

TREATMENT AND CARE OF MENTALLY ILL OFFENDERS PURSUANT TO PART 5 OF THE SENTENCING ACT 1991 AND PARTS 3 TO 4 OF THE MENTAL HEALTH ACT 1986

DISCUSSION PAPER

**RESPONSE BY THE MENTAL HEALTH LEGAL CENTRE
FEBRUARY 2004**

We note the recent media coverage in relation to the crisis in mental health care and point out the obvious that unless proper resources are put towards general mental healthcare as well as forensic mental health care, then no options, no matter how well thought out, will work for anyone - consumers, the courts, practitioners, defendants, or victims.

Levels of resourcing can effect punitiveness in significant ways- lack of resources to area mental health teams can mean patients are less likely to be successful in applications for conditional release. Once in the community a relapse or particular behaviour by a forensic patient can result in a breach which could ultimately result in a return to prison, when effective case management may have been a less punitive outcome.

CHAPTER ONE

Discussion:

What follows are some ideas we have for new sentencing options for people with a mental illness. However they come with a serious qualification - they have not been developed or discussed with consumers, those who will ultimately be subject to them. We strongly believe that any new sentencing regime for people with a mental illness must be developed in collaboration with people with a mental illness who have experience of the criminal justice system and the mental health system. They are in the best position to know what is likely to work and how to ensure their rights are protected. The Mental Health Legal Centre is going to undertake such a process in the near future to develop a workable, beneficial set of sentencing options for people with a mental illness.

However, two aspects of any sentencing orders we do believe would and should be part of any sentencing regime are:

1. Court Orders must be for a fixed duration.
2. Any order made by a court must be returnable to that court for variation, termination and breach.

Currently one of the ways some Magistrates try to integrate mental health issues into a criminal sentence, is to make a community based order without a work component, but instead with a condition that the person complies with all lawful directions of their mental health treating team or of their community treatment order. It is a useful way for a Magistrate to make a Court order that ensures if there are breaches of the order the matter will come back before the court. The orders are for a set time and if there are no continuing issues under the Mental Health Act, then the person can be discharged from the CTO, but continue to be under a court order.

We propose that such an order be made available in a formal sense to ensure that these orders are used. Some Magistrates will not countenance a community based order with no work component. Nor will they allow community based orders to be used as court monitoring

mechanisms. But in our submission it is a creative and compassionate Magistrate who uses the existing orders to provide an individualised and flexible sentencing option.

In our submission, one of the major problems with an order under 93 (1) (d) is that the authorised psychiatrist is given the power to decide if and when someone should be taken off the order. Psychiatrists have no training in issues relating to criminal justice or the law and we can only assume that in an already conservative area of practice, decisions will be even more conservative when related to responsibility for future criminal behaviour.

We tentatively suggest the establishment of a coordinating unit within within Forensic Services - to administer "mental health orders" made by the courts. This could include a dedicated team of mental health professionals, trained in issues of forensic psychiatry and the criminal justice system. We do not believe sentencing orders for people with mental illness should be administered by Corrections for several reasons, but primarily because of its culture of punishment, as opposed to one of treatment.

Such a unit may be able to provide assistance to the courts and court support networks on the implications of court dispositions on the treatment of people with a mental illness. This is crucial - uninformed decision makers can make decisions that have a disastrous impact on the person. For example if a person is deemed to be in gaol 93. 1(e) they are ineligible to Centrelink benefits, as opposed to a 93. 1(d) which deems the person to be in hospital and thus eligible. Similarly if in gaol a person can serve time concurrently for fines, if in hospital they cannot but must pay them or be imprisoned for a period as payment.

Obviously such a section must be properly resourced. If not then we believe there should be penalties imposed on the service provider for not enabling a person to comply with an order. It is our experience that many breaches of court orders are caused because of frustration when services are not provided in a timely and appropriate manner. In a criminal justice setting this often has serious ramifications when blame is placed upon the person subject to the order without looking at systemic issues, which lead to the breach.

We can see two broad options for how such order could operate. These are:

1. That the Court orders be separate from orders under the Mental Health Act, in that decisions about treatment and the need for continuing involuntary treatment would continue to be governed by the Mental Health Act and reviewable by the Mental Health Review Board. The court order would sit on top of any or no orders under the Mental Health Act. The court order would ensure that the person would return to court if there are continuing issues after the hearing. The supervisor of such orders, who would prosecute any breaches, would need to be separate from the treating teams. They would ensure compliance with extra conditions made by the court. There would need to be serious consideration given to the exact nature of the relationship between the treating team and the prosecutors to protect the relationship between treater and consumer.
2. The Court order would override any order under the Mental Health Act; the two would in effect merge. The treating team would become accountable to the administrators of the order who would prosecute for breaches. Again there would need to be careful consideration given to the exact nature of the relationship between the various parties involved with the orders.

