a SVP-type indefinite commitment in Maryland, but this was defeated in the legislature. Part of the reason was that such offenders, if committed civilly, would have had to be housed in a secure psychiatric facility, when psychiatric intervention seemed to legislators to be inappropriate for people with personality disorders, and the State's forensic psychiatry service was already severely over-stretched.

1. Virginia Law School: Discussion

132. In addition to visiting facilities in the USA, we also had a most useful discussion at Virginia Law School with three experts in psychology and the law: Professors John Monahan, Richard Bonnie and Steven Morse. The following topics were part of the wide-ranging discussion.

Risk assessment

133. Risk assessment has greatly improved because of the introduction of structured instruments for risk. In North America, the VRAG is probably the 'gold standard'. There is an active debate between those who advocate an actuarial approach modified by clinical judgement, and those who support a purely actuarial approach.

134. Because many factors which indicate risk do not change, except age, it is difficult for offenders to show that risk has reduced. However, there is evidence that close community supervision can be effective.

Dangerous offenders legislation

135. If a special sentence is required, it was suggested that it should be in the criminal justice system. There is no strong evidence that treatment of the most dangerous group will reduce risk, so the purpose of detention is incapacitation.

136. Nevertheless, there is an ethical duty to help people so detained, provided there are plausible treatments. There is work that can be done with sexual and violent offenders, particularly on specific areas of concern, such as substance abuse.

137. There are strong arguments for 'getting the sentence right' at the start, rather than introducing a new disposal at the end of a sentence. Most factors relevant to risk assessment could be known at the time of sentencing.

Personality disorder and detention

138. Detention on the basis of risk was to be preferred to detention on the basis of a diagnosis of personality disorder. Many high risk individuals were not personality disordered, and many personality disordered people were not high risk.

Sexual predator legislation

139. There was concern that civil commitment for 'sexually violent predators' has the potential to do great damage to the public mental health system by dumping sex offenders into mental hospitals. This creates a risk to people who are genuinely mentally ill.

140. Sexual predator legislation tends not to be constrained by costs, because of political concern, and so considerable amounts of resources are being eaten up by it. In general, it tends to be introduced following a single high profile case.

Megan's Law

141. Sex Offender Notification Legislation ('Megan's Law') is widespread throughout the States. It tends to work on a model of levels of risk. High risk will involve everyone in the community being notified. Medium risk will involve child care agencies being notified, and low risk will involve the police only being notified. There is a danger of over-estimation of risk, because of the potential for criticism if anything goes wrong. There does not appear to be any research evidence that the law protects the public, and some concern that it leads to vigilante behaviour.

ANNEX 5

RESPONDENTS TO THE COMMITTEE'S CONSULTATION PAPER

Social work

Local authority social work departments

Aberdeenshire Council Social Work Department

Angus Council Social Work Department

Clackmannanshire Council Social Work Department

East Ayrshire Council Social Work Department

East Renfrewshire Council Social Work Department

Falkirk Council Social Work Services

Fife Council Social Work Services

North Ayrshire Council Social Services

North Lanarkshire Council Department of Administration

Orkney Islands Council Department of Community Social Services

Perth & Kinross Council Social Work Services

Renfrewshire Council Social Work Department

South Ayrshire Council Community Services

South Lanarkshire Council Social Work Resources
(Mr Sandy Cameron, Executive Director)

South Lanarkshire Council Social Work Resources
(Mr Edward Finlayson, Team Manager)

Stirling Council Criminal Justice Service, Housing and Social Services

The City of Edinburgh Council Social Work Department

The Moray Council Community Services Department

West Dunbartonshire Council Department of Social Work and Housing

West Lothian Council Community Services

Professional organisations

Association of Directors of Social Work

British Association of Social Work

Law

Individual lawyers

McCourts Solicitors

Legal academics

Claire Connolly, University of Glasgow - Centre for Research into Law Reform

Professional organisations

Faculty of Advocates

The Law Society of Scotland

The Sheriffs' Association

Medical/Psychological

Health Boards

Borders Health Board

Highland Health Board

Professional organisations

British Medical Association
(Scottish Office)

The Royal College of Psychiatrists (Scottish Division), Forensic Section

The Royal College of Psychiatrists (Scottish Division), General Psychiatry Section

The Royal College of Psychiatrists (Scottish Division), Psychotherapy Section

NHS Primary Care Trusts

Ayrshire and Arran Primary Care Trust

Greater Glasgow Primary Care NHS Trust

Lomond & Argyll Primary Care NHS Trust, Mid Argyll/Mental Health Directorate

Lothian Primary Care NHS Trust (Royal Edinburgh Hospital)

Lothian Primary Care NHS Trust (St Roque Astley Ainslie Hospital, Edinburgh)

West Lothian NHS Trust (Bangour Village Hospital, Broxburn)

Nursing

Ayrshire and Arran Primary Care NHS Trust, Mental Health & Learning Disabilities Nurses Forum

Royal College of Nursing (Scotland)

Psychiatry (individual responses)

Dr A.V.P Mackay, Consultant Psychiatrist, Argyl & Bute Hospital

Dr Lindsay D.G. Thomson, Honorary Consultant Forensic Psychiatrist, The State Hospitals Board for Scotland

Dr W. Black, Consultant Forensic Psychiatrist, The State Hospitals Board for Scotland

Dr John Crichton, Specialist Registrar in Forensic Psychiatry, The State Hospitals Board for Scotland

Dr Steven Young, Consultant Psychiatrist, The State Hospitals Board for Scotland

The State Hospital

The State Hospitals Board for Scotland

Dr John D. McGinley, Director of Psychology, Forensic Clinical Psychology Service, The State Hospitals Board for Scotland

