Fitness to Plead: Prospects for Reform

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Introduction

Previous papers in this seminar have described in detail the problems of the current definition of unfit to plead, and have noted the problems of disposal for those individuals who are found under disability but who do not fit the Mental Health Act definition of "Mentally Disordered".

There is, quite naturally, an expectation that, having been identified, these problems will be rapidly "fixed" by government, and particularly by the Ministry of Health, which has responsibility for mental health legislation. In practice, a "quick fix" is not easy to make.

In this paper, I wish to outline and underline some of the problems which currently arise in this area, to raise some of the possible avenues of reform, and to outline the process of development of changes and what we are currently doing about it.

Four issues will be addressed:

1) The definition of unfit to plead.
2) Options for disposal, and in particular the development of appropriate legislation.
3) Interim options.
4) Development of appropriate services, particularly for those who are intellectually disabled.

Definition of unfit to plead/under disability

Previous speakers have described in detail, the problems arising form the current definition. Some of the difficulties related to the lack of detailed criteria, as outlined by Ian Freckleton. The most pressing problem currently before us is the difficulty caused by the inclusion of "mentally disordered" as a necessary criterion, and it is this problem which I intend to address.

It is clear that linking the definition of unfitness to plead to the current definition of mental disorder in the Mental Health (Compulsory Assessment and Treatment) Act 1992 is not appropriate.

One question which arises is—was it intended to make this link to exclude intellectually disabled individuals? The answer is probably not. It is significant that the exclusion of intellectual handicap as a reason for invoking the Mental Health Act, is linked to Part I and II of the Act, suggesting that it was intended that individuals with intellectual handicap could be included in the rest of the Act, including Part IV which refers to special patients.

The phrase "disorder of cognition" may be interpreted as including intellectual disability. This is disputed by many clinicians, but as we have already heard, the courts are quite clear that this covers the situation of an individual with intellectual disability so far as the definition of unfitness to plead is concerned.

There is a clear need to resolve this difficulty by broadening the criteria and removing the link to the definition of "mental disorder" in the Mental Health Act.

The Mental Health Act Amendment Bill, introduced in 1994, attempts to address this problem. In this Bill, the term "mentally disordered", in s 108 of the Criminal Justice Act, is replaced with "mentally impaired".

"Mental impairment" does not require the elements of dangerousness or diminished capacity for self care, and includes severe intellectual disability:

"Mentally impaired", in relation to any person, means suffering from:

a) an abnormal state of mind (whether of a continuous or intermittent nature), characterized by delusions, or by disorders of mood or perception or volition or cognition; or

b) a state of arrested or incomplete development of mind involving severe impairment of intelligence and social functioning.

This is certainly an improvement, but still leaves some gaps. The Law Commission[1] have suggested that a better approach is to replace "mental disorder" in s 108 by "mental impairment", but to leave this latter term undefined. In the light of what has already been outlined in this seminar, this would seem to be a very reasonable suggestion as an interim measure to remove the more pressing current difficulties.

Whether any further amendment to s 108 is considered, will in part depend upon the fate of the Mental Health Act Amendment Bill, which is yet to be reported by to the House by Select Committee. It appears at this stage that the Bill, as it stands, in unlikely to proceed, so development of other alternatives should continue.

The Department of Justice have indicated their intention to review the provisions of Part VII of the Criminal Justice Act, which includes s 108. They, quite correctly, would like to consider any changes to Part VII of this Act as a coherent whole, rather than changes occurring piecemeal, but in view of the current difficulties of s 108, they would support an interim amendment to this section.

A comprehensive review of the whole of Part VII of the Criminal Justice Act will be complex. It will take considerable time to complete the necessary research and consultation involved to do the job properly. We look forward to working with our colleagues in the Justice Department on this.

Disposition options

There is little point in amending legislation to enable persons to be found under disability

1 Law Commission, August 1994 NZLCR 30 "Community Safety: Mental Health and Criminal Justice Issues", Wellington.

who are not "mentally disordered" if the options available for their disposal are only those for "mentally disordered" persons. It is clear that there is a need to provide an avenue, or avenues, of disposition for the intellectually disabled and others who may full outside the definition of "mentally disordered".

I am assuming, as touched on by previous speakers, that disability will be a finding only in those cases where the charge is a serious one—we are not talking of options for those who may be charged with trivial offences only.

There are essentially three options for disposition of those found under disability:

- An order under s 115(1) (a) of the Criminal Justice Act requiring detention as a special patient in a hospital.
- An order under s 115(2) making a compulsory treatment order under the Mental Health Act.
- Discharge.

Detention as a special patient is a very restrictive option, and should be ideally reserved for those individuals for whom any less restrictive option cannot be safely considered.

Discharge may be inappropriate—there is no ability to impose supervision, monitoring, education or any rehabilitation. It is of course entirely possible that an alternative mechanism, such as a personal order under the Protection of Personal and Property Rights Act 1988 could be used concurrently with the discharge, providing some degree of control. The PPPR Act 1988, however, does not appear to be able to supply the degree of control necessary to ensure safety in the case of some individuals who exhibit more dangerous behaviours.

