Mental Health and Criminal Justice

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Introduction

This paper will examine the application of the Victorian Sentencing Act of 1991 and the Sentencing (Amendment) Act 1993 as applied to persons with a mental illness.

The mental health legislation for Victoria is the Mental Health Act 1986 and the purpose of this Act is to be found in the objects listed in s.4.

- best possible treatment and care;
- less restrictive environment;
- protection of the public;
- any restriction on liberty and interference with rights; and
- dignity and self-respect is the minimum necessary.

The Sentencing Act of 1991 was to promote consistency across sentencing, to provide fair procedures for imposing sentences, to prevent crime and promote respect for the law (s.1).

The Sentencing (Amendment) Act of 1993 was largely constructed to increase penalties for serious sexual offenders and serious violent offenders and to empower the courts to impose indefinite sentences on persons convicted of serious offences. (s.1).

It is the Mental Health Act which governs the treatment and care available for a person detained as a patient in a psychiatric hospital. It is our experience that stark discrepancies of policy and application must be endured by persons when issues to do with their involvement in the mental health system and the criminal justice system are confronted.

Hospital Orders

A hospital order will be entertained by the court when matters to do with the person's mental health have been raised by the police, the prosecution or the defence. A 1991 study of prisoners in Victoria found that 15 per cent had a current diagnosis of either a psychotic or mood disorder.

A person becomes an involuntary patient under the following orders:

Assessment orders (s.90)

Where the court has not received a psychiatrist's report, the court may order a person found guilty to be taken to a psychiatric in-patient service for no more than 72 hours to enable an assessment for extended hospital orders. The court must receive advice from the authorised psychiatrist of the in-patient service that it can undertake an assessment.

Diagnosis, assessment and treatment orders (s.91)
Where the court has received a psychiatrist's report recommending admission, the court may order that a person be admitted and detained as an involuntary patient for a period not exceeding three months. At the expiry of that period, or if the authorised psychiatrist, the Mental Health Review Board, or the chief psychiatrist, discharge the person from involuntary status, the court may make a further hospital order (s.93) or pass sentence taking into account the period of detention.

**Hospital orders**

The options, other than these two temporary orders open to the court at sentencing are that following the trial the person must have been found guilty (s.93(1)(a)). The court must be satisfied that

(i) the person appears to be suffering from a mental illness that requires treatment; and
(ii) the treatment can be obtained by admission to and detention in a psychiatric in-patient service; and
(iii) the person should be admitted as a patient for his or her own health or safety or for protection of members of the public

then instead of passing sentence the court may order that a person be admitted to and detained as an involuntary patient (s.93 (1) (d)). There is no provision for the return of the person to the court.

**Hospital security order** (s.93(1)(e))

A further hospital order is where by way of sentence the court may make an order for a specified period where the person is admitted to hospital and detained as a security patient. The Court must not make a hospital order unless the person would have been sentenced to imprisonment, but for the mental illness (s.93(2)). A non-parole period must be set in accordance with the **Sentencing Act** (s.12). If the person is discharged from involuntary status before the fixed term expires they are transferred to prison.

**Other Security Patients** (s.16)

Other types of security patients are:

- persons detained at the Governor's Pleasure because they have been found not guilty of an offence because they have successfully raised the defence of insanity or they have been unfit to plead at their trial; and

- persons who have been transferred from a police cell, prison or youth training centre to a psychiatric in-patient service by way of a hospital order made by the Director-General of Corrections. The Director-General must have regard to the public interest, the person's criminal record and psychiatric history.

There is an inordinate erosion of a rights, and therapeutic or treatment focus as one moves through the legislation. This is certainly our
experience as legal representatives acting for persons who come under the legislation.

Some of the areas of difficulty experienced by persons who are subject to the orders

72 hour assessment order

The issues this order raises are:
- who selects and on what basis?
- is it known past psychiatric history? (Presentation of symptoms at or during trial)
- what's available?
- bed availability. (Is a locked ward required or is an open ward adequate? who is available to make the assessment?)

It would appear that this provision is a good legislative option, but practically is very limited. There is incredible pressure on beds due to the limited number of forensic beds available and the reluctance of low security hospitals to take persons who are unwell and whose placement might be problematic.

Diagnosis, Assessment and Treatment order

The preferred option is the diagnosis, assessment and treatment order where a person is detained for up to three months.