Local Health Councils

Borders Local Health Council

Mental health

Mental Welfare Commission for Scotland

Mental health voluntary sector

Glasgow Association for Mental Health

National Schizophrenia Fellowship (Scotland)

Scottish Association for Mental Health

Police/Prison

Parole Board

Parole Board for Scotland

Police professional organisations

Association of Chief Police Officers in Scotland

Scottish Police Federation

The Association of Scottish Police Superintendents

Prison

Scottish Prison Service (Ms Morag Slessor, Department of Psychological Servcies)

Scottish Prison Service (Main SPS response sent in by Mr J. Durno, Director of Custody)

Scottish Prison Service (Mr Alec Spencer, Governor, HM Prison, Edinburgh)

Voluntary sector

Offender voluntary sector

Safeguarding Communities Reducing Offending (SACRO)

Housing/homelessness

Association of Home Visiting

Chartered Institute of Housing in Scotland

Orkney Housing Association Limited

Scottish Council for Single Homeless

Special interests

Children 1st

Equality Network

The Scottish Human Rights Centre

Victim voluntary sector

Justice for Victims (Scotland)

Victim Support Scotland

Young Women's Project

Others

Other individuals

Ms Elaine Clark

Ms Libby Coe

Mr Keith Cowan

Ms J. Freewood

Mr Sandy McCormish, University of Stirling

Mr Steven C. Menzies

Oral evidence given at meetings of the MacLean Committee

Speaker	Subject of oral evidence
Mr Mike Boyle Home Office	English proposals for severe personality disorder
Mr Sandy Taylor Civil & Criminal Justice Statistics Unit	Statistical information on convictions for serious sexual and violent crimes
Dr Anne MacDonald Department of Health Management Executive	Services for mentally disordered offenders
Dr Stephen Hart Associate Professor of Psychology, Simon Fraser University, British Columbia, Canada	Outline of his work and overview of risk assessment and psychopathy and relation to violence within the Canadian context
Dr Chris Freeman Consultant Psychiatrist Lothian Primary Care NHS Trust	The natural history of personality disorder, drug treatments and psychological treatments
Ms Roisin Hall & Ms Morag Slessor, Scottish Prison Service	Violent and sexual offending and risk assessment

Oral evidence given to MacLean Committee Services Sub-Group

Speaker	Subject of oral evidence
Mr D Miller and Ms C. Orr City of Edinburgh Social Work Criminal Justice Services Department	Offenders with and without personality disorder with regard to services available to such offenders, how these individuals are cared for in the community and discharging arrangements

ANNEX 6

CURRENT RISK ASSESSMENT INSTRUMENTS

Professor David Cooke

The actuarial approach to risk assessment

Violent re-offending

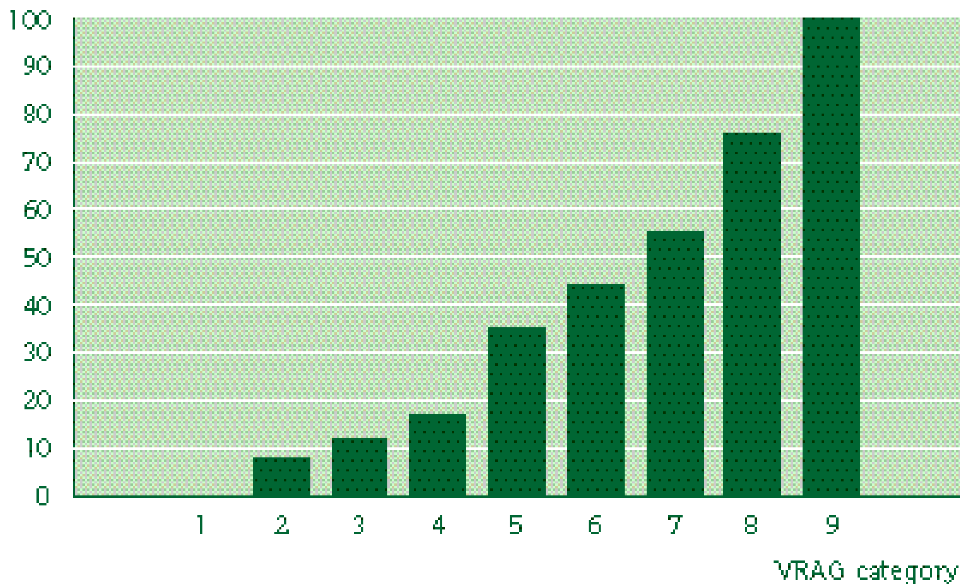
1. The actuarial approach 'involves a formal, algorithmic, objective procedure (e.g., equation) to reach the decision' (Grove ***et al.***, 1996, p. 293). The most widely used actuarial scale for the prediction of violence is the Violence Risk Assessment Guide (VRAG) (Webster, ***et al.***, 1994; Quinsey et al., 1998). This scale was developed using data from a cohort of patients detained in a Canadian secure hospital between 1965 and 1980. Follow-up data pertaining to violent behaviour were collected from Royal Canadian Mounted Police files; violent behaviour ranged from assault to murder. Hospital records were reviewed and potentially relevant variables were coded; the relationships between these variables and violent outcome were determined statistically. Twelve variables that demonstrated stable relationships across samples were retained. Variables were retained on the basis of statistical criteria: theoretical arguments about the role of these variables in 'producing' violence were not taken into account. These variables included Hare's Psychopathy Checklist Score (Hare, 1991), age at index offence, degree of victim injury and history of alcohol abuse: a full list of items is provided in Table 1 below.

