Diversion:
A Comparative Study of Law and Policy Relating to Defendants and Offenders with Mental Health Problems and Intellectual Disability

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Diversion: A Comparative Study of Law and Policy Relating to Defendants and Offenders with Mental Health Problems and Intellectual Disability

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Doctor of Philosophy

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Abstract

This thesis examines law and policy relating to defendants and offenders with mental health problems and intellectual disability. It is a comparative study of diversion in Ireland, England and Wales, Northern Ireland, Scotland and Australia. It explores the reasons why Ireland never developed formal diversion provisions, processes and initiatives equivalent to those developed in other common law jurisdictions. The thesis also considers the implications of the UN Convention on the Rights of Persons with Disabilities for mental health legislation, the insanity defence and similar defences in criminal law and for diversion practice. The thesis reviews the literature on diversion with a view to identifying best practice and models that can be used in Ireland to respond to the over-representation of persons with mental health problems in the Irish prison population. The deinstitutionalisation movement has increased visibility of persons with ID in the community, which means that anti-social or criminal conduct is also more visible, and is increasingly being dealt with in the criminal justice system. This thesis explores the relevant law and policy responding to defendants and offenders with intellectual disability in contact with the criminal justice system from a human rights perspective.

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List of Abbreviations

ACT	Australian Capital Territory
AMHP	Approved Mental Health Practitioner
ARC	Assessment and Referral Court List
CAMHS	Child and Adolescent Mental Health Service
CISP	Court Integrated Services Program
CJAs	Community Justice Authorities
CMH	Central Mental Hospital
COE	Council of Europe
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRISP	Court Referral for Integrated Service Provision list
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DHSSPS	Department of Health, Social Services and Public Safety
DOH	Department of Health
DOJ	Department of Justice
DPP	Director of Public Prosecutions
DSPD	Dangerous and Severe Personality Disorder
ECHR	European Convention on Human Rights and Fundamental Freedoms

ECtHR	European Court of Human Rights
FME	Forensic Medical Examiner
FMO	Forensic Medical Officers
FTAC	Fixated Threat Assessment Centre
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICCPR	International Covenant on Civil and Political Rights
ID	Intellectual Disability
IDA	International Disability Alliance
IDDP	Intellectual Disability Diversion Program
IHRC	Irish Human Rights Commission
IPP	Indeterminate Sentences for Public Protection
IPRT	Irish Penal Reform Trust
LLSA	Local Social Services Authority
LRC	Law Reform Commission
MDO Scheme	Mentally Disordered Offenders Scheme
MERIT	Magistrates Early Referral Into Treatment
MHC	Mental Health Commission
MHCLS	Mental Health Court Liaison Service
MHP	Mental Health Problem
MHRB	Mental Health (Criminal Law) Review Board
MI Principles	Principles for the protection of persons with mental illness and the improvement of mental health care"

NDA	National Disability Authority
NHS	National Health Service
NI	Northern Ireland
NOMS	National Offender Management Service
NSW	New South Wales
NSWLRC	New South Wales Law Reform Commission
OHCHR	United Nations Office of the High Commissioner for Human Rights
PACE	*Police and Criminal Evidence Act 1984*
PBNI	Probation Board for Northern Ireland
PCTs	Primary Care Trusts
PIRCLS	Prison In-reach and Court Liaison Service
PSNI	Police Service Northern Ireland
PSR	Pre Sentence Report
PWDs	Persons with Disabilities
Qld	Queensland
RC	Responsible Clinician
RMA	Risk Management Authority
RQIA	Regulation and Quality Improvement Authority
SA	South Australia
SC	Senior Counsel
SCCLS	Statewide Community and Court Liaison Service
Tas	Tasmania
UK	United Kingdom

UN	United Nations
US	United States
Vic	Victoria
WA	Western Australia
WHO	World Health Organization
WNUSP	World Network of Users and Survivors of Psychiatry
YPP	Young Persons' Probation

Chapter 1: Introduction

1. Background to this Thesis

When the proposal for this thesis was drafted in 2008 it suggested an examination of law and policy relating to the diversion of defendants and offenders with mental health problems (MHP) and intellectual disability (ID). As with many other jurisdictions throughout Western Europe and North America, Ireland had seen a dramatic increase in its prison population over the last number of decades. "A Vision for Change" published in 2006, the key policy document on the modernisation of mental health services was just published.[1] Its publication was a milestone in Irish mental health policy. Service users and their families were centrally involved in its development, adopting a person-centred recovery approach and placing a strong emphasis on the inclusion of service users in all aspects of mental health policy planning. The deinstitutionalisation movement was coming to an end in Ireland, in the sense that the last of the large psychiatric hospitals were closing and "A Vision for Change" contained the blueprint for the provision of community mental health services. Importantly, there was a commitment in "A Vision for Change" to the diversion of persons with MHPs and ID from the criminal justice system and the development of specialist forensic services in Dublin and high support units regionally. The literature on defendants and offenders with MHPs was very sparse in Ireland. However, the available research showed that there was a significant over-representation of persons with MHPs in the Irish prison population. Little consideration had been given to the role of diversion provisions, processes and initiatives in addressing the over-representation of persons with MHPs in the Irish prison population. By comparison there was even less literature on the experience of defendants and offenders with ID in the Irish criminal justice system.

The *Mental Health Act 2001* commenced a short time prior to the beginning of this research (November 2006).[2] The 2001 Act was heavily influenced by mental health legislation from other common law jurisdictions, in particular the *Mental Health Act 1983* (England and Wales). However, a notable absence in the legislation was provision of

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[1] "A Vision for Change" (Dublin: Stationery Office, 2006).

[2] See Statutory Instrument SI No 411/2006, *Mental Health Act 2001* (Commencement) Order 2006.

powers to divert persons with MHPs from the criminal justice system.[3] The other major legislative reform at the time of the commencement of this research was the enactment of the *Criminal Law (Insanity) Act 2006*. While this legislation was primarily focused on defences for homicides, there was provision for the transfer of prisoners with MHPs to the "designated centre" the only forensic mental health hospital in Ireland (the Central Mental Hospital). In addition to the lack of statutory provisions for diversion there was also an absence of other initiatives and processes aimed at identifying persons with MHPs and providing services and supports.

When initiating research for this thesis the first international human rights treaty of the 21st century had just been concluded and opened for signature and ratification in 2007. This treaty was the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Ireland had signed the CRPD and it was expected that it would ratify as soon as the Wards of Courts system, a form of plenary guardianship, was repealed and replaced by the new guardianship system recommended by the Law Reform Commission and adopted by the Government by way of the *Mental Capacity Bill 2008*.

Given this context and background, there was a perception that law and policy on responding to defendants and offenders with MHPs and ID was underdeveloped in Ireland, when compared to other common law jurisdictions. The lack of law and policy resulted in strategic litigation being taken by the Irish Penal Reform Trust (IPRT) shortly before research on this thesis started. In a very important judgment on *locus standi* the High Court permitted the IPRT to take an action on behalf of two applicants with MHPs who challenged "systematic deficiencies" in the treatment of prisoners with "psychiatric problems" in the State's largest prison, Mountjoy.[4] The inadequacy of existing law and policy was also confirmed with reference to the death of Gary Douch in 2006 in Mountjoy prison. A fellow prisoner with a MHP killed Gary Douch in an overcrowded holding cell.[5] In addition the problems,

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[3] There is little statutory provision for diversion of persons with MHPs beyond procedures for dealing with person deemed unfit to stand trial or who "successfully" raise the insanity defence or defence of diminished responsibility.

[4] See *Irish Penal Reform Trust Limited v The Governor of Mountjoy Prison* [2005] IEHC 305.

[5] See Chapter 3: Ireland

failures and deficiencies in providing treatment to prisoners with MHPs were well documented numerous times in the reports of the Committee on the Prevention of Torture (CPT) and the Inspector of Irish Prisons.

2. Objective of this Thesis

Given this background the objective of this thesis is to provide a critical analysis of current Irish law and policy relating to defendants and offenders with MHPs and ID. As other jurisdictions have developed a range of diversion provisions, processes and initiatives to divert defendants and offenders with MHPs and ID it was decided that a comparative study should be included in the research. This comparative study seeks to identify effective law and policy from other jurisdictions that could be applied in Ireland. In relation to defendants and offenders with ID it is difficult to establish from the available research whether there is an under-representation or over-representation in the Irish prison population. However, the de-institutionalisation movement and "resettlement" of persons with ID in the community raises important questions about the experience of persons with ID in the criminal justice system. As such an objective of this thesis is to capture information on the experiences of persons with ID involved with the criminal justice system in Ireland.

Since research on this thesis began provisions of the CRPD raise questions about the rationale and legitimacy of diversion policy and the processes involved (EG treatment for MHPs and restrictions on legal capacity). As such an objective of this research is to identify the implications of the CRPD for diversion and in the comparative study to evaluate the extent that the CRPD is influencing law and policy in the jurisdictions selected for this study.

In light of the foregoing discussion on the background to this thesis and its objectives the central research question is as follows:

1) What (if anything) can Ireland learn from the approach of other jurisdictions to diversion from the criminal justice system of persons with MHPs and ID?

This thesis also seeks to answer three sub-questions:

1) Why has Ireland not developed provisions, processes and initiatives aimed at diverting defendants and offenders with MHPs and ID from the criminal justice system?
2) Do such provisions, processes and initiatives aimed at diversion comply with international human rights law and if not how can diversion comply with international human rights law?
3) To what extent is the CRPD influencing law and policy on diversion from the criminal justice system of persons with MHPs and ID?

3. Scope of this Thesis

In line with the research questions outlined above it is necessary to limit the scope of this thesis to analysis of law and policy relating to adult defendants and offenders with a MHP or ID. Where useful and related to the research questions for the thesis other issues have been considered throughout this thesis such as the insanity defence, the partial defence of diminished responsibility, sentencing law, and the law on fitness to plead. A number of recommendations on expanding the research are made in Chapter 8: Conclusions and Recommendations.

4. Defining Diversion

There is no precise or conclusive definition of diversion. For the purposes of this thesis a broad understanding is taken to include a range of provisions, processes and initiatives that have a statutory or non-statutory basis that seek to divert defendants and offenders with MHPs and ID from the criminal justice system at all points of contact. Broad or narrow definitions of diversion manifest in practice. Some systems seek to minimise contact between persons with MHPs and ID while other diversion initiatives seek to divert persons to treatment or rehabilitation.[6]

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[6] EG The NSWLRC identified a broader understanding of diversion in the following terms: "A more complex form of diversion directs offenders away from the formal system into an alternative means of dealing with them, one that focuses on treatment rather than punishment. This form of diversion identifies the underlying causes of the offender's criminal behaviour and seeks to redress them". See "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (New South Wales Law Reform Commission, Consultation Paper 7, 2010) at page 3.