The issues raised by this order are somewhat similar as to bed availability, security issues and the reluctance of lower security hospitals to take hospital order patients because of community concern about offenders being at liberty and concerns that a bed will be occupied for a lengthy period when it could be better occupied by a short-term patient from the community that the hospital services.

If the person is reviewed by, or appeals to the Mental Health Review Board and no longer fits the criteria they are returned to the court for sentencing. They can also be discharged by the Chief Psychiatrist or the Authorised Psychiatrist.

Hospital order

The statutory requirements are a finding of guilt, that the court has a certificate from a psychiatrist stating the person appears to be suffering a mental illness that requires treatment, that treatment can be obtained by admitting the person and they should be admitted as a patient for their health or safety or for the protection of members of the public. The court can make a hospital order instead of passing sentence. This translates into an indeterminate time as an involuntary patient in a psychiatric hospital.

There are several issues which surround these orders. The first is again bed availability. It is considered that there is an implied expectation of security with persons under these orders. It may be to do with the seriousness of the offence, or may only be to do with the level of unwellness of the person. It may involve relatively minor offences.
The point of entry with this order begins with the court, but issues of treatment and care and the point of exit, come under the Mental Health Act with the Mental Health Review Board and the Chief Psychiatrist having the power to discharge.

Of people receiving hospital orders over a particular period research has found that all but two of 41 orders applied to men. The majority were diagnosed as having schizophrenia, and two thirds were between 18 and 35 years old. The majority had a lengthy history in the criminal justice system, with one third having more than 20 previous convictions extending over a ten year period. Past contact with the mental health system had occurred in the majority of cases, with the contact involving a number of admissions to psychiatric hospitals. (Mulvany forthcoming).

The following case is typical of the profiles found by Mulvany:

A twenty-six year old man came to the courts by way of a breach of an intervention order brought by his family and charges of wilful damage to family property. He had been diagnosed as suffering with schizophrenia for 5 years, although his family felt that symptoms had been apparent for 9 years following a motor vehicle accident. The symptoms were described as social withdrawal, depression, suspiciousness, irritability, increased conflict with the family, threats of violence to the family, persecutory ideation, delusions, auditory hallucinations.

The symptoms were complicated by drug and alcohol abuse. Further complicating factors were an immature and impulsive personality, poor impulse control and low frustration tolerance. Finally, there was borderline intellectual function.

The treatment for this man involved anti-psychotic medication, locked ward containment and behaviour modification. The medication controlled the positive symptoms of his mental illness but did nothing for the negative symptoms. The locked ward containment offered him nothing, except a challenge to jump the wall and abscond, which he did very regularly. The hospital's response was to withdraw his privileges, that is his walkman, his personal effects in his room, his use of the telephone, his paintings, and to place him in pyjamas for a week. After he got his clothes back he would abscond again. He would always return on his own or seek help from his parents to return to his locked ward. While away, sometimes only for a few hours he would smoke dope, and drink some wine.

In part, the argument put to the Mental Health Review Board was that treatment by way of medication was being given, and that it was effective, but the locked ward containment and behaviour modification were not effective and so treatment could not be obtained by those sorts of detention at that time. The argument was not successful. Consequently the hospital was required to address the increasing institutionalisation of this man. The young man continued to argue that he would have been better off if he had been sent to prison.

The indeterminate hospital order is known by the people who are subject to it as a quasi-Governor's Pleasure status. Rather than waiting for the Governor's Pleasure to be known, the person is caught between the criminal justice system, which has a particular response to criminality and the mental health system, which is paternalistic and very, very cautious. It is when the juxtaposition of these are being negotiated that an uneasy tension
is faced, and any clarity in the theory or in the practice of implementing the objects of the Mental Health Act is obscured.

**A transition option for hospital order people**

A person under a section 93(1)(d) hospital order may be placed on a Restricted Community Treatment Order (RCTO) if certain criteria are met. The Authorised Psychiatrist may then apply to the Chief Psychiatrist for a RCTO in respect of that person (s.15A(2)). A RCTO must be approved by the Board. The Board has power to approve, review or revoke a RCTO.

The hospital must prove that

- the person appears to be suffering from a mental illness that requires treatment;
- treatment can be obtained by making the person the subject of an RCTO; and
- the person should be subject to an RCTO for the person's health or safety or for the protection of members of the public(s.15A(1)).