Table 1

	Items used in the VRAG	Predictive direction of variable
1	Psychopathy Checklist (PCL-R) Score	+VE
2	Elementary School maladjustment	+VE
3	DSM-III diagnosis of personality disorder	+VE
4	Age at index offence	-VE
5	Lived with both parents to 16 (except for death of parent)	-VE
6	Failure on prior conditional release	+VE
7	Non-violent offence score	+VE
8	Marital status	+VE
9	DSM-III diagnosis of schizophrenia	-VE
10	Victim injury	-VE
11	History of alcohol abuse	+VE
12	Female victim	-VE

2. An algorithm is applied to weight an individual's scores on the twelve variables, e.g. psychopathy contributes more to the overall score than marital status. The overall score is used to assign individuals to one of nine risk categories ('bins'); members of each category having a different likelihood of re-offending. The distribution of risk categories is illustrated in Figure 1 below.

Figure 1: Probability of violent recidivism at seven-year follow-up by VRAG category



3. For example, 33% of the individuals who were in VRAG category 5 recidivated violently within seven years, whereas 100% of those in VRAG category 9 recidivated violently within seven years.

4. The process by which the key variables of the VRAG were derived resulted in some unexpected relationships between variables and risk of violent recidivism. For example, a DSM-III diagnosis of schizophrenia was negatively related with violence. This is contrary to the available evidence which indicates that schizophrenia has a small but significant relationship with future violence (Douglas & Hart, 1999). This anomalous relationship may reflect the sample composition; compared to psychopaths - the other major diagnostic group in the sample - the violence risk of the schizophrenics was lower. Similarly, those who killed female victims, and those who inflicted greatest injury in the index offence (i.e. killed), were less likely to re-offend than those who inflicted less injury or had male victims.

5. The VRAG has been subject to criticism (e.g. Hart, 1999): three criticisms stand out. First, risk is conceptualised in a limited fashion, i.e. the absolute probability of violent recidivism over a seven or ten year time period; important dimensions of risk - from a risk management perspective - including the nature, severity, frequency and imminence of future violence are not encompassed by this approach. Second, the prediction, for example, that patient X has an 82% probability of re-offending violently within 10 years of release does little to assist the clinician in deciding how to manage the patient's risk. Third, in the most recent account of the VRAG and its application (Quinsey ***et al.***, 1998), the authors suggest that assessors ignore risk factors not included in the VRAG. As Hart (1999) indicated, assessors would be

negligent if they ignored variables such as prior history of violence or homicidal ideation and threats: variables that have been shown to be linked to violence (e.g. Grisso ***et al.***, unpublished).

Sexual re-offending

6. Several actuarial approaches have been developed for the prediction of recidivism amongst sex offenders. These include the Sex Offender Risk Appraisal (SORAG) (Quinsey ***et al.***, 1995), Rapid Risk Assessment for Sex Offence Recidivism (RRASOR) (Hanson, 1997) and Static-99 (Hanson & Thornton, 1999). The SORAG is an extension of the VRAG for sexual offenders, the major modification being the addition of items to measure sexual deviance. The additional variables include number of previous convictions for sex offences, history of sex offences against male children or adults, and phallometrically determined sexual deviance score. The variables utilised in the RRASOR and Static-99 are listed in Table 2 below.

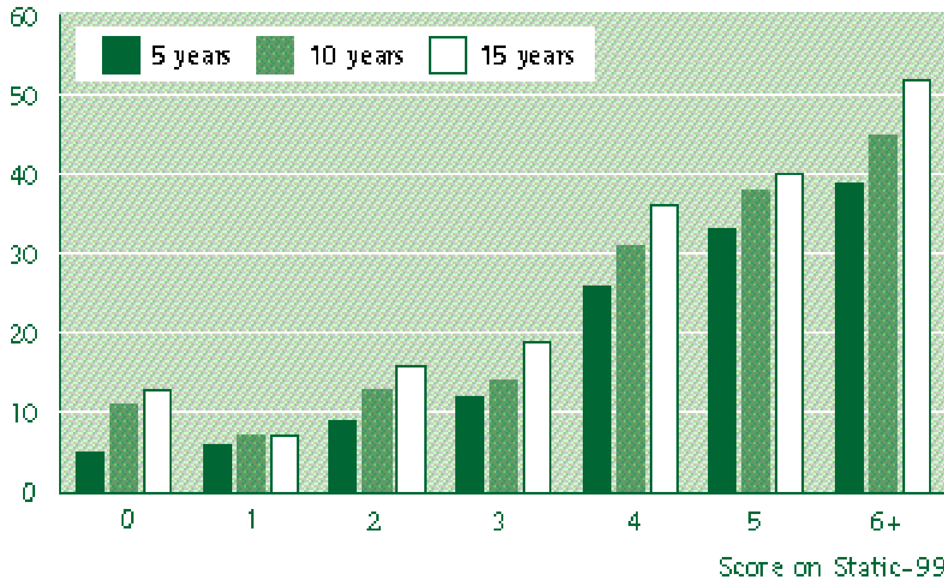
Table 2

Type of risk factor	RRASOR	Static-99
Sexual deviance	Male victims	Male victims Never married Non-contact sex offences Unrelated victims
Range of potential victims	Unrelated victims	Unrelated victims Stranger victims
Persistence	Prior sex offences	Prior sex offences
Antisociality		Current non-sexual violence Prior non-sexual violence 4+ sentencing dates
Age	18-24.99 years	18-24.99 years

7. In a meta-analytic study, Hanson and Bussiere (1998) identified a number of risk factors that were reliably linked to sexual re-offending. Based on this research, the RRASOR was developed as a screening instrument for predicting sexual re-offending. The instrument was developed using Canadian samples but, importantly, it has been shown to cross-validate to a large sample from H.M. Prison Service. The Static-99 was developed in an attempt to improve on the success of the RRASOR, more indicators of both sexual deviance and antisociality being included. The variables included are consistent with theory about factors which contribute to sexual offending. Data from four samples indicates that the Static-99 is a

significantly better predictor of sexual re-offending than the RRASOR. The relationship between reconviction (over 5, 10 and 15 years) and score on the Static-99 is illustrated in Figure 2 below.