A compulsory treatment order under the Mental Health Act has the advantage of being a potentially more flexible instrument, allowing for "treatment" to be provided in any setting which is appropriate for the individual. The problem is that this can only be used for those individuals who meet the criteria for "mental disorder".

As has already been noted by previous speakers, problems have arisen in those cases where the court has found an individual with intellectual disability to be mentally disordered for the purpose of the disability hearing, only for the individual to be (quite properly) discharged from the compulsory treatment order by the Responsible Clinician, when the case is reviewed using the criteria set out in the Mental Health Act. Quite understandably, this causes frustration for both the Court and for the clinician involved, and runs the risk for the individual concerned that they may either be placed in a situation where they will offend again or that there may be no option but to impose an overly restrictive special patient order.

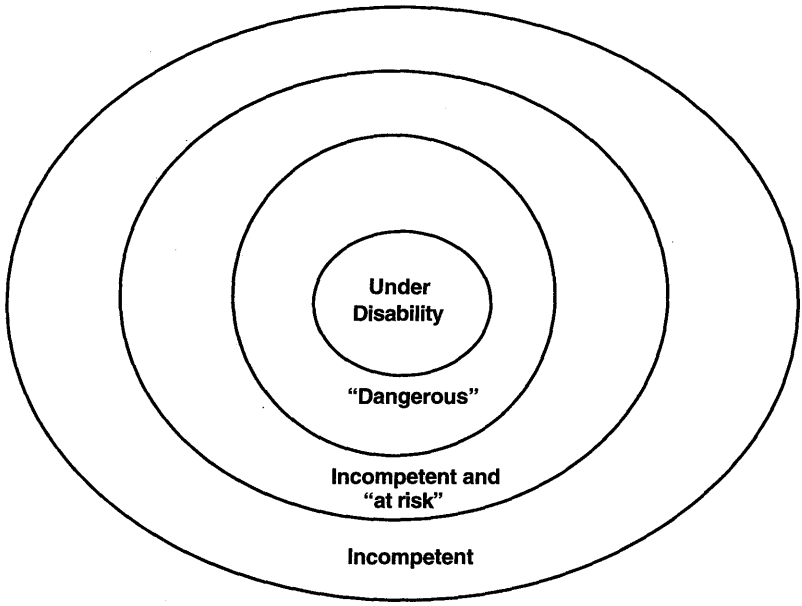
It appears, then, that there is a need for a fourth disposal option designed to meet the needs of those who are under disability but not mentally disordered, particularly those who are intellectually disabled. This option should be flexible in terms of placement of the individual, and must be focussed on the needs of the individual: education, rehabilitation, monitoring and safe management rather than detention.

This avenue is currently being looked at by the Ministry. We are calling the option a "compulsory care order", though it is important to note that this is not the same type of order as that proposed in the Mental Health Act Amendment Bill.

1 *Possible compulsory care legislation*

Any legislation in this area needs to fit coherently with other legislation covering the needs of those who are disabled or incompetent to make decisions about their own welfare. It seems inappropriate to develop specific legislation for the needs of a very small group—those under disability—without linking this to legislation to cover a wider group of people who may need some degree of restrictive care to safely manage risky or frankly dangerous behaviours.

This may be conceptualized as "layers of an onion":



The core group, those particularly the focus of our attention today, are those individuals who are charged with a serious offence, but who because of their disability are found unfit to plead.

The next layer out consists of those individuals who as a result of their disability, exhibit behaviour which is clearly and demonstrably dangerous, but who have not necessarily been charged with an offence. This may be a small group, but a group which causes considerable problems. The next layer are those who, because of their disability, are not able to make decisions about their own care, but who need some degree of restriction because of risk, usually to themselves.

The outer layer consists of individuals who lack competence as a result of their disability, but who do not pose a risk or require any restriction.

The needs of the outer 2 layers are largely met by the provisions of the PPPR Act.

The core group clearly need some new provision. The inner layer, those who exhibit dangerous behaviours, are the most difficult group, both to define, and to provide for. It seems most logical that compulsory care legislation should be aimed primarily at the core group and the inner layer, but should be developed in a way which interfaces with the PPPR Act as well as the Criminal Justice Act. It is important that the legislation umbrella is coherent, consistent and comprehensive.

This proposal raises a number of questions:

- How wide should the scope for this legislation be?
- How can we define the "dangerous" few so that the provision remains focussed on those who require such care and not broadened to impose unnecessary labels or restrictions on those who do not?
- How can we dovetail the legislation with existing legislation, especially the PPPR Act?
- What range of conditions should be included? Intellectual disability and head injury should be included but what about the elderly, the medically frail or the profoundly deaf?—all conditions which may lead to any individual being unfit to face charges in a court of law?
- Some commentators have suggested that development of new legislation is unnecessary—that the provisions of the PPPR Act can be applied and are sufficient. While this Act as it stands lacks the power to deal with the more difficult individuals who may be in our two inner groups, there may well be merit in considering whether expanded powers of the PPPR Act may be an alternative to new legislation.