The Chief Psychiatrist may impose any conditions as he thinks are appropriate. (One of the conditions for one applicant included among other things, no bushwalking).

**Hospital security order**

The further option open to the courts when dealing with a person with a mental illness is the hospital security order. This is by way of sentence if, but for the mental illness, the person would have been sentenced to a term of imprisonment. Again the issues are primarily bed availability. There have been numerous occasions where the courts have voiced their concern whilst sentencing persons to prison when aware of a history of mental illness, or at best precarious mental conditions at the time of sentencing.

**Security patients and a question of leave**

A security patient has the right to appeal to the Board and the Chief Psychiatrist for leave applications. This can include special one-off leave, as well as ongoing gradual leave which is arguably consistent with rehabilitation and treatment in a less restrictive environment. The Chief Psychiatrist has set up an advisory panel which makes recommendations to him, on leave applications. This panel comprises representatives from the Office of Corrections, the Adult Parole Board, the police, VOCAL (Victims of Crime) and the Public Advocate. The applicant has no right of appearance, but rather, has their interests put to the panel by the hospital. Recommendations from the panel are not always followed by the Chief Psychiatrist, however the Mental Health Review Board in attempting to exercise their dual jurisdiction has recently stated that they will first await the panel's recommendations, before proceeding with a leave application they may have received. Of course, it is worthwhile noting that the Board is bound by the rules of natural justice under the legislation. The reluctance of the Board to squarely exercise its power on this issue is one that is continuing to be addressed. For persons who are Governor's Pleasure patients and therefore security patients under the MHA, it is not unusual to find comments on the paperwork for leave decisions that leave is 'too soon!!', this is without regard to current clinical considerations. In view of the fact that a person has successfully raised the defence of
insanity at the time of the offence, sentencing principles are irrelevant when there are very strong clinical grounds for moving an incarcerated person towards less restrictive treatment and care. Treatment and care which correlates to the primary object of the Act demands the provision of treatment or care in the least restrictive environment.

**Sentencing (Amendment) Act 1993**

The Victorian government has recently introduced amending legislation to increase penalties for serious sexual offenders and serious violent offenders. The court **must** regard the protection of the community as the principal purpose of the sentence, and **may** impose a sentence longer than that which is proportionate to the gravity of the offence considered in the light of its objective circumstances (s.5A).

The **serious offences** include: murder, manslaughter, intentionally causing serious injury, threat to kill, rape, assault with intent to rape, incest, various offences of a sexual nature against children, abduction and armed robbery.

The **sexual offences** include: rape, indecent assault, assault with intent to rape, offences against children and conspiracy to commit, incitement to commit or attempting to commit any of these offences.

The **violent offences** include: murder, manslaughter, intentionally causing serious injury, threats to cause serious injury and threat to kill.

The persons to whom this legislation applies are
- for sexual offenders – those who have been convicted of two or more sexual offences (or one sexual and one violent offence) and have received periods of detention; and
- for violent offenders – those who have been convicted of a violent offence and have received a period of detention.

Certain sentences are cumulative, while some sentences are to be of an indefinite period, that such sentences are reviewable only at three years intervals and only after the expiry of a nominal sentence. It is anticipated that the application of the indeterminate legislation will be several years in the unfolding. Firstly because of the persons to whom the legislation applies. Secondly, because of the nature of the offences and the conduct of a defence (rather than entering a plea of guilty the accused may be advised to defend any charge in face of the cumulative nature of a sentence against conviction). Thirdly, because of the response of the courts to the interpretation of the legislation and the application of the sentencing principles.

**Conclusion**

So at one end there is rights-based legislation which is to ensure that persons who are mentally ill receive the best possible treatment and care in the least restrictive environment. In the middle there is legislation which is directed towards consistency in sentencing principles, crime prevention and the promotion of respect for the law. And finally, with a further move away from rights-based legislation, there is indefinite
sentencing legislation with its primary purpose being the protection of the community.

We are right not to assume that the people within the criminal justice system most in need of care and treatment within the mental health system are getting it. Neither can we assume that when people are directed to the mental health system by through the criminal justice system that they are getting treatment or care consistent with the legislative framework which guides the provision of that care. There is an uneasy tension between the two.

It is arguable that the two in fact cannot be reconciled. The lack of reconciliation will become even more entrenched as the pressure on beds increases, as does the prison population and the demands for the provision of better and more encompassing services for people within the criminal justice system who have a mental illness.

References