Figure 2: Sexual reconviction by Static-99 score (%)



8. Of individuals who fall in the top category (12% of original sample), 39% were reconvicted of a sexual crime within five years, 52% being reconvicted within 15 years.

9. The authors of the VRAG argued that predictions should be based purely on actuarial scales: the authors of the Static-99, by way of contrast, indicated that information about dynamic risk factors (i.e. risk factors that are potentially alterable through management or treatment) should be used to influence final risk ratings. It is noteworthy, however, that Hanson and Thornton (1999) argued that 'in most cases, the optimal adjustment would be expected to be minor or none at all' (p. 18).

10. A more recent approach to actuarial prediction is to use a classification tree (Monahan ***et al.***, 2000; Steadman ***et al.***, 1999). The assessor is guided through a series of binary decisions and arrives at an empirically derived estimate of future risk. For example, on the first step the assessor allocates individuals on the basis of their score on the Psychopathy Checklist: Screening Version (PCL:SV); 35.7% of the high scorers engaged in violence in the 20 week follow-up compared with 12.6% of the low scorers. Of those high PCL:SV scorers, 41.1% of those who reported serious child abuse engaged in violence in the 20 week follow-up period, compared with 15.4% of those who did not report serious child abuse. Thus, contingent on each response another question is posed until individuals are classified as being either high or low risk. This approach has the advantage over the VRAG in that the variables selected for inclusion in the model were selected ***a priori*** as having a theoretically meaningful, and empirically based, relationship with future violence. The method has the disadvantage of only identifying high or low risk individuals; a group of individuals remain unclassified. It is these individuals, whose risk level is equivocal, with whom the assessor needs most assistance.

The structured clinical approach

11. The HCR-20 is the best known, and best researched, empirically-based guide to risk assessment: it was developed, not only by examining the research literature to determine which variables are salient in the prediction of violence, but also through consultation with experienced forensic clinicians. The HCR-20 entails twenty items: ten **H**istorical items, five **C**linical items and five **R**isk management items (see Table 3 below for a complete list).

Table 3: Items in the HCR-20 risk assessment scheme

SUB-SCALES	ITEMS
Historical Scale	
H1	Previous violence
H2	Young age at first violent incident
H3	Relationship instability
H4	Employment problems
H5	Substance use problems
H6	Major mental illness
H7	Psychopathy
H8	Early maladjustment
H9	Personality disorder
H10	Prior supervision failure
Clinical Scale	
C1	Lack of insight
C2	Negative attitudes
C3	Active symptoms of major mental illness
C4	Impulsivity
C5	Unresponsive to treatment
Risk Management Scale	
R1	Plans lack feasibility
R2	Exposure to destabilszers
R3	Lack of personal support
R4	Non-compliance with remediation attempts
R5	Stress

12. The HCR-20 was designed to provide empirically-based structured clinical guidance in relation to the assessment and management of individuals who are potentially violent. It is designed to be used in a wide range of settings including community, hospital and prison settings. It is designed to be testable in terms of reliability and validity.

13. Research studies are now becoming available from Canada and Sweden: as yet none are available in Scotland, or, more widely, in the United Kingdom. Research on the HCR-20 has been carried out in civil psychiatric, forensic psychiatric, and prison samples. Douglas & Webster (in press) found that the HCR-20 total scores predicted violent crime within a sample of 193 civil psychiatric patients released from hospital. In this study, those who scored above the median on the HCR-20 total score were 13 times more likely to be arrested for a violent offence following release from hospital than were those who scored below the median. In an unpublished thesis, Klassen (1999) found that the H scale of the HCR-20 was related with moderate strength (correlations averaging 0.30) to the in-patient violence of civil psychiatric patients.

14. In a retrospective study, Douglas ***et al,*** (1999) found that forensic psychiatric patients who scored high (i.e. greater than the median score) on the HCR-20 were five times more likely to have engaged in previous violent behaviour than those scoring below the median. Strand ***et al.*** (1999), in a retrospective study of mentally disordered offenders, found that the HCR-20 was related to violence; they obtained moderate to large effect sizes. Wintrup (1996) determined that HCR-20 total scores were related, with moderate strength, to community violence committed by forensic psychiatric patients after release from a secure forensic facility.

15. There have now been two small studies in prison settings. In a retrospective study of correctional inmates, the HCR-20 H scale correlated strongly (0.53) with the number of charges for violent arrests, while the C scale was related with moderate strength (0.30) to this same dependent measure (Douglas & Webster, 1999). In this study, persons who scored above the median on the HCR-20 were, on average, four times more likely than those scoring below the median to have been charged with a violent offence in the past, to have been violent in the institution, and to have attempted or succeeded in escaping from prison. In a small Swedish prison study (n = 41), Belfrage ***et al,*** (1999) found that the clinical and risk management items were highly predictive of institutional violence. These results suggest that the HCR-20 shows considerable promise for the prediction and management of individuals who pose a risk of future violence.

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ANNEX 7

CURRENT SENTENCING OPTIONS AND RELATED ORDERS

Prison sentences

Mandatory life sentence

1. The life sentence must be imposed in cases of murder. When passing a mandatory life sentence a judge may make a recommendation as to the minimum period which should elapse before Scottish Ministers release that person on licence. (There are different procedures for persons convicted of murder when under the age of 18.