We reiterate that we believe the best way to get the details rights is to consult consumers.

Having put forth our view as to how we believe the criminal justice system could usefully and respectfully deal with people with a mental illness who are found guilty of a crime, we will address the discussion paper.

1.4.1 Options for restricting the use of the hospital order

Two options for implementing the Vincent Review recommendations and restricting the use of hospital orders are:

- *Restricting the making of S93(1)(d) orders to cases where the court was not considering a term of imprisonment. Where a term of imprisonment is being considered, section 93(1)(e) could be used.*
- *Restricting the making of S93(1)(d) orders to a defined group of crime.*

Comments on either of these options is requested.

In general we are not in favour of restricting the use of any sentencing options unless there is a very good reason. Here, we see no reason why judges should be limited in their options simply because they are considering a jail term. It should in fact be one of the purposes of these orders to divert people from the prison system, so that a judge who is considering a prison term as appropriate can have an option that is available which does not involve incarceration. 93 (1) (e) orders would remain as a further option if the judge feels containment and treatment are warranted.

In relation to the option of limiting 93(1)(d) to only certain crimes we believe this is unworkable and pointless as the circumstances around any crime can vary widely. We submit that its use be broadened to apply to any crime.

1.4.2 making of orders by the Court

- *Should S93(1)(d) be remodelled to create a “restricted involuntary treatment order”, whereby a person becomes an involuntary patient whose treatment and care pursuant to the Mental Health Act would be subject to additional conditions aimed at effective treatment of their mental illness? Should there be a duration limit on such orders?*

Again, at this stage, while we have made some suggestions above as to how a new sentencing option could work, we believe any proposals must be developed with consumers.

Having said that, it seems to us that RCTO's are unworkable as they are, and should be abolished. In terms of effective treatment we believe that the terms of the Mental Health Act are generally appropriate. We submit that for the court to add more conditions onto an order under the Mental Health Act and for this order then being under the control of the authorised psychiatrist or the MHRB, results in an absurd merging of the two systems resulting in great injustices. We strongly believe that for issues relating to criminal justice orders, the court which makes the order, should also decide how long they are for and if they have been breached.

Example:

A forensic patient on conditional release in the community on a RCTO, who smokes cannabis, may be breached for failing to comply with the conditions of their release. If their

breach results in a return to hospital, they could spend many months before returning to the community (a client of the MHLC spent 14 months back in hospital following a minor breach- for which there were no charges). This would be an extremely severe sentence of detention if it were to be meted out in Court as the result of a drug prosecution.

We are concerned that a lower test applies for a RCTO -
s. 15A (1) (a) the person appears to be mentally ill and to require treatment.

The test for the making of a CTO-

s.14 (1A) (a) the person appears to be mentally ill; and

(b) the persons mental illness requires **immediate** treatment

s.14 then includes criteria (d) refused or unable to consent and (e) treatment not able to be provided in a manner less restrictive way, not included under the provisions of an RCTO. We submit that this is inappropriate and that the MH Act should consistently apply the same criteria as in s14. Even these criteria are a diminution of the principles outlines in the United Nations Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care.

It is our experience that the courts are far more rights focussed than the Mental Health Review Board or psychiatrists, who generally take a best interest approach. A person who is the subject of a court order must have recourse to the body that made the order for variation, termination breach etc. The MHRB and the authorised psychiatrist are not, in our view, equipped to deal with the issues raised by crime. They are not experienced at making the decisions courts are making every day in relation to risk assessment on the principle of rights. They use a best interests model and this is not appropriate and discourages people from using options because they result in diminished rights eg. Crimes Mental Impairment.

We strongly believe that the court orders must be of a fixed duration. There is always the possibility of an order under the Mental Health Act being made after any court orders have expired.

- *Should Courts be explicitly required to have regard to the person's current mental state, their medical, psychiatric and forensic history and social circumstances in considering whether to make an order requiring involuntary treatment?*

In relation to whether the court should be explicitly required to take into account all these things we would hope they would anyway. While we are at least at this stage not in favour of the court making an order for involuntary treatment, whatever order is available for the court to make for someone with a mental illness, then we believe the court ought to specifically take into account these factors.