More complex forms of diversion have become increasingly popular in the jurisdictions included in this comparative study. In the literature the terms rehabilitation, diversion and therapeutic jurisprudence are used interchangeably or in isolation. This can be problematical and lead to confusion. However, for the purposes of this thesis the terms "rehabilitation" and "therapeutic jurisprudence" are understood to form part of diversion, as policies and practices that seek to respond to the needs of persons with MHPs and ID and form part of the process that very often leads to diversion. Court based diversion has a number of different meanings in terms of the types of defendants it targets in the criminal justice system. Namely, court diversion seeks to intervene in respect of drug users, persons with MHPs and minors.[7] For the purpose of this thesis the focus is on diversion in relation to adult defendants and offenders with a MHPs or ID.

5. The Problem with Definitions in this Thesis

There is no definition of disability included in the CRPD. Article 1 of the CRPD provides an open-ended approach to defining disability "[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".[8] This open ended approach reflects the idea that disability is "an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others".[9] This reflects the social model of disability, which is entwined in the different provisions of the CRPD. In order to avoid taking an approach that is mired in the medical model of disability, a fluid and flexible approach to the definition of disability is adopted in this thesis.

In the thesis when referring to persons with a disability in contact with the criminal justice system this should be understood to refer to

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[7] See James "Court Diversion in Perspective" (*Australian and New Zealand Journal of Psychiatry*: 40, 2006, pages 529-538) at page 529.

[8] See Article 1 of the CRPD.

[9] See Preamble to the CRPD.

defendants and offenders with a MHPs or ID. For the purposes of this research a broad approach is taken in relation to who can be considered to have a MHP or an ID. Terminology is very problematical as meanings vary from jurisdiction to jurisdiction. Participation in diversion schemes and processes across the different jurisdictions examined in this study is dependent upon meeting eligibility requirements. Whether or not the eligibility is agreed is based on definitions in national legislation (EG civil mental health legislation, criminal justice legislation or disability related legislation) or definitions developed by the different diversion schemes. ID encompasses terms used in other jurisdictions such as cognitive impairment, cognitive disability, learning disability or learning difficulty.[10] Most research internationally tends to adopt a narrow definition of "learning disability", which is based on measurements of IQ of 70 or below.[11] The term MHP encompasses terms such as mental illness, mental disorder and mentally disordered offenders.[12]

6. Methodology

The primary methodology for this research was a desk based comparative study of law and policy relating to defendants and offenders with MHPs and ID. Legal research methods have been used to undertake a comprehensive analysis of primary and secondary sources of law and policy that related to or impacted upon defendants and offenders with MHPs and ID who are in contact with the criminal justice system. A number of libraries were used in accessing the materials cited in this thesis, namely the James Hardiman Library at NUI Galway, the reference library at the Centre for Disability Law and Policy and the Law Library at the School of Law, University of California Berkeley. In addition to the use of the resources of these libraries, material was sourced through the inter-library loans (ILL) service at NUI Galway. A number of legal and social science databases were used to

[10] ID is the term most commonly used in policy documents in Ireland and is the term used by Inclusion Ireland, which is the "National Association for People with an Intellectual Disability".

[11] Loucks "No One Knows: Offenders with Learning Difficulties and Learning Disabilities: Review of Prevalence and Associated Needs" (London: Prison Reform Trust, 2007) at page vii.

[12] The term "mental health problem" is used by Amnesty International Ireland in its work on its mental health campaign. The term was the preferred term of the majority of the Experts by Experience Advisory Group, which guided Amnesty's work. See "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011) at page 10.

conduct searches, which yielded identification of and access to the literature on diversion and related fields.

In addition to the desk-based research methods, when it was considered necessary contact was initiated with relevant government departments (EG the Department of Health and Department of Justice), practitioners, non-governmental bodies working in the areas of mental health law and penal policy, academic commentators. Correspondence was initiated with a view to informing the research and bridging gaps in the literature and to gain an understanding of the practical and procedural issues relating to the thesis topic.

A literature review of diversion was written at the early stages of the research and a detailed bibliography of materials compiled. This literature review facilitated the detection of key writings, legislative approaches, policies and academic commentators across a number of different disciplines. Following the initial literature review it was identified that there was little consideration of diversion of adults from the criminal justice system in Ireland. It was decided to undertake key informant interviews with a number of key stakeholders in order to inform the gaps in the Irish research. Ethical approval was applied for and sought from the Research Ethics Committee in early 2011 and subsequently granted to undertake the research. It was initially envisaged that the interviews with key informants would involve a large sample. However, this was not feasible for a number of reasons. In total 11 interviews were conducted with key informants. The sample included 3 legal practitioners, 2 forensic psychiatrists, 2 advocates (who work with persons with MHPs in contact with the criminal justice system), 2 forensic psychologists (who primarily work with persons with ID), a social worker (working in forensic mental health services) and a manager (working in a service for persons with ID). As this is a limited sample and other key informants such as members of the Gardaí were not available for interview it was decided not to include an analysis of the interviews in this thesis. However, in chapter 3 there are references to some of the useful and important points raised in the interviews with the key informants.

7. Outline of this Thesis

7.1. Chapter 1: Introduction

This chapter sets out the background to this research, the objectives of the thesis and the research questions that this thesis seeks to answer. There is a definition of diversion for the purposes of this thesis. In addition this chapter discusses the problems with definitions and terminology and sets out the scope of the thesis.

7.2. Chapter 2: Literature Review

This chapter is divided into two parts. The purpose of **Part 1** of this chapter is to map the historical context of the experiences of persons with MHPs and ID through contact with the legal system and to chart the literature on the institutionalisation and deinstitutionalisation of PWDs. Differing theoretical perspectives on diversion, disability and criminality are discussed. This chapter explores the literature on the correlation between the provision of psychiatric beds and the use of prison and explores concepts such as trans-institutionalisation. The literature on diversion is reviewed and the different provisions, processes and initiatives on diversion are identified and divided into broad categories. There is a separate section that examines the experience of defendants and offenders with ID in the criminal justice system. **Part 2** of this chapter attempts to reconcile different and conflicting sources of international human rights law as they relate to diversion. Certain Articles of the CRPD have been interpreted in ways that challenge the legitimacy of diversion provisions, processes and initiatives. This part of the chapter critically explores the background to this development. There is also a consideration of how these interpretations sit with existing human rights law and whether the evolving understanding of the CRPD can be reconciled with corresponding provisions of the ECHR. The potential of the CRPD to embed human rights based approaches to diversion provisions; processes and initiatives is also discussed.

7.3. Chapter 3: Ireland

Formal diversion of defendants and offenders with MHPs and ID from the criminal justice system in Ireland is almost non-existent with the exception of a few initiatives. This chapter attempts to explain why

Ireland has not developed diversion at the different points of the criminal justice system. This chapter begins with a historical overview of the development of asylums and psychiatric hospitals, as this narrative is necessary to understanding the development of current law and policy in Ireland. This chapter then provides an overview of the existing law and policy relating to defendants and offenders with MHPs and ID in Ireland and the informal diversion processes that have developed in the absence of law and policy. This chapter also evaluates evidence of therapeutic jurisprudence approaches in the criminal justice system and the main criminal justice policies and the relevant mental health policies. A separate section considers the invisibility of defendants with ID in Ireland.

7.4. Chapter 4: England and Wales

This chapter is divided into two parts. Part 1 outlines the background to diversion in England and Wales and sets out the statutory provisions facilitating diversion. There is consideration of the effectiveness of diversion system in England and Wales. Part 2 identifies the competing rationale and objectives of diverting defendants and offenders with MHPs and ID from the criminal justice system. In addition there is a consideration of the barriers to achieving an effective diversion system in England and Wales. The extent to which the diversion system in England and Wales complies with the CRPD is also considered.

7.5. Chapter 5: Scotland

This chapter considers the relevant law and policy on diversion of defendants and offenders with MHPs and ID in Scotland. The relevant statutory provisions facilitating diversion are examined. The chapter considers the use of community disposals both at the prosecution stage and at the court stage. This chapter then considers the development of Scottish forensic mental health services, and the comparative success of developing these services in light of the failure to develop similar services in Ireland. There is consideration of the recent law reform of the insanity defence and the defence of diminished responsibility, with a particular focus on the discourse on the law reform process on the abolition of the defences. The emergence of risk management in Scottish criminal justice policy is also explored. The underexplored process of diversion to social work in Scotland is also examined.

7.6. Chapter 6: Northern Ireland

This chapter considers the law and policy in Northern Ireland (NI) relating to persons with MHPs and ID who come into contact with the criminal justice system. It considers the extensive and on-going reform process of mental health law and policy that began in NI over a decade ago. It also critically considers the attempt to create a single piece of legislation that covers mental health and mental capacity and the implications of the fused approach for defendants and offenders in the criminal justice system. In light of the proposed fused approach this chapter also considers the rational for a fused legislative framework and its implications for diversion. The diversion provisions, processes and initiatives in NI are discussed. These are of particular interest given that the Irish Government considered the NI model as a potential template when developing mental health legislation in the early 1990s. There is a separate section that examines the literature on the diversion of defendants and offenders with ID.

7.7. Chapter 7: Australia

As discussed in the introduction to this thesis Australia was selected as a comparator jurisdiction as there has been a significant amount of research and policy formation on persons with MHPs and ID involved in the criminal justice system. The purpose of this chapter is to examine innovative diversion provisions, processes and initiatives and their potential application in Ireland. In particular, this chapter critically discusses the trend across Australia of developing mental health courts in response to the over-representation of persons with MHPs in the Australian criminal justice system. Australian law and policy on responding to offenders with MHPs has been heavily influenced by therapeutic jurisprudence and this philosophy is embedded with the diversion programmes that have been developed in Australia since the 1990s. There is discussion of a specific court diversion programme for persons with ID in Western Australia.

7.8. Chapter 8: Conclusions and Recommendations

This chapter outlines the main conclusions based on the research carried out for this thesis and discusses the research questions that guided the research. A number of recommendations are made to

advance the development of diversion in Ireland. There are also a number of suggestions for future research in this area.

Chapter 2: Literature Review

1. Introduction

This chapter is divided into two parts. The purpose of Part 1 of this chapter is to set the historical context of the experiences of persons with MHPs and ID through contact with the legal system and to chart the literature on the institutionalisation and deinstitutionalisation of PWDs. There is a discussion on the different schools of thought on how to respond to defendants and offenders with MHPs and ID. This chapter also explores the literature on the correlation between the provision of psychiatric beds and the use of prison and explores concepts such as trans-institutionalisation. The literature on diversion is reviewed and the different provisions, processes and initiatives on diversion are divided into broad categories. There is a separate section that examines the experience of defendants and offender with ID in the criminal justice system. Part 2 of the chapter then attempts to reconcile different and conflicting sources of international human rights law as they relate to the notion of diversion.