2. Scottish Ministers may only release an adult mandatory life prisoner if they have a recommendation to do so from the Parole Board and after consulting the Lord Justice General and, if available, the trial judge. Even in these circumstances, Scottish Ministers are not bound to release the prisoner.

3. The decision about when to refer a case to the Parole Board for the first time is taken by Scottish Ministers on the advice of a non-statutory body - the Preliminary Review Committee - which first considers a case at around the four-year stage.

4. Scottish Ministers will specify conditions for any mandatory life prisoner released on licence, and will take into account any recommendations made by the Parole Board. The licence remains in force for the remainder of the prisoner's life and he or she is liable to be recalled to custody for breach of licence conditions. The conditions of a life licence, including the supervision requirements, may be varied or cancelled in the light of the supervision reports received on a prisoner's behaviour in the community.

5. Section 1 of the Crime and Punishment (Scotland) Act 1997 provides for an automatic life sentence in certain situations - essentially where a person is convicted of two or more serious offences. This Section has not been implemented.

Discretionary life sentences

6. A discretionary life sentence may be imposed by the High Court for all common law crimes and certain statutory offences.

7. When a discretionary life sentence is imposed, the minimum time to be served in custody for punishment and deterrence (the'designated part) is set by the court. The 'designated part' is calculated according to the following key principles[1]:

   (a) the period selected must be the minimum period which the prisoner should actually serve in prison as a punishment for his/her crime before he/she can be released;

   (b) the designated period should normally bear a fair and reasonable relationship to the minimum period which a prisoner would actually serve under a determinate sentence imposed in circumstances which were similar (although lacked the special requirement of public protection which has led to the life sentence); and

[1] As set out by the High Court in the case of O'Neill v HM Advocate (1999) SCCR 300

(c) the designated part of a discretionary life sentence should, in the usual case, be set at one half of the period of custody which is considered appropriate purely as a punishment for the crime.

8. Once the designated part is served, the decision on whether or not the person requires to continue to be confined for the protection of the public is determined by the Parole Board (sitting as a Designated Life Tribunal). Where the Board directs release, Scottish Ministers are obliged to implement the direction. Where the Board does not direct release, the prisoner is entitled to another review in a further two years, but his/her case may be reviewed earlier if the Board so recommends and Scottish Ministers so agree.

9. As with adult mandatory life prisoners, release in such cases is on licence and is subject to recall. However, the grounds for recall are narrower than for a mandatory life sentence, and must be based on public protection.

Determinate sentences

10. The current system governing parole and the early release of long-term prisoners was introduced under the Prisoners and Criminal Proceedings (Scotland) Act 1993.

11. For long-term prisoners (defined as those sentenced to four years or more), once one half of the sentence has been served a prisoner is eligible for consideration for parole. Decisions on release of all prisoners sentenced to terms of more than four but less than 10 years are taken by the Parole Board. Decisions on those sentenced to 10 years or more, whose early release has been recommended by the Parole Board, are taken by Scottish Ministers. Once two thirds of the sentence has been served, all prisoners must be released, subject to any extra days added for misconduct in prison.

12. Prisoners on licence (which means both prisoners granted parole, and those released on non-parole licence after serving two thirds of their sentence) are liable to be returned to prison by the court to resume serving their original sentence if convicted of a further offence punishable with imprisonment before their original sentence has expired.

13. All licences contain standard conditions, including keeping in touch with the supervising officer and being of good behaviour and keeping the peace. Additional conditions may be imposed by Scottish Ministers, after consultation with the Parole Board. All prisoners released on licence are liable to recall to custody by Scottish Ministers for breach of licence conditions.

14. A court passing sentence of up to four years, in cases on indictment, may impose a supervised release order requiring the person to be under the supervision of an authority designated by Scottish Ministers on release from custody. The criterion for the imposition of such an order is that the supervision is required to protect the public from serious harm on the release of the offender. The duration of the supervision cannot exceed 12 months, or extend beyond the date on which the full term of imprisonment has elapsed. Supervised release orders are no longer an available disposal for those convicted of sex offences committed on or after 30 September 1998.

Extended sentences

15. Sections 86-88 of the Crime and Disorder Act 1998 introduced 'extended sentences', which include additional post-release supervision for sexual and violent offenders. They enable the courts to add a period of extended post-release supervision to the sentence it would normally impose.

16. The criterion for imposing the extended sentence is that any existing supervision to which the offender is liable would not be adequate to protect the public from the risk of serious harm.

17. An extended sentence can be imposed in indictment cases:

    - on sex offenders who would have received a determinate custodial sentence of any length; or
    - on violent offenders who would have received a determinate custodial sentence of four years or more.

18. The extended sentence has two parts: the custodial sentence the offender would have received for the offence (the 'custodial term'); and the additional period of supervision (the 'extension period').

19. The duration of an extended sentence is the aggregate of the custodial term and the extension period. The 'extension period' is in addition to any licence period to which a long-term prisoner may be subject. The offender is on licence up to the end of the extension period.

20. The maximum length of the extension period is 10 years for sex offenders and five years for violent offenders. Two other restrictions apply:

    - if the sentence is imposed by a sheriff sitting with a jury, the maximum extension period is restricted to three years; and
    - the maximum length of the whole extended sentence cannot exceed the statutory maximum penalty for that offence.

21. If, while on licence, the offender behaves in such a way as to suggest that he/she presents a risk of serious harm to the public, Scottish Ministers have the power to revoke his/her licence and recall him/her to custody. The offender then has the right to require the case to be referred to the Parole Board, which must order his/her release if it is satisfied that his/her continued detention is not necessary on public protection grounds.

