Institutional Concerns: a Psychiatrist's Perspective

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"Fitness" is an important pre-trial issue. In spite of the importance of medical input it remains a legal concept and has several principal underpinnings:

1) That conviction or punishment of a mentally disordered person would not deter future criminal offending, and

2) That it is fundamentally unfair to try a mentally incompetent defendant.

The Court in *R v Dashwood* [1943] 1 K B 1 held that it is a cardinal principle of our law that no man can be tried for a crime unless he is in a position to defend himself, and that that includes his being in a mental condition to defend himself.

Terms such as mental condition, mental state, mental illness, mental disease, syndrome, are medical terms. Mental disorder is a legal term used in the Mental Health Act and in the Criminal Justice Act to define disability.

Legal disability is defined in s 108 CJA:

> ... a person is under disability if, because of the extent to which that person is mentally disordered, that person is unable
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> a) to plead,
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> b) to understand the nature or purpose of the proceedings, or
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> c) to communicate adequately with counsel for the purposes of conducting a defence.

From the above it is apparent that having a mental disorder is a necessary but not sufficient basis for a finding of "disability". That is; many people have mental illness but only a small percentage of these will be found to be under (legal) disability.

A finding of disability can be made at any stage of the trial process (s 109). Generally, a disability hearing is only held after a person has been remanded for thorough assessment of his/her mental status and after advice is given to the court that that status will continue for an appreciable length of time. In the case of severe mental illness, which might respond to medicine, a further remand to a hospital may well see the remandee/patient improve and able to make a plea. So in general, those presenting for disability hearings are those with chronic, severe mental illness, and those who have intellectual disability, from birth or from other causes, such as head injury.

If a finding of disability is made (after a properly constituted hearing), several disposition options can be taken by the judge. These have been dealt with in detail by previous

speakers but I again raise the matter because of the problems sometimes associated with the disposition. Briefly:

In the matter of charges to minor offences, the judge may:

a) (s 115(2)(a)) "make an order that the person be detained in a hospital as a committed patient; or

b) (2)(b) make an order for that persons immediate release; or

c) (3)(c) decide not to make any order...."

The judge in making the order must be satisfied that it would "be safe in the interests of the public". Public safety is important but in this context seems to be placed above the patient's interests, and quite different to what clinicians are used to in the MHA when the primary motivation for committal is "assessment and treatment" with a threshold of dangerousness and ability for self-care stated in reference to the patient's illness/ disorder. Section 115(2)(a) CJA committals are in every respect treated as s 30 MHA committals.

Any order made pursuant to s 115(2) will be deemed to be the finish of the case (s115(5)), ie, the defendant cannot be brought back to court on the same charges. The ultimate disposition is now within the jurisdiction of the "responsible clinician" in charge of that individual's assessment, care and treatment who now regards the patient to be committed under the equivalent of a Compulsory Treatment Order (ie, s 30 MHA) and who can exercise his/her discretion accordingly, including the discretion to discharge the patient from the Act. This can constitute a dilemma. Persons have been committed to a hospital, only to be discharged the following day by a clinician who may not have been familiar with the case and from a hospital institution which may have a different threshold of admission criteria from that held by the court as well as resource contraints necessitating priority admissions. You will also remember that the bias in the MHA is toward community committals. As stated above, many hospitals see their function as providing assessment and treatment for the mentally ill (as apposed to the mentally disordered). In the rush to dismantle the evils of the institutions, gaps have been left in the care of the chronically mentally disordered, who may be so, not because of illnesses but because of injuries, substance abuse or other causes.

In the case of serious charges, the court, upon the finding of disability, will make an order that the person be detained in a hospital as a "special patient" under the Mental Health Act 1992. Any order made pursuant to s 115(1) makes that person a special patient (ref part IV MHA 1992).

Special patients under s 115(1)(a) of the CJA Act are under strict control. They can only be permitted leave by the Director of Mental Health.

If they remain under disability then the "special patient" status continues for

a) "... seven years (from the date of making the order) in a case where any offence charged was punishable by imprisonment for life or preventative detention....", or

b) A period, "... equal to half the maximum term of imprisonment to which the defendant was liable on conviction...." (s 116).

If the patient's mental status changes and they are deemed to be no longer under (legal) disability, notification is made to the Attorney-General who has the option (after consultation with the police) of:

1) bringing the defendant back to court for trial (s 116 2(a)) or

2) directing that the former special patient be held as a committed patient. (In this option, all charges are deemed to have been dealt with) (s 116(4)).