Chapter 2: Literature Review Part 1

1. Background

The historical connections between mental illness and criminality can be partially explained by reference to the 19th century when the boundaries between the two were not clearly demarcated.[1] Indeed the conflation of disability and criminality in the 19th century went further than the lines between "mental disorder" and crime but also encompassed physical disabilities. Long and Midgley suggested that creating a link between mental disorder and the commission of crime was not positive for either group, as the perception of unpredictability and dangerousness re-enforced each other.[2]

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[1] Long and Midgley "On the closeness of the concepts of the criminal and the mentally ill in the nineteenth century: Yesterday's opinions reflected today" (*The Journal of Forensic Psychiatry*: 3(1), 1992).

[2] *Ibid*.

Controversies and theoretical divergence of views on criminality and criminal responsibility have featured prominently in the debate amongst different schools of criminological thought. The different perspectives on classical theory and the positivist perspective help inform the rationale for diversion. The foundations of our contemporary criminal justice system were laid in the 18th century, which was the period where the principles and practices of what is referred to as classical theory were developed and institutionalised for the first time in Europe.[3] Jeremy Bentham developed the classical theory to see human beings and society within the context of utilitarianism.[4] Bentham argued that all human behaviour could be boiled down to seeking pleasure and avoiding pain.[5] Classicism was modified with the introduction within its framework of principles drawn from positivism.[6] The obvious modifications were in relation to the treatment of minors and persons deemed to lack full rationality such as "the insane and feeble-minded".[7] As such the doctrine of "free will" required modification in order to factor in the "circumstantial factors and influences".[8] The amalgamation "of classicism and positivism – often labelled "neo-Classicism" – has, however, constituted the dominant criminological paradigm in Anglo-Saxon legal thought and practice, and is the main source of the eclectic synthesis … has

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[3] For a general introduction see White and Haines *Crime and Criminology: An Introduction* (Oxford: Oxford University Press, 2nd edition, 2001) at page 20. One of the leading thinkers in the development of classical theory was Beccaria who was very critical of the arbitrary nature of the criminal justice system and judicial system in the 18th century. He was opposed to excessive use of the death penalty and the routine use of torture. He was a proponent of the utilitarian idea of the greatest happiness for the greatest number of people in society. See the seminal work Beccaria *An Essay on Crimes and Punishment* (London: J. Almon, 1767).

[4] See Gottfredson and Hirschi *A General Theory of Crime* (Stanford: Stanford University Press, 1990).

[5] Bentham "The Principles of Penal Law" in *The Works of Jeremy Bentham* (J. Bowring ed. 1938-43) excerpt Von Hirsh and Ashworth *Principled Sentencing: Readings on Theory and Policy* (Oxford: Hart Publishing, 2004) at page 53. "Pain and pleasure are the great springs of human action. When a man perceives and supposes pain to be the consequence of the act, he is acted upon in such a manner as tends, with a certain force, to withdraw him, as it were, from the commission of the act."

[6] See Young "Thinking Seriously About Crime: Some Models for Criminology" in Fitzgerald, McLennon and Pawson (eds) *Crime and Society: Readings in History and Theory* (London: Routledge, 1981).

[7] *Ibid*.

[8] *Ibid*.

dominated British and North American criminology ever since."[9] The classical paradigm of criminology "has the largest history of any contemporary criminological theory but still continues to be a major influence both on institutions of social control and in controversies in criminology."[10]

The central tenets of the classical approach to criminology – free will, rationality, calculating offenders, make it an uneasy fit with the circumstances of persons with MHPs and ID. Positivism examines the psychological or biological factors behind offending and take a pathological perspective on criminal conduct that requires treatment and indeterminate detention. The positivist perspective seems to fit better in terms of examining the criminal conduct of offenders with MHPs. However, this "immediate temptation … to argue that mentally disordered offenders fit neatly within positivism, whilst classicism is the explanatory mode of choice for the majority of ordered offenders … falls into the trap of seeing mentally disordered offenders as distinct groups".[11] Nevertheless, Peay contends that "it is a useful device for thinking about how helpful it might be to assume that criminal behaviour is determined" and as such the behaviour is amenable to accurate prediction and controlled intervention.[12]

A further criticism of the positivist perspective is that intervention with an offender at an individual level is unlikely to be effective as the causes of crime are multifaceted. Therefore, it is suggested that the treatment intervention needs to be broad to address the different factors and the approach needs to tackle "the prevailing economic and social conditions."[13] In order for have effective interventions for offenders a range of other programmes need to be put in place to address social and economic issues such as education, training, employment and housing.[14] The treatment approach is also limited in changing "… the

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[9] *Ibid*.

[10] *Ibid*.

[11] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at pages 10-11.

[12] *Ibid*, at page 11.

[13] *Ibid*.

[14] Crow *The Treatment and Rehabilitation of Offenders* (London: Sage Publications, 2001) at pages 78-79.

predicted likelihood of future offending … since treatment can only address dynamic factors" and static factors such as previous offending "are amongst the strongest predictors [for] both criminal activity and desistence".[15] From a disability perspective the treatment approach advocated by positivist theorists is a medical model approach, which from the perspective of disability studies is objectionable (see below). The individual positivist approach to crime has been influential. However, as Peay notes "all one can ever sensibly ask is what difference, if any, to the multiplicity of factors that influence criminal behaviour, might mental illness make – either to increase or decrease the likelihood of its occurrence? There is no doubt that the position is complex". [16] Regardless of the different perspectives mental illness and criminality there is a long history of legal and regulatory responses that requires consideration.

2. The Legal and Regulatory History

To understand the context of diversion and how the current provisions, processes and initiatives developed it is necessary to understand the history relating to offenders with MHPs and ID. From the perspective of regulation early English mental health laws were concerned with the protection of private property as opposed to the protection of the individual. While statutes that date from the time of Edward I during the late thirteenth century had a protective purpose they also resulted in yields for royal income. Feudal Lords could abuse people of unsound mind when the sovereign intervened, on the basis of the principle of *parens patriae* to protect their lands as the monarch had the prerogative power to manage the lands of people of unsound mind. People of unsound mind became wards of the sovereign and the sovereign could decide where they were to live and what was to be done with them.[17] Medieval law has no specific provisions relating to persons with MHPs who did not have property. The 18th century marked the introduction for the first time, of express provisions that responded to persons with MHPs through providing for detention even though they did not have property. The *Vagrancy Act 1744* provided

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[15] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at page 11.

[16] *Ibid*, at page 43.

[17] Lithiby *Law Relating to Lunacy and Mental Deficiency* (London: Knight and Co, 1914, 4th edition) at page 52.

that justices could order "pauper lunatics" to be locked up and chained in a secure place.[18] The idea that dangerousness and mental ill health were intertwined was established from the beginning of the regulation in this area. Section 20 of the 1744 Act stated "sometimes there are persons, who by lunacy, or otherwise, are furiously mad, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad". These provisions were motivated by a fear that persons with MHPs would interfere with the property of third parties unless they were secured in institutions.[19]

The focus on treatment of persons with MHPs was addressed for the first time through the *Madhouses Act 1774*. This legislation sought to address the lack of regulation of private asylums as a result of concerns that they were operating under poor conditions.[20] Throughout the 19th century a greater number of legal rules and procedures were introduced in England that sought to protect persons held in private asylums and to safeguard people who were at risk of being committed to these institutions. The safeguards introduced at this time concluded the requirement of certification from medical practitioners. Public mental health hospitals were also introduced at this time and the Lunacy Commission was established.[21] The *Lunacy Act 1890* has been described as the legislative response to the unsatisfactory care provided to persons in institutions. Institutions at this time were focused on containment as opposed to treatment and the institutions were used as a place of confinement for socially deviant persons in addition to persons with MHPs.[22] It has been suggested that the conditions in these institutions led to a cynical attitude to mental health professionals and there was a fear that "sane" persons would be subject to involuntary detention.[23] As a result of these concerns the 1890 Act

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[18] For a discussion on the legislation see Lisle "Vagrancy Law its Faults and Their Remedy" (*Journal of Criminal Law and Criminology*: 5(4), 1915, pages 498-513) and Glover-Thomas *Reconstructing Mental Health Law and Policy* (London: Butterworths, 2002) at pages 4-5.

[19] Glover-Thomas *Reconstructing Mental Health Law and Policy* (London: Butterworths, 2002) at page 4.

[20] Lithiby *Law Relating to Lunacy and Mental Deficiency* (London: Knight and Co, 1914, 4th edition) at page 54.

[21] Glover-Thomas *Reconstructing Mental Health Law and Policy* (London: Butterworths, 2002) at page 7.

[22] *Ibid*, at page 16.

[23] *Ibid*.

put in place a legal framework that closely regulated the detention and treatment of persons in these institutions.[24]

Until the early 16th century royal officials acted as agents of the crown in handling petitions and appointing tutors or guardians.[25] In the 17th century the power of the royal officials was transferred to the Courts of Chancery.[26] The Chancery Courts appointed a guardian known as the committee charged with looking after the property and person of the ward.[27] The courts also relied on juries to determine, as a matter of fact, whether the person should be considered an "idiot" or "lunatic" and "juries sometimes used their discretion to avoid financially ruinous findings of idiocy.[28] Lunacy was preferred to idiocy because if the latter were found, the ward's assets were forfeited to the crown".[29] In the 19th century the decision-making in respect of wards was transferred to judges and court officials.[30] The *Lunacy Act 1890* consolidated the shift in resting responsibility for wards to judges and court officials in England. The Act provided a framework that set out how the property and personal matters of a person with an ID or MHP was to be administered. In England the *Mental Deficiency Act 1913* and subsequently the *Mental Health Act 1959* permitted persons with ID and MHPs to be taken into guardianship. This legislation entitled the guardian to make decisions on behalf of a person as though they were under the age of 14 and the guardian was the person's father.[31] These guardianship provisions were rarely used, as there was a reliance on committal to hospital.[32] Guardianship laws were not commonly used

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[24] *Ibid*, at page 3.

[25] See Carney and Tait *The Adult Guardian Experiment: Tribunals and Popular Justice* (Sydney: Federation Press, 1997) at page 10.

[26] Rees "The Fusion Proposal: A Next Step" in "McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 77.

[27] Carney and Tait *The Adult Guardian Experiment: Tribunals and Popular Justice* (Sydney: Federation Press, 1997) at page 10.

[28] *Ibid*.

[29] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 78.

[30] *Ibid*.

[31] Bartlett and Sandland *Mental Health Law: Policy and Practice* (Oxford: Oxford University Press, 2007) at page 488.

[32] Glover-Thomas *Reconstructing Mental Health Law and Policy* (London: Butterworths, 2002) at page 75.

until relatively recently as persons who would be subject to the provisions of the legislation were placed in institutional settings where decisions were made on the persons behalf across all areas of their life.[33] The later deinstitutionalisation movement meant that there was a large category of people coming out of institutions in particular people with ID who no longer were subject to mental health legislation as they were no longer forced to live in these institutional settings. In addition the cost of accessing the courts even when the deinstitutionalisation process began did not result in increased used of guardianship, due to the expense associated with using the provisions.[34] It was not until guardianship law was substantially reformed in the latter part of the 20th century that it became a popular method of substitute decision-making, particularly for persons with ID who were moving from institutional settings to community living.[35] As will be seen in Chapters 4, 5 and 6 guardianship legislation was connected to provisions in mental health legislation and provided for guardianship orders to be issued as a type of diversion.