Community disposals

Registration of sex offenders

22. The Sex Offenders Act 1997 requires persons who have committed certain sex offences, including discharged patients where appropriate, to register their name, address and date of birth with the police. The duration of notification requirements depends on the length of sentence or disposal. Failure to notify, or false notification, is an offence punishable on summary conviction by a fine and/or imprisonment for up to six months.

Sex offender order

23. Section 20 of the Crime and Disorder Act 1998 created a new civil order - the sex offender order. The police can apply for an order against anyone with a conviction for a sex offence whose present behaviour in the community gives them reasonable cause for concern that an order is necessary. The order may impose any prohibitions on the person's behaviour which are considered necessary to protect the public from serious harm. The orders require sex offenders to register under the Sex Offenders Act 1997 while they are in effect. Breach of an order without reasonable excuse is a criminal offence with a maximum penalty on indictment of five years in prison.

Restriction of liberty order

24. Restriction of liberty orders, introduced under Section 5 of the Crime and Punishment (Scotland) Act 1997, include provision for the electronic monitoring of offenders. The maximum length of a restriction of liberty order is 12 months.

Probation

25. A probation order can last between six months and three years, and provides for community-based supervision. Specialised probation programmes may be provided and specific conditions may be attached to the probation regarding, for example, the undertaking of unpaid work; place of residence; curfew times; financial recompense to the victim. Any further offending behaviour is a breach of the order and the offender is returned to the courts.

Other orders

26. Other orders which can be imposed include antisocial behaviour orders and non-harassment orders.

Mental health disposals

Hospital order

27. A court may make a hospital order, under which a convicted person will be detained in a psychiatric hospital, if the court is satisfied that the person meets the criteria for detention in hospital under the 1984 Act, and that it is necessary for his/her health and safety or the protection of the others that he/she should receive such treatment.

28. A hospital order has no specified duration. The responsible medical officer is under an obligation to discharge the patient once he/she is satisfied that the patient no longer meets the criteria for detention. It is also possible (though rare) for the Mental Welfare Commission to discharge the patient.

29. The hospital order falls to be renewed after six months and one year, and annually thereafter. On renewal, the patient can appeal to the sheriff for discharge, on the grounds that the criteria for detention no longer apply.

30. Throughout, the criteria for continuing detention are the same as for civil mental health legislation. These relate to the person's continuing need for treatment. The nature of the original offence is irrelevant, except insofar as it is evidence of the person's mental state and level of risk presented if the patient should relapse.

<u>Restriction order</u>

31. If the court considers it necessary for the protection of the public from serious harm, a person subject to a hospital order may also be made subject to a restriction order. He/she will then be subject to the special restrictions set out in Section 62 (1) of the Mental Health (Scotland) Act 1984. Restriction orders are without limit of time.

32. The patient's management, including transfer, leave of absence and discharge, is the responsibility of Scottish Ministers who receive regular reports from the patient's responsible medical officer.

33. The patient can appeal to the sheriff to be discharged, between six and 12 months after the order, and once in every 12 months thereafter.

34. Under the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, if a person is suffering from a mental disorder (which under the provisions of the Act explicity includes personality disorder), whether medical treatment is required or not, and if the sheriff is satisfied that continued detention in hospital is necessary to protect the public from serious harm, he/she must refuse an appeal against the person's detention. Prior to this Act coming into force, the grounds for continued detention were similar to those for a civil detention or a hospital order without restriction, being based on the continuing need for treatment. Where a restricted patient does not present a serious risk of harm, these criteria continue to apply.

35. If satisfied that it is appropriate that the patient remain liable to be recalled to hospital, the sheriff can order a conditional discharge. The sheriff may specify conditions, which can subsequently be varied by Scottish Ministers.

36. Scottish Ministers can discharge a restricted patient if satisfied that the order is no longer necessary for the protection of the public from serious harm. Alternatively, Scottish Ministers may discharge the patient subject to certain conditions. In that event, the patient remains liable to be recalled at any time, although the European Convention on Human Rights case of Kay v UK[2] established that there must be evidence of mental disorder to justify recall.

<u>Hospital direction</u>

37. Hospital directions allow a person who is convicted of an offence and sentenced to imprisonment, but who is mentally disordered and requires treatment in hospital, to be sent straight to hospital.

38. The hospital direction remains in force until the person is considered by his/her Responsible Medical Officer to no longer require detention in hospital for treatment, or until the expiry of the prison sentence.

39. If the patient does not pose a risk of serious harm, and should his mental state improve so that he no longer requires to remain in hospital for medical treatment, he will be discharged under the 1984 Act and transferred to prison to serve the remainder of his sentence (if any) or discharged direct from hospital if his sentence has expired. Whilst the hospital direction remains in force, the Mental Health (Public Safety and Appeals)(Scotland) Act gives Scottish Ministers the power to order that the person remain in hospital if a danger to the public and suffering from a mental disorder (which need not require treatment).

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[2] Kay v United Kingdom, Application No 17821/91: Report of the European Commission of Human Rights adopted on 1 March 1994

40. If the person's mental health subsequently deteriorates on return to prison he may be transferred to hospital by way of a transfer direction. Should the grounds for detention continue to apply after the expiry of the prison sentence, the patient's responsible medical officer may make an application for his/her continued detention in hospital under the Mental Health (Scotland) Act 1984.

Other mental health disposals

41. In addition to these sentencing options, there is a range of procedures under which prisoners serving sentences or awaiting trial can be transferred to hospital if they are mentally disordered: both under the Mental Health (Scotland) Act 1984 and the Criminal Procedure (Scotland) Act 1995. Also, the court can, before making a final disposal, make an interim hospital order, if there is reason to believe that a hospital order naming the State Hospital might be made. The interim order lasts for up to 12 weeks and can be renewed for up to 28 days at a time, with a maximum total duration of 12 months.