Whatever the final format, it is clear that legislation for this group should be firmly focussed on rehabilitation, education and therapeutic needs, and should allow the least restrictive alternative compatible with safe management.

The Ministry of Health is currently in the process of examining the options for compulsory care, though it does appear that meetings to date have produced more questions than answers.

2 *Possible format*

One possible format for compulsory care is to follow a similar pattern to compulsory treatment under the Mental Health Act, including a similar system of rights and reviews.

Input to a compulsory care order could be via a finding of disability under s 115 of the Criminal Justice Act, following a conviction (similar to s 118 of the Mental Health Act) or possibly via a direct application to the court on the grounds of a high probability of dangerous behaviour likely to result in a serious offence.

The aim would be to enable safe, therapeutic management to be given to a disabled person to avoid the over-restrictive option of hospitalization as a special patient, or inappropriate placement in a penal institution.

Temporary options

1) Definition of under disability

   Amendments to the Mental Health Act, which are expected to include an amendment to s 108 of the Criminal Justice Act as outlined earlier in this paper, are expected to be introduced to Parliament later in this year, and may be enacted and operational by early next year at the soonest.

2) Disposition options

   Development of Compulsory Care legislation will take longer to develop, because of the difficulty of firstly determining the scope, and secondly of drawing up a framework which is workable and comprehensive—a time frame of two years would be an optimistic estimate.

   In the interim, what do we do about the small but important group who do not fit into the existing framework?

One option may be to introduce a "quick and dirty", time-limited provision to "plug" the current gap. One possibility that has been suggested is to amend the exclusion criteria in s 4(e) of the Mental Health Act so that those individuals found under disability as a result of intellectual handicap are removed from the exclusion. This would allow such individuals to be placed on a compulsory treatment order, allowing a more flexible set of management options.

The problems with this are self evident:

- The definition could be seen as "arbitrary".
- The distinction between intellectual disability and mental illness is blurred, a backward step both clinically and philosophically.
- There is a risk that a "time limited" interim provision could become a more permanent provision.

The advantage would be to allow a less restrictive option than the detention in hospital as a special patient, which may be the only option at present available for safe containment of an individual whose behaviour poses a significant risk to the community.

It is difficult to see other workable interim solutions. Suggestions would be most welcome! In the meantime, we must struggle on with the law as it stands.

Service provision

The traditional option for the detention of the person found unfit to plead, was the psychiatric hospital. While detention and treatment in hospital may well be appropriate for someone who is clearly mentally disordered, long term incarceration in a mental hospital for an intellectually disabled individual is inappropriate and potentially damaging.

Previous speakers have referred to the change in attitude and service provision for intellectually disabled people, separating the needs of this group from those who are mentally ill.

For those intellectually disabled individuals who are charged with, or convicted of a serious offence, or certain individuals who pose a danger as a result of their behaviour, a more flexible range of services is required.

Such services range from community supervision, through specialized education and habilitation programmes, special living and residential services, to secure facilities with intensive skilled staffing.

Emphasis in all services should be on the programme provided, including skilled staff input for monitoring and oversight, education, habilitation, behavioural and other therapeutic management, rather than detention per se.

It is necessary for services and legislation to develop in parallel. There is little point, for example, in developing a programme in the community for intellectually disabled individuals who are found unfit to plead if the only disposition option available is a special patient order.

In the interim, hospital based services should develop programmes and facilities to meet the needs of this group, and should ensure that intellectually disabled and brain-injured patients are managed and treated in specialized programmes, rather than in units provided for treatment of those with mental illness, including secure forensic psychiatric units.

Such services will require the expertise of both disability services and forensic psychiatry. Whether they are operated as a specialized area of forensic services with disability service input, or as a disability service with forensic input is debateable. It would seem most appropriate for the latter, though the most essential feature is to ensure both sides of the needs are met.

As Dr Chaplow has noted, there are already innovative local initiatives occurring to address these matters.

The Ministry of Health will be working with RHAs to ensure that appropriate services are defined and purchased to meet the needs of this group.

Further research is needed to define the extent of need for services.

Conclusions

In this paper, I have tried to outline the problems arising from the present provisions, to discuss some of the possible solutions, and outline the processes being taken to develop options for legislation and services.

The problems, some of which were created by the change in mental health legislation in the 1992 Act, and some of which are of longer standing, need to be tackled in a coordinated, coherent manner, rather than by piecemeal changes in legislation.

This is a process that will take a long time to develop.

In the meantime, we need to consider carefully whether the problems we face are so severe, and so urgent, that some "dirty" short term changes are needed, or whether we can afford to utilize the present legislation unchanged while the process of development proceeds.

In the meantime, consultation will be undertaken, and helpful suggestions are more than welcome.