3. The Rise and Decline and Rise of Institutionalisation

Scull suggested that at the end of the 19th century the poor law system was unable to respond to the growing number of poor persons unable to provide for themselves, and that the traditional methods of social control through feudal system, which had imposed social obligations on the rich in respect of the poor, lost their effectiveness.[36] Under this set of circumstances the economically efficient way of responding to these challenges and ensuring social control was to create a system of large institutions to deal with persons who were socially deviant and unable to provide for themselves.[37]

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[33] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010).

[34] *Ibid*, at page 79. Although another explanation for the avoidance of guardianship in Australia, for example, was that the trial leave, which subsequently became formalised by way of community treatment orders permitted psychiatrists to impose treatment in the community without the need to use guardianship powers.

[35] Carney and Tait *The Adult Guardian Experiment: Tribunals and Popular Justice* (Sydney: Federation Press, 1997) at page 13.

[36] Scull *Decarceration: Community Treatment and the Deviant: A Radical View* (Oxford: Polity Press/New Brunswick, New Jersey: Rutgers University Press, 1984).

[37] *Ibid*.

The literature explaining the deinstitutionalisation process proffers a number of explanations for the transition to provision of services in the community. These include the changing views of society towards persons with disability, the availability of psychopharmacology and the poor conditions of the institutions.[38] Scull uses the term decarceration to refer to the policy of closing down asylums, reformatories and prisons.[39] He explains that this decarceration movement involved at the same time the "community correction movement" and the move towards "community care".[40] The "community correction movement" was a trend to deal with people in the community as opposed to the use of custodial sentences.[41] The "community care movement" similarly sought to treat persons with MHPs in the community.[42] Scull's theory of decarceration was illustrated by policies at the time in the United Kingdom (UK) and the United States (US). He suggested that the decarceration policies were economically motivated.

The suggestion was that by the late 20th century the economic and social environment changed in a way that meant this system no longer made sense, as the burden on the state in providing welfare, housing and other programmes placed the state in a precarious fiscal position.[43] The decarceration movement made sense economically as the state could now spend less money by subsidising others to look after these populations in the community. Scull in his work was sceptical about the actual cost saving of moving from institutions to community care.[44] However, his thesis is that regardless of the real savings the primary rationale for the move from the institution to the community was not based on development of better or more effective treatment or any commitment to respecting the rights of persons housed in institutions.

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[38] See Turner "The History of Deinstitutionalization and Reinstitutionalization" (*Psychiatry*: 3(9), 2004, pages 1-4).

[39] Scull *Decarceration: Community Treatment and the Deviant: A Radical View* (Oxford: Polity Press/New Brunswick, New Jersey: Rutgers University Press, 1984).

[40] *Ibid*.

[41] *Ibid*.

[42] *Ibid*.

[43] *Ibid*.

[44] *Ibid*.

Scull suggested that decarceration was neither to the benefit of the community or the deviant.[45]

This view that "decarceration" was neither to the benefit of the community or the deviant is informed by some of the results of the process. Slovenko describes that process of trans-institutionalisation as involving "the mentally ill … alternately and repeatedly routed between the mental health and criminal justice systems".[46] In his article he concludes that many of the reasons why the "seriously mentally ill are now walking the streets or sitting in jails or prisons" is because of the "virtual demise of public psychiatric hospitals as the caring and treating agency for individuals with debilitating mental illness".[47] Of course this analysis is not a new theory; Penrose's law or Penrose's hypothesis developed in 1939 explored the inverse relationships between the number of psychiatric beds and the prison population. Lionel Sharples Penrose in his study examined 18 European Countries.[48] In its simplest terms the theory suggests that a decrease in the number of psychiatric beds available in a jurisdiction results in an increase in the prison population. While seemingly a simple theory it has given rise to a significant number of studies that examined the relationship between psychiatric beds and prison.

A study on Penrose's law showed that between 1963 and 2003 the number of persons in Irish psychiatric units and hospitals decreased from 19,801 to 3,658 approximately a five-fold decrease.[49] During the same period the Irish prison population increased from 534 to 3,176 (an increase of 2,642) a five-fold increase.[50] The statistics demonstrate a "significant inverse correlation between the number of individuals in Irish psychiatric units and hospitals and the daily average number of

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[45] *Ibid*.

[46] Slovenko "The Transinstitutionalization of the Mentally Ill" (Ohio North University Law Review: 29(3), 2003, pages 641-660) at page 641.

[47] *Ibid*, at page 660.

[48] Penrose "Mental disease and crime: Outline of a comparative study of European statistics" British Journal of (*Medical Psychology*: 18. 1939, pages 1-15).

[49] Kelly "Penrose's Law in Ireland: An Ecological Analysis of Psychiatric Inpatients and Prisoners" (*Irish Medical Journal*: 100(2), 2007, pages 373-374). This study involved a review of date from the annual census of psychiatric patients and prison statistics between 1963 and 2003.

[50] *Ibid*.

prisoners in Irish prisons over this period".[51] While this study has limitations it suggests that there has been a continual decline in the number of psychiatric inpatients and a continual increase in prisoners between the 1960s and the 2000s.[52] The data also reveals that there has been a significant net deinstitutionalisation in Ireland in this period as the number of increased prisoners is still much lower than the rate of persons detained in psychiatric units and hospitals in the period.[53]

A more recent study by Large and Nielssen examined the relationship between the numbers of psychiatric hospital beds and prisoners they found that prison and psychiatric populations were positively correlated in low-and middle-income countries but that there was no correlation in high-income countries.[54] A number of studies examining Penrose's Law concluded that the decline in psychiatric hospital populations resulted in an increase in the prison population. However, other researchers suggest that while the same inverse relationship exists they concluded that the variations were caused by distinct factors and were only indirectly related.[55] There are a number of studies where the researchers reached the conclusion that the decline in the provision of psychiatric beds resulted in an increase in the prison population.[56] In addition the suggestion in the research was that the same persons who may have been hospitalised in institutional settings

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[51] *Ibid*.

[52] *Ibid*.

[53] *Ibid*. The study is limited in that it looks at variables at a group rather level than individual level and the absence of data on potential variables such as crime rates, mental health service developments or socio-economic changes.

[54] Large and Nielssen "The Penrose hypothesis in 2004: Patient and prisoner numbers are positively correlated in low-and-middle income countries but are unrelated in high-income countries" (*Psychology and Psychotherapy: Theory, Research and Practice*: 82, 2008, 113-119).

[55] See for example Gunn "Future directions for treatment in forensic psychiatry" (*British Journal of Psychiatry*: 176, 2000, pages 332-338) and Priebe, Badesconyi, Fioritti, Hansson, Kilian, Torres-Gonzales, Turner and Wiersma "Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries" (*British Medical Journal*: 330(15), 2005, pages 126-126).

[56] See for example Biles and Mulligan "Mad or bad? The enduring dilemma" (*British Journal of Criminology*: 13, 1973, pages 275–279); Palermo, Smith and Liska "Jails versus mental hospitals: A social dilemma" *(International Journal of Offender Therapy and Comparative Criminology*: 35, 1991, pages 97-106) and Kelly "Penrose's Law in Ireland: An Ecological Analysis of Psychiatric Inpatients and Prisoners" (*Irish Medical Journal*: 100(2), 2007, pages 373-374).

were later subject to imprisonment.[57] A study published recently examined Penrose's law in post-communist countries.[58] The findings of the study did not support the "Penrose hypothesis in that historical context as a general rule for most of the countries".[59]

Prins argues that despite the broad consensus that persons with serious MHPs are over-represented in "correctional settings" in the US there is less agreement in relation to the policy trends that may have resulted in this over-representation.[60] Some of the research suggests that there is a direct link between the deinstitutionalisation process and trans-institutionalisation while others consider this to be a "reductionist explanation".[61] While other research from the US supported the notion that there has been a process of trans-institutionalisation in Pennsylvania.[62]

While the literature on the correlation between the provision of number of psychiatric beds and the over-representation of persons with MHPs in the criminal justice system is contested there is nonetheless a strong argument for a correlation. The research demonstrates that "mental disorder" amongst the prison population is substantial in both the remand and sentenced prison population and that the existence of the mental disorder will predate the commission of the criminal offences.[63]

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[57] *Ibid*.

[58] Mundt, Franciskovic, Gurovich, Heinz, Ignatyev, Ismayilov, Kalapos, Krasnov, Mihai, Mir, Padruchny, Potocan, Raboch, Taube, Welbel and Priebe "Changes in the Provision of Institutionalized Mental Health Care in Post-Communist Countries" (*PLoS One*: 7(6), 2012, e38490, pages 1-6). The background to this study was that the political changes after 1989 in post-communist countries resulted in a substantial reduction in the use of general psychiatric hospital beds. It was thought that in some countries this could be partly compensated by an increase in supported housing capacities and the provision of more beds in forensic psychiatric settings.

[59] *Ibid*.

[60] See Prins "Does Transinstitutionalization Explain the Over-representation of People with Serious Mental Illnesses in the Criminal Justice System?" (*Community Mental Health Journal*: 47(6), 2011, pages 716-722).

[61] *Ibid*.

[62] See Primeau, Bowers, Harrison, XuXu "Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions" (*Comprehensive Psychology*: 2(2), 2013, pages 2-10).

[63] See for example Singleton, Meltzer, Gatward, Coid and Deasy "Psychiatric morbidity among prisoners" (London: National Statistics, 1998).

It is clear from the above discussion that there is a rich academic literature that has sought to explain the policy on mental health and the criminal justice system and the "shifting populations in prisons, mental hospitals, care homes and the community".[64] This discourse, as Peay points out, supports the thesis the there is "fluidity between these defined populations and their vulnerability to being collapsed together or cut apart; but it is a fluidity that is difficult to establish on a categorical statistical basis".[65] Regardless of this complex relationship diversion has emerged as a part of the response to the over-representation of persons with MHPs in prison in North America and Western Europe and in other parts of the world.

4. The Different Types of Diversion

Institutionalisation continues to be a significant issue for policy-makers. Diversion has become a significant part of the criminal justice system across the common law world. It has developed as a way of responding to offenders with MHPs and persons with ID in contact with the criminal justice system. However, as identified in Chapter 1: Introduction there is no precise definition of diversion and a broad understanding of diversion is adopted for the purposes of this research. Diversion is taken to involve a range of processes, schemes and initiatives that have a statutory and non-statutory footing that seek to divert persons with MHPs and ID from the criminal justice system, at all points of contact. It is worth noting here that there is no consensus on what is best practice in terms of a diversion programme.[66] The reasons why there is no consensus might be explained (partially at least) in that diversion practice and procedure vary widely from jurisdiction to jurisdiction. Adopting a broad understanding of

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[64] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at page 40.