Disability is a legal issue determined by a judge.

As the definition suggests, there are legal criteria which must be met before a judge can make a determination.

In practical terms, a medical practitioner assesses the defendant who is remanded as an inpatient (usually) for the purpose of "determining a) if the defendant is under disability..." (s 121 CJA). Practically, the expertise of the medical practitioner is focused on whether or not the defendant has a mental disorder. Whether or not they can plead, or communicate is perhaps best determined by counsel. Often, those of us writing reports, raise a query about whether or not the defendant can communicate for the purposes of making a defence, and refer the ultimate decision to counsel as to whether or not they can take instructions.

The definition of legal disability given in s 108 is not helpful to the medical practitioner who has been requested to assist the court in the determination of the matter.

Smith J in *R v Presser* [1958] V R 45 outlined six criteria necessary for a person to have "ability":

1) He needs to be able to understand what it is that he is charged with.

2) He needs to be able to plead to the charge and exercise his right of challenge.

3) He needs to understand, generally, the nature of the proceedings, namely, that it is an inquiry as to whether he did what he is charged with.

4) He needs to be able to follow the course of the proceedings so as to understand what is going on in court in a general sense...

5) He needs to able to understand ... the substantial effect of any evidence that may be given against him and he need to be able to make his defence or answer to the charge.

6) Where he has counsel, he needs to able to do this through his counsel by giving any necessary instructions....

I would add one more to the list. That the defendant needs to know or understand the consequences of his plea.

The first and essential component in the assessment of disability is the determination of whether the defendant is "mentally disordered".

Definition:

> Mental Disorder, in relation to any person, means an abnormal state of mind (whether of continuous or intermittent nature) characterized by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it;
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> a) poses a serious danger to the health or safety of that person or of others; or
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> b) seriously diminishes the capacity of that person to take care of himself or herself

Several problems arise in respect of this definition: It leaves some doubt about the disposition of those solely with intellectual disability, (who do not have additional mental illness) and who may not meet the definition of "mental disorder" but nevertheless cannot plead, understand or communicate. Not only is it highly contentious that an intellectually disabled person has a disorder of cognition (on the grounds that for them it is part of their normal state), but also because of the exclusion clause given in s 4 of the MHA which states;

> The procedures by Part I and II of this Act shall not be invoked in respect of any person by reason only of;
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> ...e) Intellectual Handicap.

This clearly means to a clinician that intellectual handicap of itself cannot be a mental disorder. That is, committal procedures under Part I and Part II of the Act cannot be enacted to commit such a person if all they present with is intellectual disability. However, those with sole intellectual disability, who offend and present to the court are dealt with under the CJA and Part IV of the MHA (titled "Special Patients and Restricted Patients"). Thus they can be committed, as these defendants fall outside the exclusion criterion of s 4 MHA 1992. While it is quite understandable for a judge, in the absence of any other option (in respect to an intellectually disabled individual who may exhibit dangerous behaviours), to commit the intellectually disabled person under the provisions of Parts II and IV of the Act, this only increases the dilemma for the clinician. Once the order is made, the committed person comes under the provisions of the MHA 1992, and, in the case of a 115(2)(a) committal, is treated like any other ordinary committed person and is subject to the definition of ss 2 and 4 and the review mechanism. As you have heard, the definition expressly excludes those with sole intellectual disability from the definition of mental disorder. Is it any wonder that the responsible clinician or the members of the Mental Health Review Tribunal, feel compelled to discharge the solely intellectually disabled from the Act? The temptation for judges to prevent this by committing the intellectually disabled, pursuant to s 115 (1)(a) thereby making them a "special patient" and immune to the interference of the Mental Health Review Tribunals, must be great and to date has not occurred, to my knowledge. Even in this scenario, a problem remains. After three months, the responsible clinician must review the special patient (s 77) and certify whether or not the patient remains under disability, or conversely whether the patient in his/her opinion is no longer under disability. This section (s 77) makes it explicit that the provisions of ss 2 and 4 (and others) "shall apply". This means that at review the clinician

is again faced with the dilemma: whether to strictly interpret the Act and state that the patient is no longer under disability, or whether to ignore the matter. In the former scenario, the certificates will go before the Attorney-General who will either redirect the case to court (when the same problems will arise) or who will order the patient committed pursuant to s 116(4) which brings the matter within the jurisdiction of the Responsible Clinician, who may well feel obliged to discharge the patient, on the grounds that continued committal is illegal, even though this may have disastrous consequences for the individual and for the community.