42. Other disposals which can be made at sentencing include guardianship under the 1984 Act (guardianship will continue as an option under the Adults with Incapacity (Scotland) Act 2000 when introduced) and, for accused persons found either not guilty by reason of insanity or insane in bar of trial, a hospital order; a hospital order and restriction order; or a supervision and treatment order. The latter provides for community treatment subject to specified conditions.

ANNEX 8

INDETERMINATE SENTENCES AND CONVENTION RIGHTS

Professor Christopher Gane

Introduction

1. An indeterminate sentence may be imposed in the following cases:

    (a) the mandatory sentence of life imprisonment (in the case of adults convicted of murder)

    (b) mandatory detention in a young offenders institution (for persons aged 18-21 convicted of murder)

    (c) detention without limit of time in such place and under such conditions as the Secretary of State may direct (for persons aged under 18 who are convicted of murder)

    (d) discretionary life sentence (available for all common law crimes, and certain statutory offences)

2. With the exception of (b) (which is closely analogous to imprisonment in the case of adult offenders convicted of murder) all of the above have been the subject of consideration by the European Court of Human Rights, principally in relation to Article 5 of the Convention, although a number of other articles have been touched upon in the cases which have come before the Court.

3. Discussion of life sentences in the United Kingdom has focussed upon the legality of the discretionary life sentence, and the release procedures for prisoners subject to such sentences. Distinctions are drawn within the Convention case law based upon the differing justifications and purposes of discretionary life sentences and mandatory life sentences.

<u>The justification for life sentences</u>

4. Life (indeterminate) sentences may be justified on two grounds - punitive and protective. In general, mandatory life sentences are justified on the former ground, while discretionary life sentences have both a punitive and a public safety element. The significance of this distinction was explained by the Home Secretary, during the debates on the Criminal Justice Bill[1]:

    'In a discretionary case, the decision on release is based purely on whether the offender continues to be a risk to the public. The presumption is that once the period that is appropriate to punishment has passed, the prisoner should be released if it is safe to do so.

    The nature of the mandatory sentence is different. The element of risk is not the decisive factor in handing down a life sentence. According to the judicial process, the offender has committed a crime of such gravity that he forfeits his liberty to the State for the rest of his days. If necessary, he can be detained for life without the necessity for a subsequent judicial intervention.'

[1] Parl. Debs., H C, 16/July 1991

Life sentences and the ECHR

Are indeterminate sentences as such objectionable?

5. Indeterminate sentences as such are not incompatible with the Convention, provided that, having regard to the circumstances of the offence and the offender, they do not fall to be regarded as inhumane within the meaning of Article 3.

6. In the case of ***Weeks v United Kingdom***[2] the applicant was sentenced to life imprisonment at the age of 17. He had pleaded guilty to the robbery of 35p from a pet shop, while armed with a starting pistol loaded with blank shot. The sentence of life imprisonment was not, therefore, based upon the gravity of the offence. The sentence was based upon the view taken by the trial judge (and upheld by the Court of Appeal) that, having regard to the applicant's antecedents and mental condition, he presented a particular danger to the public. On the nature of the sentence imposed the Strasbourg court had this to say:

   'Having regard to Mr Weeks' age at the time and to the particular facts of the offence he committed ... if it had not been for the specific reasons advanced for the sentence imposed, one could have serious doubts as to its compatibility with Article 3 of the Convention, which prohibits, ***inter alia***, inhuman punishment.'

7. Without the additional consideration of risk, therefore, discretionary indeterminate sentences may, in certain cases, be incompatible with the Convention. Where the sentence is seriously disproportionate to the offence, the sentence may be open to challenge, and the age of the accused at the time of the offence is also relevant in determining whether or not the sentence is inhumane.[3]

8. The situation is different in the case of mandatory indeterminate sentences. Here, the gravity of the offence is by itself sufficient to justify the indeterminate sentence, and probably irrespective of the age or circumstances of the accused.[4]

Review of indeterminate sentence

9. The differing justifications of mandatory and discretionary life sentences mean that they are treated differently by the Strasbourg court. The discussions have centred on the procedures governing release from custody of persons sentenced to life imprisonment, and in particular the question of access to effective means of reviewing the continuing legality of detention under an indeterminate sentence.

10. According to Article 5, everyone has the right to liberty and security of person.[5] No-one may be deprived of their liberty except in the cases set out in Article 5(1)(a)-(f) (which include 'lawful detention after conviction by a competent court'). Article 5(4) provides that everyone who is deprived of their liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court and their release ordered if the detention is not lawful.

11. ***Mandatory indeterminate sentence***: Adults upon whom a mandatory life sentence has been imposed are not entitled to invoke Article 5(4) with a view to demanding access to a 'court' to determine the continuing legality of their detention. The legality of that detention, and judicial involvement in the determination of that

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[2] ECHR. Series A. No. 114

[3] Cf, Tyrer v United Kingdom, ECtHR, Series A, No. 26.

[4] Cf. Wynne v United Kingdom, ECtHR, Series A, No. 294-A, T. v United Kingdom, V. v United Kingdom, RJD 1999-

[5] 'Everyone' in this context includes persons convicted of offences and upon whom a custodial sentence has been imposed.

legality, is to be found in the fact that their detention derives from a sentence imposed by a court. In ***Wynne v United Kingdom***,[6] the applicant was sentenced to life imprisonment for murder in 1964. He was released on licence in 1980, and the following year he was convicted again when he pleaded guilty to the manslaughter of an elderly woman. On this occasion a discretionary life sentence was imposed. In June 1992 he was informed that the 'tariff' period fixed in respect of his 1964 conviction had expired, and that his continued detention was based on the risk he represented. (The tariff fixed by the trial judge in respect of his second offence had expired in 1991).