[65] *Ibid*.

[66] However, there have been some attempts to identify effective diversion programmes and pinpoint best practice. See for example: "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012); Livingston, Weaver, Hall and Verdun-Jones "Criminal Justice Diversion for Persons with Mental Disorders: A Review of Best Practices" (Ottawa: Canadian Mental Health Association, 2008); ""The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) and "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Melbourne: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010).

diversion this section will now attempt to provide a loose categorisation of the different diversion provisions, processes and initiatives.[67] By taking this broad approach the following provisions, processes and initiatives are identified from the literature review:[68]

- Diversion in the community;
- Diversion following arrest;
- Diversion before the trial;
- Diversion at the court and
- Diversion following conviction.

4.1. Diversion in the Community

There is scant literature on diversion in the community in comparison to the literature on the other diversion provisions, processes and initiatives. Diversion at this very initial stage is sometimes referred to as pre-offending diversion. Diversion at this point is generally community based and involves police, clinical and social support services and communities working in partnership with a view to facilitating access to supports for persons with mental problems and ID in the community. These types of diversion programmes run prior to the commission of an offence where an elevated risk of contact with the criminal justice system is identified. There are clear benefits to diversion at the earliest opportunity. For example, community diversion could facilitate access to services and supports in the community and avoid contact with the criminal justice system. Livingston, Weaver, Hall and Verdun-Jones suggest that an effective diversion model should begin with a "mental health and addiction service delivery system—before the behaviour of an individual with mental disorder is brought to the attention of the criminal justice system".[69]

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[67] Chapters 3, 4, 5, 6 and 7 will set out in detail the different elements of these diversion provisions, processes and initiatives in these comparative chapters.

[68] For an overview of the different types of diversion models see "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012); "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Melbourne: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010) and Livingston, Weaver, Hall and Verdun-Jones "Criminal Justice Diversion for Persons with Mental Disorders: A Review of Best Practices" (Ottawa: Canadian Mental Health Association, 2008).

[69] Livingston, Weaver, Hall and Verdun-Jones "Criminal Justice Diversion for Persons with Mental Disorders: A Review of Best Practices" (Ottawa: Canadian Mental Health Association,

The community based diversion model involves a broader range of stakeholders than just the police. Although it should be acknowledged that police are very often the first point of contact.[70] Other stakeholders include social services and mental health professionals who work with the police and other emergency services to facilitate support for persons with MHPs and ID when there is an "elevated risk of contact with the criminal justice system".[71] It has been acknowledged that community diversion has great potential as part of an effective diversion policy.[72] Neighbourhood policing that involves working with persons with MHPs and ID within their own community is considered important in the prevention of crime in the first instance.[73] This type of diversion process has the potential to address the needs of persons with MHPs who are homeless and have a co-occurring drug or alcohol addiction.[74] While the literature is not developed on these initiatives they are considered to have significant potential in "integrating criminal justice, healthcare, and community support services" for persons with mental health services in contact with the criminal justice system.[75] However, the process involves intervention on the basis of assessments or perceptions of risk, which is problematical from a rights perspective as no offence has being committed. This type of diversion also runs the danger of responding to perceptions of risk through forced treatment

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2008) at page 9.

[70] See "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009).

[71] "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Melbourne: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010) at page 17.

[72] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 29. However, despite recognition of the potential the community-based diversion the issue did not benefit from a full consideration in the review. Early intervention is seen as key to voiding vulnerable children and adults entering the criminal justice system and is considered to be the "key objective.

[73] *Ibid*.

[74] See Weisman, Lamberti and Price "Integrating Criminal Justice, Community Healthcare, and Support Services for Adults with Severe Mental Disorders" (*Psychiatric Quarterly*: 75(1), 2004, pages 71-85). This article describes "Project Link", which was an initiative developed by the University of Rochester Department of Psychiatry who collaborated with 5 local community based agencies.

[75] *Ibid*.

in the community, which may be mandated by mental health legislation and lead to involuntary detention for the purpose of treatment. These risks with the development of diversion at this point of the criminal justice system have not yet been explored to any great extent in the literature.

4.2. Diversion Following Arrest

A key component of post arrest diversion is the use of police caution or discretion in connecting persons to supports and services in the community as opposed to proceeding with prosecution. It has been noted that there has been an increased use of this type of process.[76] However, the research on diversion following arrest is not considered developed, particularly in relation to its effectiveness and further research is recommended to address the gaps in the available research.[77] Despite this some of the positive elements in the research have been identified as "treatment compliance", integration in the community, reduced homelessness, the development of skills necessary for independent living and evidence of improved quality of life.[78] However, negative elements associated with diversion at this stage have been identified as including the persistence of offending, readmission of participants to hospital, subsequent imprisonment and continued alcohol and drug abuse.[79]

The research suggests that formal procedures are essential in facilitating early identification of defendants requiring services. Stable accommodation arrangements for the person in receipt of diversion at this stage is also considered important, as is continued support through "active case management".[80] Diversion following arrest involves a

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[76] See Hartford, Carey and Mendonca "Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey" (*Behavioral Sciences and the Law Behavioral Science Law*: 24, 2006 pages 845-856).

[77] *Ibid*.

[78] *Ibid*, at page 854.

[79] *Ibid*.

[80] See Hartford, Carey and Mendonca "Pretrial Court Diversion of People with Mental Illness" (*The Journal of Behavioral Health Services and Research*: 34(2), 2007, pages 198-205). See also Hartford, Carey and Mendonca "Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey" (*Behavioral Sciences and the Law Behavioral Science Law*: 24, 2006 pages 845-856).

number of stakeholders including but not limited to police, emergency services, frontline workers in health services and mental health professionals. These stakeholders can if provided with appropriate training and other supports minimise contact with the criminal justice system and assist the person in accessing a range of community services and supports. The use of this type of diversion process is very much contingent upon the willingness of the police to exercise their discretion to prosecute. Bail can be used as a process at this point to refer a person to supports and services in the community.

4.3. Diversion Before the Trial

This type of diversion takes place in the period following the arrest of the person with a MHP or ID and before the court disposes of a case. There is an element of crossover with diversion following arrest and in the literature it can also be referred to as post-arrest diversion. The state agency with responsibility for making decisions about prosecution (or the police) normally determines whether to prosecute defendants with MHPs or ID. There may be a specific policy to guide decisions on whether to prosecute or divert these defendants.[81] There may also be specific schemes at the pre-trial point. Eligibility requirements for participation in pre-trial diversion programmes are a frequent feature. An applicant must meet these eligibility requirements in order to benefit from the scheme and risk assessments are undertaken routinely. [82] In the US pre-trial diversion programmes involve supervision and treatment and may also include a restorative justice element, community service and "counselling" and treatment.[83] Other aspects of programmes may require drug treatment and urinalysis.[84]

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[81] For example, guidance on the use of cautions or conditional cautions may be issued to guide prosecutors when making decision about persons with MHPs or ID. See "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 42.

[82] See "Promising Practices in Pretrial Diversion" (National Association of Pretrial Services Agencies, 2010) and See also "Pretrial Diversion in the 21st Century: A National Survey of Pretrial Diversion Programs and Practices" (National Association of Pretrial Services Agencies, 2009). A feature in the US is also "post-plea diversion programs", which require participants to plead guilty in order to access supervision, treatment and or other services in the community.

[83] See Camilletti "Pretrial Diversion Programs: Research Summary" (Bureau of Justice Assistance, US Department of Justice, 2010) at pages 1-2.

[84] *Ibid*.

Some research indicates "successful pre-trial programs appear to integrate relevant mental health, substance abuse and criminal justice agencies by having regular meetings between key personnel from the various agencies".[85] The literature indicates that there are many different ways to go about pre-trial diversion.[86] It is of note that some research has suggested that there are differences between persons diverted at the pre-arrest stage and later at the pre-trial stage. It was suggested that persons diverted earlier "were more educated, more involved with employment, and generally more satisfied with their lives, health, and finances".[87] In addition those diverted earlier have been arrested less often than persons diverted later, had less involvement with services and treatment, and were "less likely to use emergency rooms for MHPs, less likely to be prescribed psychotropic medication, and less seriously involved with drugs and alcohol in comparison to the subjects who were diverted at the postbooking sites".[88]

4.4. Diversion at the Court

Diversion at this point involves defendants who have been arrested, charged and are facing court proceedings in relation to the criminal offences they are accused of. The key feature of diversion at the court level is that the discretion exercised, for the benefit of defendants with MHPs or ID, is exercised not by the prosecution body or the police but rather by the judge in the court setting.[89] Diversion at the court stage for the purposes of this thesis is taken to include situations where a person is considered not fit to stand trial. The judge normally determines issues of fitness, with medical professionals informing the court as to the defendant's mental capacity. Programmes at this stage in the process can operate before or after the person has entered a

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[85] See Hartford, Carey and Mendonca "Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey" (*Behavioral Sciences and the Law Behavioral Science Law*: 24, 2006 pages 845-856).

[86] See Lattimore, Broner, Sherman, Frisman and Shafer "A Comparison Of Prebooking And Postbooking Diversion Programs For Mentally Ill Substance-Using Individuals with Justice Involvement" (*Journal of Contemporary Criminal Justice*: 19(30), 2003, pages 30-64).

[87] *Ibid*, at page 58.

[88] *Ibid*.

[89] See Livingston, Weaver, Hall and Verdun-Jones "Criminal Justice Diversion for Persons with Mental Disorders: A Review of Best Practices" (Ottawa: Canadian Mental Health Association, 2008).

plea. Participation in the programme may result in a suspension of the criminal proceedings until such time as the diversion programme comes to an end.[90] Diversion at this point may not involve a suspension of the criminal proceedings rather the delivery of treatment and services, and may take place alongside "the usual court processes".[91] Due to the large number of different models for court assessment and support provision it is difficult to describe these models in a concise or neat manner. However, it can be said that two of the most evident models from the literature are court liaison services and mental health courts.

Court liaison programmes are integrated within the court and facilitate many of the elements of court-based diversion.[92] These liaison services are integrated within the mainstream courts system.[93] The court liaison model generally involves the suspension of criminal proceedings in order to facilitate a person to engage with support services and treatment in the community. This may lead to charges being withdrawn or conviction with the imposition of a suspended sentence.[94] Court liaison services fulfil a number of different functions in supporting the decision-making of the court in respect of defendants and offenders with MHPs and ID. The undertaking of assessments of defendants is a key component of their work and includes assessments of fitness to stand trial, eligibility for diversion, and decisions on bail and the provision of reports to inform the court in sentencing.[95] Court liaison services may also provide support for defendants through providing clinical services and through connecting persons to service providers and other supports in the community.[96] In effect court liaison programmes can be an effective "linkage to other service providers, case management or service brokerage and liaison with community or

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[90] See "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Melbourne: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010) at page 24.

[91] *Ibid*.

[92] *Ibid*, at page 26.

[93] *Ibid*.

[94] *Ibid*.

[95] *Ibid*.