1.4.3 RCTOs - Making RCTOs

- *Should the Sentencing Act enable a person to receive community treatment immediately following the making of a restricted involuntary treatment order, where the legislative criteria for community treatment are satisfied and in circumstances where hospital admission is considered clinically unnecessary by the authorised psychiatrist? How should this occur?*

We believe that there should be a separate order available to sentencing judge to enable an order to be made for people who have a mental illness. The exact nature of such an order we don't have a firm view on until we have consulted our clients. However we definitely believe the judge should be able to make any such order without hospitalisation being

required, although it ought to be available if it is required. NSW experience reflects the difficulties in this area with the sentencing magistrate making an order when the person may not require involuntary detention in a MH facility. The person then gets returned to court.

- *Should the authorised psychiatrist be permitted to make a RCTO (rather than the chief psychiatrist and board as is currently the case) where the legislative criteria for community treatment are satisfied?*

In any situation, as soon as hospitalisation ceases to be necessary a person should be discharged. The authorised psychiatrist should be able to do this, but equally a person should be able to go to the Court to seek to be released from hospital even if the authorised psychiatrist does not agree. The person would still be on the court order.

Re-admission/revocation

- *Should the authorised psychiatrist be able to revoke an RCTO?*

Yes. Just as now the authorised psychiatrist can revoke a CTO. But again there would need to be a right to apply or appeal to the Court of original jurisdiction.

- *Should the Mental Health Act prevent prolonged use of the leave of absence provision for people subject to restricted voluntary treatment orders?*

No. We are opposed to any restrictions placed on the person for unforeseeable situations. Rather than place such a restriction, we recommend the leave of absence provisions be eliminated and there be proper, fair processes for being released. i.e. an application back to the court which originally made the order.

Reporting and monitoring

- *Should reports on the progress of all restricted and voluntary patients be provided to the chief psychiatrist by the authorised psychiatrist?*

Until we see the final shape of our ideal sentencing option, we cannot answer whether this will benefit anyone, least of all our clients. We certainly believe that accurate, useful and public statistics ought to be kept. We fail to see the purpose of reporting to this office. The Office of the Chief Psychiatrist is not an independent body nor a complaints authority, we would be concerned if it was being held as so for these purposes.

Variation

- *Should the authorised psychiatrist be permitted to vary an RCTO where necessary for the person's treatment and care?*

Yes so long as the defendant has an equivalent right to apply or appeal to the court for a variation.

Discharge

- *Should the Act permit a person to be discharged from an RCTO to a CTO in circumstances where additional conditions are no longer required for effective involuntary treatment?*

With fixed term court orders we don't believe that there will be the option of having the authorised psychiatrist discharge a person off the court order. But if they have the power to vary they can reduce any additional conditions and a person can apply themselves to have the order varied. We envisage that at the expiry of any court order there is always the capacity for the Mental Health Act to be applied.

- *Should the Mental Health Act explicitly require the chief psychiatrist or board to have regard to the person's current mental state, their medical, psychiatric and forensic history and social circumstances in considering whether to discharge a person from a restricted involuntary treatment order?*

We reiterate that we do not believe that the chief psychiatrist or Board should have the capacity to discharge an order made by a court. Also we argue for fixed terms making such a step largely unnecessary.

- *Should the Mental Health Act be amended to ensure broad consistency between RCTO and CTO provisions?*

As stated above, we believe that if there are to be two types of order sitting along side one another, one under the Mental Health Act and the other under a court order but essentially for the same purpose, to ensure proper treatment, then we believe they should be consistent.

- *Should the Mental Health Act be amended to clarify that a person's involuntary status does not automatically cease on expiry of an RCTO?*

We believe the legislation should be amended to make it clear that a new assessment and decision is required before a person becomes or continues as an involuntary patient under the Mental Health Act at the expiration of a court order.

1.4.4 Other Amendments

- *Are any other amendments required to ensure effective operation of these provisions?*

As stated above we believe a comprehensive process of development and consultation needs to take place to produce the best model for sentencing options. We believe that proper resources dedicated at the early sentencing stage, which increase the chances of any such orders working, will inevitably save money by helping recidivism rates and thereby ultimately reducing the cost of prison.

We believe that there needs to be a thorough exploration of sentencing options to ensure that they are properly used and applied to people with a mental illness. There is a need to educate all decision makers about the services available to people living in the community with mental health issues so that they are fully informed when considering dispositions.

We applaud a flexible and creative approach to sentencing, as initiated by the Magistrate's Court, in its development of a separate diversion stream for people with disabilities. We believe that such options in all courts must be explored before the introduction of 'special' dispositions for people with a disability.