12. The applicant complained that he was unable to have the continued lawfulness of his detention reviewed by a court, and that there was therefore a violation of Article 5(4). This argument was rejected by the Court. The life licence granted in 1980 was revoked by his conviction for manslaughter. The fact that he had committed a further offence (and that he was suffering from a mental disorder) did not affect the continuing validity of his original sentence. Although the applicant attempted to argue that the two types of life sentence were converging, there remained significant differences between them, and the case law of the Court which insisted that discretionary life sentence prisoners should have access to a court under Article 5(4) did not apply to persons serving a mandatory sentence of life imprisonment for murder.

13. ***Discretionary life sentences***: Persons serving a discretionary life sentence must have access to a court to determine the continuing legality of their detention, once the punitive element of their sentence has been served.[7] In ***Weeks v United Kingdom***, the Court held that where the stated purpose of detention was the protection of the public, based upon the perceived risks which the offender posed, it was necessary for the accused to have access to a court in order to determine whether or not the grounds for his continued detention remained operative:

    "The grounds expressly relied upon by the sentencing courts for ordering this form of deprivation of liberty ... are by their very nature susceptible of change with the passage of time, whereas the measure will remain in force for the whole of his life. In this, his sentence differs from a life sentence imposed on a person because of the gravity of the offence."[8]

14. If the decision not to release were to be based on grounds inconsistent with the objective of the sentencing court, the applicant's continuing detention would no longer be 'lawful' for the purposes of Article 5(1), and he would therefore be entitled to apply to a 'court' having jurisdiction to decide speedily whether or not his deprivation of liberty had become unlawful in this sense. This right is exercisable on the expiry of the punitive element of the sentence, and at reasonable intervals thereafter.[9]

15. ***The need for a 'court' under Article 5(4)***: Any body which has the responsibility of reviewing the legality of continuing detention must meet the following conditions:

    - it must be independent of the executive and impartial;

[6] Above.

[7] ***Weeks v United Kingdom***, above; ***Thynne, Wilson and Gunnell v United Kingdom***, (1990) 13 EHRR 666

[8] ***Weeks***, judgment, at para. 46.

[9] ***Ibid.***, para 58. See also, ***Van Droogenbroeck v Belgium*** Series A, No. 50, T***hynne, Wilson and Gunnell v United Kingdom***,

- it must have more than merely advisory functions, and must have the competence to 'decide' the lawfulness of detention, and to order release if the detention is unlawful[10]

16. In the Scottish context, the body which reviews the detention of discretionary life prisoners is the Parole Board, sitting as a 'Designated Life Tribunal', chaired by a judicial member of the Parole Board.[11] The Tribunal has the power to order release of the prisoner, and therefore satisfies this aspect of article 5(4). Whether the DLT satisfies the requirements of independence and impartiality depends upon whether or not the parent body, the Parole Board, satisfies these requirements.

17. In ***Weeks v United Kingdom***, the applicant argued that the Parole Board for England and Wales was not independent of the Home Secretary, primarily because the Home Secretary appoints members of the Board, staffs the Board and makes the rules under which its procedures are conducted.[12] The Court's view was that the manner of appointment of the Board did not mean that the Board was not independent of the Home Secretary. The Court was also satisfied that in the exercise of their duties the Board remained independent of the Home Secretary. It also concluded that, even from the perspective of the life prisoner, the Board did present an appearance of independence.[13] There was not, however, in these cases, any detailed consideration of the manner of appointment, terms of office or manner of removal of Parole Board members.

18. In Scotland, the chairman and members of the Parole Board are all appointed by the executive.[14] Scottish Ministers are also responsible for deciding upon the period that individuals should serve, and their remuneration. Remuneration is on a fee basis, and members also receive travel and subsistence at civil service rates. Members of the Board are subject to standard terms and conditions which provide, ***inter alia,*** that their appointment may be terminated by Scottish Ministers at any time prior to the expiry of their term of office, on the grounds of ill health, failure to attend regularly to the business of the Board or that they are otherwise unable or unfit to discharge the functions of a member of the Board. Board members may, on expiry of their original term of appointment, be appointed for a further term. There have been occasions when members have not been offered a second term.

19. As was indicated in ***Starrs and Chalmers v Ruxton***[15], when considering the independence of a court or tribunal, the manner of appointment to that body is probably of less significance than the security of tenure enjoyed by its members, and any possibility that they might be influenced by personal considerations. While it may well be, as Lord Reed suggested in ***Starrs and Chalmers***, that the same standards would not be required of a tribunal as would be required of a court, it is likely, given the role of the Parole Board (and the DLT), that the standards of independence expected of a court would be applicable also in the case of the Board.

20. There is a possibility - albeit a remote one - that the Parole Board might not be seen as satisfying the requirements of a 'court'. The conditions under which Board members serve, and in particular the question of renewal for a further term, over which there appears to be no objective control, might lead to the view that the Board was not sufficiently independent of the executive.

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[10] ***Weeks; Thynne, Wison and Gunnell***

[11] Prisoners and Criminal Proceedings (Scotland) Act 1993, Parole Board (Scotland) Rules 1993 (S.I. 1993/2225).

[12] ***Weeks v United Kingdom***, above, para. 62.

[13] ***Ibid.***

[14] Prisoners and Criminal Proceedings (Scotland) Act 1993, Schedule 2.

[15] ***Starrs & Chalmers v Ruxton,*** 2000 JC 208; 2000 SLT 42