[96] *Ibid*.

prison based mental heath services".[97]

It should be noted that the courts are generally provided with a range of statutory provisions (normally located in mental health legislation) to facilitate diversion from the court. The literature demonstrates that these legislative provisions are not effective in and of themselves and court liaison services are essential to support diversion, by identifying persons with MHPs and ID. The implications of not identifying persons eligible to participate is significant as it can lead to delays in accessing community based services or indeed result it not being able to access them at all.[98] Mental health courts have become a dominant feature of diversion at the court stage over the past two decades. There is a rich literature on mental health courts, which will be considered separately and in greater detail below.

4.5. Diversion Following Conviction

Following conviction a judge may decide not to impose a custodial sentence and choose from a range of non-custodial sanctions, when available and considered appropriate. A person with a MHP may become unwell following conviction and while serving a custodial sentence in prison. Taking the broad definition of diversion, provision of transfer of prisoners from prison to mental health services outside of the prison is considered diversion. The literature indicates that there are significant issues in arranging transfer in a timely manner with prisoners waiting for long periods of time in prison while unwell.[99] Persons who "successfully" invoke the insanity defence (or other similar defence(s)), and who are not sent to prison, but rather sent to a psychiatric hospital are for the purpose of this thesis also considered to have been diverted from the criminal justice system. The insanity defence and other related offences are considered separately and in

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[97] *Ibid*. See also Winstone and Pakes "Provision of Mental Health Services to Individuals Passing Through the Criminal Justice System: A Qualitative Literature Review" (London: Office for Criminal Justice Reform, 2009).

[98] See Exworthy and Parrot "Comparative Evaluation of a Diversion from Custody Scheme" (*The Journal of Forensic Psychiatry*: 8(2), 1997, pages 406-416) at page 407.

[99] Earthowl, O'Grady, and Birmingham "Providing Treatment to Prisoners with Mental Disorders: Development of a Policy" (*British Journal of Psychiatry*: 182, 2003, pages 299-302) and Reed "Mental Health Care in Prisons" (*British Journal of Psychiatry*: 182, 2003, pages 287-288).

greater detail below.

5. Diversion: Arguments For and Against

Having set out the different categories of diversion, this section now considers the arguments for and against diversion. There is a significant amount of literature on diversion and this literature has identified arguments that both support diversion and criticise different aspects of diversion programmes. The form that diversion takes is dependent upon a number of factors including but not limited to; the provisions in the national mental health legislation and the historical development of the interaction between mental health services and the criminal justice system.[100] These factors can influence how effective diversion programmes are and the level of support that they receive from the relevant stakeholders in the diversion process. The debates and controversies around mental health courts will be considered separately below.

5.1. The Argument for Diversion

The WHO has acknowledged that the prison environment is harmful to mental health, substance abuse is widespread and diversion is often underdeveloped, under-resourced and badly administered.[101] The rationale of diversion of offenders with MHPs from the criminal justice system is that they are connected with services and supports in the community and in so doing an opportunity is provided to address the underlying problems that are resulting in contact with the criminal justice system. However, as will be seen from the discussion below some disability rights organisations are critical of diversionary programmes from a human rights perspective, as participation in such programmes may require psychiatric treatment, supervision and control in psychiatric setting or in the community.[102] In addition

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[100] See James "Court Diversion in Perspective" (*Australian and New Zealand Journal of Psychiatry*: 40, 2006, pages 529-538) at page 529.

[101] "Trencin Statement on prisons and mental health" (Geneva: World Health Organisation, October 2007) at page 5.

[102] For example, the World Network of Users and Survivors of Psychiatry has suggested that the "SMR should prohibit the diversion of people with psychosocial disabilities into medical supervision and control at any stage of detention or proceedings under the criminal law- trials, sentences and parole should be handled on an equal basis with others, as criminal rather than

connection to the mental health system can result in detention for indefinite periods of time where psychiatric treatment can be administered involuntarily. It has been suggested "diversion from the prison system to a secure psychiatric hospital is no longer beneficial for offenders, as detention in a secure hospital may lead to long-term deprivation of liberty without the legal safeguards available to ordinary offenders".[103]

Following on from the deinstitutionalisation process many persons with mental illness now live in the community and research has indicated that persons with "severe mental illness" are at great risk for crime victimisation and that this represents a "major public health problem".[104] This 2005 study from the US suggested that more than 25% of persons considered to have "severe mental illness" were the victims of a violent crime in the previous year.[105] This rate of violence is more than 11 times higher than that for the general population.[106] The annual incidence of violent crime in the "severe mental illness" sample was more than 4 times higher than the rate for the general population and depending on the type of violent crime (EG rape/sexual assault, robbery, assault) the prevalence was found to be 6 to 23 times greater among persons with "severe mental illness" than among the general population.[107]

This evidence-base is in contrast to media portrayal of persons with MHPs as being the perpetuators of violent crime. Research from the US also suggests, "mentally disordered people" are more likely to be

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medical matters". See WNUSP Submission on Revision of the SMR, 14 March 2011. Available at: www.chrusp.org/home/resources. <Last accessed 10 October 2013.>

[103] Shah "Human Rights and Mentally Disordered Offenders" (*International Journal of Human Rights*: 14(7), 2010, 1107).

[104] See Teplin, McClelland, Abram, and Weiner "Crime Victimization in Adults With Severe Mental Illness: Comparison With the National Crime Victimization Survey" (*Arch Gen Psychiatry:* 62(8), 2005, pages 911–921). Sever mental illness for the purposes of this survey involved the recruitment of persons who answered yes to one of the following questions - "(1) "Have you taken psychiatric medications for the past 2 years?" or (2) "Have you ever been hospitalized for psychiatric reasons?" We did not recruit clients arriving for their first visits or who were receiving crisis management services."

[105] *Ibid*.

[106] *Ibid*.

[107] *Ibid*.

victimised by violence.[108] The research indicated that the possibility of victimisation was "particularly strong" in circumstances where "mental disorder co-occurred with illegal drug use".[109] In addition "mentally disordered people" were more likely to be in "conflicted social relationships with others".[110] This research also suggested "one important reason mentally disordered people are more likely than non-mentally disordered to become victims of violence is that their relationships with others are more likely to involve conflict".[111] As such the research clearly identifies the need for community supports for this group, so as to safeguard against violence and victimisation.

5.2. The Prevalence of Mental Disorder in Prisons

One of the main rationales for diversion is the over-representation of person with MHPs in the criminal justice system. The research internationally suggests that throughout the world there is a significant over-representation of persons with MHPs in the criminal justice system. Diversion in the broadest sense has emerged as the main tool used to address this over-representation. The over-representation of persons with MHPs in the world's prisons is supported by the available statistics from the WHO, which estimates that 6–12% of all prisoners need to be transferred to "specialized institutions".[112] The literature reveals that throughout the world several million prisoners are likely to have serious mental disorders.[113] The study reported that prisoners were numerous times more probable to have "psychosis and major depression, and

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[108] Silver "Mental Disorder and Violent Victimization: The Mediating Role of Involvement in Conflicted Social Relationships" (*Criminology*: 40(1), 2002, 191–212) at page 206.

[109] *Ibid*.

[110] *Ibid*.

[111] *Ibid*.

[112] See Møller, Stöver, Jürgens, Gatherer and Nikogosian (eds) "Health in prisons: A WHO Guide to the Essentials in Prison Health" (Geneva: World Health Organization, 2007) at page 133. See also Birmingham "The mental health of prisoners" (*Advances in Psychiatric Treatment*: 9, 2003, pages 191–201).

[113] See Fazel and Danesh "Serious Mental Disorder in 23,000 Prisoners: A systematic Review of 62 Surveys" (*Lancet*: 359, 2002, pages 545–50). The study was based on a review of 62 surveys from 12 countries that included 22790 male prisoners. The study revealed that 2568 of 9776 were violent offenders). It also reported that 3-7% of men had psychotic illnesses, 10% major depression, and 65% a personality disorder, including 47% (46–48) with antisocial personality disorder. 4·0% of women were reported to have psychotic illnesses, 12% major depression, and 42% a personality disorder, including 21% with antisocial personality disorder.

about ten times more likely to have antisocial personality disorder, than the general population".[114]

5.3. Decisions on Bail Applications

While it could be argued that there is formal equality for persons with MHPs in eligibility to apply for bail, the literature suggests, "circumstances often conspire against" them and that they are more likely than counterparts without a MHPs to be remanded in custody.[115] This may be explained in that they are more likely to be homeless, "considered less likely to comply with bail or be perceived as more dangerous by virtue of their mental illness".[116] The literature has suggested that persons with MHPs are at greater risk of being detained on remand, as they may be considered unable to meet the bail conditions or obtain legal representation.[117] It has also been suggested that the lack of specialists facilities available when decisions are being made about bail may "mean that there is no other practical alternative" to remanding a person with a MHP on remand.[118] Diversion then is seen as a tool that addresses or at least seeks to address this discrimination. Identifying a person with a MHP or an ID and connecting them to supports in the community provides the court with an alternative to imprisonment. The diversion scheme may alleviate the courts concerns about risk.

5.4. Reductions in Offending

Researchers suggest that diversion programmes reduce offending.[119] The research suggests that the reduction in offending brought about

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[114] *Ibid*, at page 545.

[115] See Taylor and Gunn "Violence and Psychosis. I: Risk of Violence Among Psychotic Men" (*British Medical Journal*: 288, 1984, pages 1945-1949) and Birmingham "Diversion From Custody" (*Advances in Psychiatric Treatment*: 7, 2001, pages 198-207) at page 201.

[116] *Ibid*.

[117] See Davis "Assessing the 'Criminalization' of the Mentally Ill in Canada" (*Canadian Journal of Psychiatry*: 37, 1992, pages 532-538).

[118] See Birmingham "Diversion From Custody" (*Advances in Psychiatric Treatment*: 7, 2001, pages 198-207) at page 202.

[119] See James et al "Outcome of psychiatric admission through the courts" (London: Home Office: RDS Occasional Paper, 2002, 79).

by diversion is related primarily to theft and other comparable offences.[120] This has led researchers to put forward the premise that the reduction in offending as a result of admission through diversion, could be explained in that persons were connected to housing, social welfare payments and received care and support in their communities.[121] Connecting persons to services and supports in the community is considered an effective way of addressing offending.[122] All prisoners risk the loss of their home and their employment. For offenders with MHPs who have employment and accommodation it makes sense to ensure that they stay connected to their community and are not so severely disadvantaged by the loss of their income and home, particularly for short custodial sentences.

5.5. Responding to Reduced Culpability and Multiple Disadvantages

The New South Wales Law Reform Commission in its work on diversion identified one of its rationales for supporting diversion was that a persons "impairment" could result in "reduced culpability making the application of traditional criminal law processes and penalties unfair or inappropriate".[123] In addition the literature has identified that persons with MHPs and ID "face multiple social disadvantages that make them more likely to offend, and become caught up in a cycle of offending and incarceration".[124] Diversion then is seen as essential in breaking this cycle as part of the response to multiple disadvantages.