CHAPTER 2

In relation to hospital security orders, it is our submission that one of the major problems is that in our view a hospital security order is only given consideration as a sentencing option, if the defendant's mental illness has significantly contributed to the commission of the offence. The discussion paper notes that this is not a pre requisite but refers to Fox and Freiberg, stating that there is an assumption of connection.

This then leads to the question why would a person plead guilty and risk a prison term and not 'not guilty by reason of mental impairment'? We submit it is because of the indefinite sentence and then the nominal term under the Crimes (Mental Impairment and Unfitness to be Tried) Act that a person would opt for, or be advised to plead guilty and seek a hospital security order instead.

With a hospital security order, much or possibly the entire sentence could be in hospital. There may be some time in prison when the person is relatively well, but the length of sentence will be known and finite. When this is compared with an indefinite order with a maximum nominal term if you plead not guilty by reason of mental impairment, then a hospital security order suddenly seems like a good alternative.

In our view a hospital security order is not the best option in many situations where someone commits a crime when severely mentally unwell. Such a person should not be sentenced to prison and more places need to be available in proper forensic psychiatric facilities such as Forensicare.

The nominal term should be abolished and proper resources put towards the courts, legal aid and Forensicare to enable proper reviews to be undertaken and decisions to be made based on a full consideration of all the circumstances.

However we can see that for some situations the hospital security order would be appropriate. Generally we are in favour of as many options as possible being available for sentencing judges, in particular for defendants with special needs such as those with a mental illness. Therefore to address the formal questions raised by Chapter 2:

2.3.1 General

- *Should S93(1)(e) be retained as a sentence substituted for a term of imprisonment?*

Yes in our view, 93 (1)(e) should be retained as a sentencing option. More sentencing options allow more flexibility for the wide range of people and situations which come before the courts. As it is an order for the defendant to be held as a secure patient (ie. in custody), we think it only appropriate in situations where the court is considering a custodial sentence anyway.

In our view it is clearly not a diversionary sentence, in that it does not divert people from prison. We believe there should be alternative sentencing options for diversion of mentally ill offenders but for those people where clearly the court intends to give a prison sentence, the hospital security order needs to be available.

- *Should the admission criteria in a S93(1)(b)(i) be amended to be consistent with the criteria of the Mental Health Act for transfer of mentally ill prisoners, or should they permit longer term rehabilitation?*

We do not believe that the criteria for admission to Thomas Embling Hospital or other specialist, secure, forensic psychiatric services, should be reduced to the same criteria for those being transferred in prison. A court making a hospital security order is making a statement about the persons need for treatment, about the connection between their mental illness and crime and is attempting to be merciful in sentencing. They are hoping for the best quality care available for this person with prison as the last resort, when and if they become well enough.

We would argue against the restriction on proper treatment for those in prison as well. There are many people with a mental illness in prison, August 2003 NSW corrections Health Service report tells us that 70% of prisoners experience mental illness. We understand that the capacity at Thomas Embling is limited, and there is a dearth of services in mainstream prisons, so long as prison numbers continue to increase in line with harsher sentences, then we would argue more money be spent on forensic psychiatric care than is currently the case and that there be more beds in facilities like Thomas Embling.

2.3.2 Parole Issues

- *Are there any foreseeable problems in extending the jurisdiction of the parole board to include patients subject to S93(1)(e) who are detained in an approved mental health service?*

We agree with the discussion paper that the Parole Board ought to be able to grant parole to a person who is being held in an approved mental health service. We also believe that people who are either still under sentence or eligible for parole but are residing in Thomas Embling Hospital should be able to be released under the same terms and conditions as exist under Part 7 of the Crimes (Mental Impairment) Act and such leave be regulated by the Forensic Leave Panel. These leave provisions allow for patients to have graduated integration into the community. In our view all people held within the forensic mental health system should be able to access the same leave provisions.

We are concerned that present leave provision are inflexible and not consistent with good rehabilitation planning. We suggest leave (s.49 Forensic leave panel provisions) should include special leave of absence, on-ground leave, limited off ground, accommodation transition leave and extended leave. Also that s.53 be amended to include an extension of hours and placement and to allow trial accommodation in a range of settings, for transition to the community, including supervised staff settings, supported accommodation facilities, community transitional housing and family/ home care settings.

2.3.3 Effective Discharge to prison on operation of 93(1)(e) order

- *What effect should discharge to prison and subsequent re-admission to a Mental Health Service have on operation of S93(1)(e) order?*

In our view a 93(1)(e) order ought to continue for the entirety of a persons sentence. They are sentenced to hospital first and foremost with prison only being there if they should not need to remain in hospital. If they need to go back and forth between prison and hospital they should continue to have the same status.