How did this problem arise? There are two dimensions, clinical and legislative:

The clinical notion that "intellectual disability" is subsumed under mental disorder is an old one. The MHA 1969 defined Mental Disorder in term of "Mental Illness, Mental Infirmity and Mental Handicap". In the days of the mental "asylum", all categories of disabled people were incarcerated together. Modern convention now regards the mentally ill, who need doctors and nurses for their assessment and treatment, quite differently from the intellectually disabled, who require psychologists, teachers and care-givers for their well being. It is well appreciated that the intellectually disabled can have co-existent mental illness. Hospitals in fact can be quite hostile environments for the intellectually disabled, particularly the forensic hospitals, which contain the angry, the predatory, the personality disordered, the very (mentally) ill, the drug addicted and others. The intellectually disabled learn maladaptive behaviours; they become double victims. In addition, their inappropriate presence in a hospital prevents the hospital being available for mentally ill persons, for which it was designed, and forces the hospital into providing a custodial role for a society which understandably is reluctant to see the intellectually disabled go to prison.

The legislative component to this dilemma is partly a lack of synchronicity between the MHA and the CJA, and partly an absence of legislation for those who may need it on occasions, namely the intellectually disabled. In regard to the former problem, the reference to "mental disorder" in s 108 CJA, could be deleted so that if a person is unable to plead, understand and/or communicate, whatever the reason (mental illness, intellectual disability, head injury), then the courts could deem that person to be under disability and make an appropriate disposition. Alternatively the words, "or intellectually disabled" could be added, in the s 108 definition. The individual would first be remanded, as at present, be assessed as to disability, and the cause of it. At the disability hearing, the most appropriate person to speak to the issue (viz, a doctor in the case of the mentally ill, and a psychologist in the case of the intellectually disabled), would do so, and additionally advise the court as to the most appropriate disposition.

The lack of legislation governing the intellectually disabled is contentious but has concerned the Mental Health Services and the Services for the Provision of the Intellectually Disabled since the introduction of the MHA 1992, when these service gaps and anomalies first became apparent. One of the issues in managing the intellectually disabled is their varying degree of incapacity. Generally speaking, the greater the incapacity (ie, the greater the disability), the less likely that individual is to be in a position to offend (because they are so dependent upon care-givers). Most of the intellectual

disabled who come before the courts are in the "borderline, mild and moderate" range of intellectual ability. The absurdity is that there is no adequate legislation for the few intellectually disabled persons whose predilection to fire setting, sexually inappropriate and maladaptive behaviours are well-known and who could be protected from offending behaviour by the application of legislation similar to the MHA. The provisions of the Protection of Personal and Property Rights Act 1988 do not appear to suffice but perhaps could be "beefed up". The current problem due to the absence of suitable legislation, is that those intellectually disabled persons who are "uncontrollable" remove themselves from care, sometimes offend, and come before the courts to enter the medical arena, solely due to the legislative muddle (the preserve of the law) and the lack of disposition options (the preserve of the health purchasers).

Are there any answers?

Yes. In regard to a suitable disposition for the intellectually disabled, the Spectrum Trust of SPIDS (a CHE provider service to the intellectually disabled) and the Regional Forensic Services, Auckland, have persuaded the purchasers of health (North Health), to fund a unique, community based, adequately resourced, 24 hourly staffed, secured home for this client group. For the first time, they will be managed in a IH specific environment by specialist care givers. Those with additional disorders including mental illness, will access the appropriate Mental Health Services. The safety issues will be addressed in consultation with the Regional Forensic Service. The service as of March 1995 is not yet up and running and there is much work to be done to ensure quality services to this client group and safety to the community at large.

In regard to the legislative issues, the above matters need tidying up and serious consideration given to legislation for the committal of the intellectually disabled before they offend and to enable their maintenance in an appropriate domicile, not necessarily in a hospital.

I have not addressed the Mental Health Amendment Act 1994, but comment that we as a nation came perilously close to having draconian law introduced, due in the main to pressure politics, lack of understanding of the effects that political and fiscal changes have on the Mental Health sector and because of lack of consultation.

I am grateful to be part of this seminar, and on behalf of Mental Health Service Providers, plead to be heard by the legal profession and the law-makers in these matters affecting the disposition and jurisdiction of the intellectually disabled.