5.6. The Economic Benefits of Diversion

A review of the literature on diversion reveals that another significant rationale for diversion is the potential savings yielded from diversion from the criminal justice system.[125] This rationale (much like the

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[120] *Ibid*.

[121] *Ibid*.

[122] "Diversion: The Business Case for Action" (London: Centre for Mental Health, Rethink and the Royal College of Psychiatrists, 2011).

[123] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012), at page 28.

[124] *Ibid*.

[125] See for example James "Court Diversion in Perspective" (*Australian and New Zealand Journal of Psychiatry*: 40, 2006, pages 529-538), Scott and Moffatt "The Mental Health Treatment Requirement: Realising a Better Future" (London: Sainsbury Centre for Mental

economic arguments for deinstitutionalisation see above) is likely to appeal to policy-makers more so than more benevolent or rights based arguments. The cost savings are yielded through diverting from the prison setting, which is costly particularly for persons with MHPs.[126] Research has identified that significant additional costs are required to treat prisoners with MHPs, compared to prisoners not requiring such treatment.[127] However, it should be noted that this cost is mitigated if treatment is not available or if only poor quality services are provided. The literature certainly supports the notion that mental health services provided in prison are insufficient to meet the needs of prisoners with MHPs.[128] A quantitative review of the effectiveness of Mental Health Courts concluded that there was cost savings yielded from their operation.[129] The cost savings from diversion are obvious; they include reductions in the number of arrests; prosecutions, remand costs, ineffective court hearings and other delays in the criminal justice system.[130] Cost savings are also yielded in terms of, the reduced use of custodial sentences, as community sanctions and alternatives in the community are used.[131]

Despite the fact that there are cost-savings from diversion the overall cost of diversion may not bring an overall cost saving. This is because the development of diversion systems such as those in England and Wales, NI, Scotland and Australia require investment in the creation of

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Health, November 2012) and Cowell, Broner and Dupont "The Cost-effectiveness of Criminal Justice Programs for People with Serious Mental Illness Co-occurring with Substance Abuse (*Journal of Contemporary Criminal Justice*: 20(3), 2004, pages 292-315).

[126] James "Court Diversion in Perspective" (*Australian and New Zealand Journal of Psychiatry*: 40, 2006, pages 529-538). The UN also noted that prisoners with ID are "likely to be in need of special health care services, such as behavioural therapy, speech therapy, occupational therapy and physiotherapy. Studies have shown that people with ID face a higher prevalence of psychosocial or psychiatric disabilities than the general population and they will therefore need greater access to appropriate treatment". See "Handbook on Prisoners with Special Needs" (Vienna: United Nations Criminal Justice Handbook Series, United Nations Office On Drugs And Crime, 2009) at page 14.

[127] *Ibid*.

[128] See Fellner "A Corrections Quandary: Mental Illness and Prison Rules" (*Harvard Civil Rights Law Review*: 41, 2006, pages 391-412).

[129] See Sarteschi, Vaughn and Kim "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review" (*Journal of Criminal Justice*: 39, 2011, pages 12–20).

[130] Parsonage "Diversion: A Better Way for Criminal Justice and Mental Health" (London: Sainsbury Centre for Mental Health, 2009) at page 34.

[131] *Ibid*.

systems (see Chapters 4, 5 and 6). Expenditure is required in order to carryout assessments, to provide services (treatment and rehabilitation), to set up case management and arrange accommodation for the person in the community.[132] These costs are significant particularly where they have not been provided for before and the long-term savings to be yielded may not be sufficient to ensure that the investment is made or if made initially renewed. A study of jail diversion programmes in the US suggested that while diversion yields lower costs in the criminal justice system, diversion results in greater costs in the short run as treatment costs are greater than the savings in the short run.[133]

The literature supports the proposition that diversion can yield a reduction in expenditure in the criminal justice system. However, this requires the provision of community treatment and engagement with the health care system and the potential saving in the criminal justice system is aggravated by a greater expenditure in the health care system. However, a long-term view is essential as research from the US suggests that while the cost of diverting a person to the community for treatment outweighs the initial saving in first year the costs were recovered by the end of the second year.[134]

5.7. The Impact of Prison on Persons with MHPs and ID

A further rationale for diversion has been identified in terms of the impact of imprisonment on persons with a MHP or ID.[135] Some research has reported that the impact of imprisonment has resulted in the deterioration of their mental health, most significantly as a result of

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[132] For a discussion on this see "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 38.

[133] See Steadman and Naples "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders" (*Behavioural Science and the Law*: 23, 2005, page 163) at page 168.

[134] This study examined data from Travis County, Texas, US. See Hughes, Steadman, Case, Griffin and Leff "A Simulation Modelling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness" (*Criminal Justice and Behaviour*: 39(4), 2012, pages 434-446) at page 441.

[135] For a discussion on this see "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at pages 31-32.

being separated from family and especially their children.[136] Reception into prison has also been reported as bringing about feelings of shock and depression.[137] It has been suggested that imprisonment intensified the symptoms of MHPs that existed prior to detention and indeed served to bring about new symptoms.[138]

A number of prison practices are likely to have a greater detrimental impact on persons with MHPs and ID. For example, the negative impact of the use of solitary confinement in prison is well documented.[139] While there are negative effects on physical health such as heart palpitations, diaphoresis, back and joint pains deterioration of eyesight, poor appetite, weight loss, diarrhoea, lethargy, weakness, tremulousness and the aggravation of pre-existing medical problems the impact of solitary confinement on mental health is considered one of the "most widely reported effects of solitary confinement".[140] The impact on mental health varies depending on "the individual and the context, length and conditions of confinement".[141] It is also reported that the "experience of previous trauma will render the individual more vulnerable, as will the involuntary nature of confinement as punishment, and confinement that persists over a sustained period of time".[142] The psychological effects of solitary confinement can result in anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis and can result in self-harm and suicide.[143] It is obvious then that persons with MHPs should not be subject to provisions by way of the requirement to reasonably accommodate (see below for discussion on

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[136] Plugge, Douglas, and Fitzpatrick "The Health of Women in Prison Study Findings" (Oxford: Department of Public Health University of Oxford, 2006) at page 49.

[137] *Ibid*.

[138] See Walsh "Diverting Mentally Ill Women Away From Prison in New South Wales: Building on the Existing System" (*Psychiatry, Psychology and Law*: 10, 2003, 227) at page 228 and Perry "Court Mandated Outpatient Treatment for Mentally Ill Offenders in New South Wales" (*Current Issues in Criminal Justice*: 19(3), 2008, 369).

[139] See in particular Shalev "A sourcebook on Solitary Confinement" (London: Manheim Centre for Criminology, London School of Economics, 2008).

[140] *Ibid*, at page 15.

[141] *Ibid*, at page 15.

[142] *Ibid*, at page 15.

[143] *Ibid*, at pages 16-17.

reasonable accommodation), which would be unnecessary if diversion to the community was provided for in the first instance. The implications of the use of solitary confinement has been highlighted by the Special Rapporteur Torture who stated:

> "[W]here the physical conditions and the prison regime of solitary confinement cause severe mental and physical pain or suffering, when used as a punishment, during pre-trial detention, indefinitely, prolonged, on juveniles or persons with mental disabilities, it can amount to cruel, inhuman or degrading treatment or punishment and even torture. In addition the use of solitary confinement increases the risk that acts of torture and other cruel, inhuman or degrading treatment or punishment will go undetected and unchallenged."[144]

Indeed the Committee on the Prevention of Torture (CPT) have found that solitary confinement of prisoners "can have an extremely damaging effects on the mental, somatic and social health of those concerned".[145] The CPT standards acknowledge that solitary confinement "can provide for the deliberate infliction of ill- treatment".[146] Diversion then can be seen as an important tool in mitigating the effects of imprisonment that are likely to have a disproportionate impact on persons with disabilities (PWDs). Similarly, the UN have identified that specific groups are particularly vulnerable within the prison system, amongst them persons with MHPs and ID.[147] As such it is recommended that legislative reforms should be considered and "community sanctions and measures" be used to reduce the imprisonment of vulnerable prisoners.[148]

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[144] "Interim report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" (United Nations: General Assembly, A/66/268, 2011).

[145] See "European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT): CPT Standards" (Strasbourg: CPT/Inf/E (2002) 1, revised 2011) at page 29.

[146] *Ibid*, at page 37.

[147] See "Handbook on Prisoners with Special Needs" (Vienna: United Nations Criminal Justice Handbook Series, United Nations Office On Drugs And Crime, 2009) at page 1. The other prisoner groups identified as vulnerable include: ethnic and racial minorities and indigenous peoples; foreign national prisoners; lesbian, gay, bisexual, and transgender prisoners; older prisoners; prisoners with terminal illness and prisoners sentenced to death.

[148] *Ibid*, at pages 2 and 49.

5.8. Benefits to the Criminal Justice System

There are a number of other benefits flowing from a policy of diversion to the criminal justice system. One of the main benefits is that diversion programmes involve the creation of formal liaison services that link persons with MHPs and ID to services in the community (provided that they are eligible to participate in such programmes). Persons with MHPs and ID very often have difficulty in accessing services and the creation of a liaison service bridges the gap between the criminal justice system and social services and services in the community. Other benefits flowing from diversion include raising-awareness of mental health amongst stakeholders in the criminal justice system; facilitating speedier psychiatric evaluations; reduction of risk of dangerous or disorderly conduct in custody as a result of early identification of prisoners with MHPs and transfer to hospital or being discharged into the community on bail.[149] Parsonage also identified that diversion can result in less of a need for formal psychiatric reports, which consequently can reduce unnecessary detention on remand in order to wait for a psychiatric report on the person with a MHP.[150]

5.9. The Case Against Diversion

While the literature on diversion broadly supports diversion as an idea many of the different provisions, processes and initiatives seeking to divert persons with mental health and ID from the criminal justice system gave attracted criticism. It is important to note that these criticisms do not necessarily amount to a call to abandon diversion; rather criticisms very often are aimed at refining the effectiveness of the different provisions, processes and initiatives. One of the main critiques of diversion is that diversion has a net widening effect. The premise is that the result of creating special programmes, processes and initiatives in respect of defendants and offenders with MHPs or ID is that diversion increases involvement with the criminal justice system.[151] Diversion programmes are very often risk adverse and seek to manage

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[149] Parsonage "Diversion: A Better Way for Criminal Justice and Mental Health" (London: Sainsbury Centre for Mental Health, 2009) at page 19.

[150] *Ibid*.

[151] See King, Freiberg, Bagtagol and Hymas *Non-Adversarial Justice* (Sydney: Federation Press, 2009) at page 175.

risk by excluding persons who have committed what are considered to be more serious crimes. The rationale for this exclusion is that it would not be appropriate to include such persons in programmes and that punishment ought to be administered. Another criticism of diversion is that acceptance on to a diversion programme very often involves an admission of liability and a guilty plea and it has been suggested that participants have felt forced into pleading guilty.[152]

5.10. Effectiveness

One of the main perceived advantages to diversion is that the process facilitates access to treatment and this in turns addresses the cause or at least one of the main causes of the persons offending behaviours and reduces further offending.[153] However, the literature on diversion is imperfect and different perspectives abound as to the effectiveness of diversion. Nonetheless there is a consensus in the literature that diversion can be effective and diversion programmes and schemes can respond effectively to defendants and offenders with MHPs and ID. While the evidence on the effectiveness of diversion is contradictory there is evidence that diversion can be "highly effective" in terms of accessing in-patient treatment (if you consider this desirable).[154] James suggests that when diversion at the court stage is ineffective this is due to court diversion services being inadequately planned, organised or resourced, which serves to limit their effect.[155] In order for diversion to be effective James argues that there is need for a "central strategy" with appropriately designed and sufficiently supported court services that are incorporated as a "core part of, mainstream local psychiatric provision". [156] This reflects other research that suggests that effectiveness of "criminal justice liaison and diversion services" is dependent upon the methods of service delivery, the availability of services in the community and the commitment of participants with the

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[152] See Freiberg "Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Incrementalism?" (*Law in Context*: 20, 2002, page 6) at page 19.

[153] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 26.

[154] See James "Court diversion at 10 years: can it work, does it work and has it a future?" (*Journal of Forensic Psychiatry*: 10(3), 1999, pages 507-524).

[155] *Ibid*.

[156] *Ibid*.

programme and treatment.[157] Another study suggested that there is little evidence of the effectiveness of diversion programmes in actually reducing recidivism amongst persons with serious mental illness.[158] However, this study while suggesting that there is little evidence of the effectiveness in reducing recidivism (amongst persons with serious mental illness) it was conceded that there was evidence that diversion schemes do reduce the amount of prison time, which persons with a "mental illness serve".[159]

6. The Relationship Between Mental Illness and Crime

The available literature on the certainty and strength of a relationship between mental disorder and crime has not been conclusive and this provides theoretical and conceptual difficulties in relation to diversion. Peay has described the relationship as ricocheting "between positions of scepticism and conversion".[160] However, there is an "emerging consensus" that there is a relationship between some crimes and some people who are experiencing some symptoms of a "mental disorder" but that the relationship is slight.[161] One school of thought on the relationship between violence and mental disorder does not focus on treating violence as the evidence-base rather they argue that the focus should be on clinical risk management.[162] Madden suggests that even if the numbers are very small there is an obligation on clinicians to predict violence and intervene in order to prevent harm and that a failure to do so would amount to negligence. This can be contrasted to Thornicroft's position; while Thornicroft accepts the assertion that there is a link between mental illness and crime he argues that the incidence

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[157] See Scott, McGilloway, Browne and Donnelly "Effectiveness of Criminal Justice Liaison and Diversion Services for Offenders with Mental Disorders: A Review" (*Psychiatric Services*: 64(9), 2013, pages 843-849). It should be noted that the methodology of the studies that evaluated the effectiveness of the criminal justice liaison and diversion services were described as only "moderately rigorous".

[158] Sirotich "The Criminal Justice Outcomes of Jail Diversion Programs for Persons With Mental Illness: A Review of the Evidence" (*Journal of the American Academy of Psychiatry and the Law*: 37, 2009, pages 461-72).

[159] *Ibid*.

[160] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at page 41.

[161] *Ibid*.

[162] See *Madden Treating Violence: A Guide to Risk Management in Mental Health* (Oxford: Oxford University Press, 2007).

of this link and the perception of the link should be of concern, as this perception informs the response to persons with MHPs.[163]

In the UK high profile homicides committed by persons with MHPs have been reported in the mass media as evidence that the provision of mental health services in the community are unsuccessful. However, the research conducted by Taylor and Gunn into the frequency of these homicides has, in light of changes to psychiatric services, revealed that there was little variation in the numbers of people with a mental illness committing criminal homicide.[164] This study, which looked at a period of 38 years, reported a 3% annual decline in their contribution to the official statistics. Taylor and Gunn concluded in their study that there is no evidence to claim that the presence of persons with "mental illness" living in the community is a "dangerous experiment that should be reversed".[165] This study found that demands for greater control and compulsion over persons with MHPs to accept treatment because of the potential for dangerous conduct had little relationship to the real risk posed and was much lower than deaths in road traffic accidents.[166]

Thornicroft has explored in detail the stigma and discrimination experienced by persons with MHPs in all areas of their lives.[167] Thornicroft suggests that the majority of people learn about mental illness through their own experiences of persons with MHPs and through the mass media. He argues that the mass media report stories regarding persons with MHPs in an inaccurate and sensational manner; portraying persons with "mental illness" as unpredictable, dangerous, violent and different.[168] Other commentators have also considered the disproportionate media reporting on mental illness and violence was

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[163] Thornicroft *Shunned: Discrimination Against People with Mental Illness* (Oxford: Oxford University Press, 2006) at page 126.

[164] Taylor and Gunn "Homicides by People with Mental Illness: Myth and Reality" (*British Journal of Psychiatry*: 174, 2009, pages 9-14).

[165] *Ibid*.

[166] *Ibid*.

[167] Thornicroft *Shunned: Discrimination Against People with Mental Illness* (Oxford: Oxford University Press, 2006).

[168] *Ibid*. See also "What's the Story? Reporting on Mental Health and Suicide: A Resource for Journalists and Editors" (London: Shift, 2008).

"[o]ne of the most damaging public misconceptions about people with MHPs is that they are dangerous and unpredictable".[169]

Given that the evidence linking mental illness and criminality is weak the question that is then posed why the "myth of mental illness as criminality" persists?[170] The explanation for this in part is that the "folk notion of madness as craziness which in some of its forms can be associated with occasional extremely bizarre crimes which lead people to conclude that the offender must be mad".[171] As we have seen above there had been a historical conflation of psychopathy and mental illness. Beyond the historical reasons a further explanation for the conflation of mental illness and criminality is the connection of alcohol and drug abuse with serious crime.[172] It is suggested that there is a tendency to view these addictions as mental illnesses, which is reinforced by the involvement of psychiatrists in treating these addictions.[173]

The "medicalisation" of crime can be identified as a further explanation for the conflation of crime and mental illness.[174] Examples of this medicalisation include recognising arson as pyromania and theft as kleptomania as evidenced by their inclusion in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[175] However, while it can be argued it is appropriate to recognise certain signs as symptoms as pyromania and kleptomania "the general medicalization of crime has the unfortunate effect of encouraging the belief in a close association of mental illness and criminality".[176] In addition the "combined effects of the medicalization of crime by the caring professions and the

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[169] *Ibid*.

[170] Campbell and Heginbotham *Mental Illness Prejudice, Discrimination and the Law* (Dartmouth, 1991) at page 133.

[171] *Ibid*.

[172] *Ibid*, at page 134.

[173] *Ibid*.

[174] *Ibid*.

[175] *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (American Psychiatric Publication, 5th Edition, 2013). For a discussion on the DSM and deviance see Gosden "The Medicalisation of Deviance" (*Social Alternatives*: 16(2), 1997, pages 58-60).

[176] Campbell and Heginbotham *Mental Illness Prejudice, Discrimination and the Law* (Dartmouth, 1991) at page 134.

criminalization of mental illness in popular mythology makes the area of criminal law a potent channel for mental illness and discrimination".[177]

The correlation between mental illness and substance abuse in the probation and parole populations has also been identified in the research.[178] Research suggests that persons with a diagnosis of schizophrenia are almost 3 times more likely to have a criminal conviction are 4 times more likely to have a criminal conviction for a violent offence.[179] However, while schizophrenia and other "psychoses" are associated with violence and the commission of violent crimes in particular homicide, the research also shows that "most of the excess risk appears to be mediated by substance abuse comorbidity".[180] Some of the literature suggests that persons with MHPs are responsible for 5-10% of violent crimes committed in the community.[181] It is important to note that research relating to persons with ID has identified that persons with ID have a propensity to commit certain crimes. A survey across a number of different continents reported high rates of aggression amongst persons with ID.[182] At any rate it is clear from the research that the situation is complex and a cautious approach to the literature is essential.

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[177] *Ibid*.

[178] See for example Lurigio, Cho, Swartz, Johnson, Graf and Pickup "Standardized assessment of substance-related, other psychiatric, and comorbid disorders among probationers" (*International Journal of Offender Therapy and Comparative Criminology*: 47(6), 2003, pages 630–652).

[179] See for example Tiihonen, Isohanni, Rasanen, Koiranen and Moring "Specific major mental disorders and criminality: A 26-year prospective study of the 1966 Northern Finland birth cohort" (*American Journal of Psychiatry*: 154(6), 1997, pages 840-845) and Arseneault, Moffitt, Caspi, Taylor and Silva "Mental disorders and violence in a total birth cohort: Results from the Dunedin study" (*Archives of General Psychiatry*: 57(10), 2000, pages 979-986).

[180]Fazel, Långström, Hjern, Grann and Lichtenstein "Schizophrenia, Substance Abuse, and Violent Crime" (*Journal of the American Medical Association*: 301(19), 2009, pages 2016-2023).

[181] See Walsh, Buchanan, and Fahy "Violence and schizophrenia: examining the evidence" (*British Journal of Psychiatry*: 180, 2002, pages 490-495) and Fazel and Grann, "The population impact of severe mental illness on violent crime" (*American Journal of Psychiatry*: 163, 2006, pages 1397-1403).

[182] See Taylor and Novaco *Anger Treatment for Offenders with Intellectual Disabilities: A Theory, Evidence and Manual Based Approach* (Chichester: Wiley, 2005).

7. The Social Model of Disability and Users and Survivors of Psychiatry and Anti-Psychiatry Movement

The relationship between mental illness and crime is an uncertain, controversial issue that can serve to stigmatise persons with MHPs. However, as already discussed treatment of mental illness is a key component of the different diversion processes, schemes and initiatives. This is problematical as this medical approach is at odds with the paradigm shift in thinking from the "medical model" of disability to the now dominant "social model" of disability. Members of the users and survivors of psychiatry movement challenge the legitimacy of diversion, which they consider a tool of forced psychiatric treatment.[183] This is an important argument against diversion and one that has been given more weight as the social model of disability has been influential in the development of the CRPD (this will be discussed in greater detail below).

The medical model has long been associated with disability and has been the focus of much criticism.[184] The social model of disability sees disability as a consequence of an environment that is organised to meet the needs of persons who are considered "normal".[185] The social

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[183] See for example Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012) and "Submission to Second Intergovernmental Expert Group Meeting on the Review of the Standard Minimum Rules on the Treatment of Prisoners" (United Nations: Submission by World Network of Users and Survivors of Psychiatry, 2012, UNODC/CCPCJ/EG.6/2012/NGO/5).

[184] The focus of the medical model of disability is on the individual and the underlying approach has been to use medicine to "treat" disability. The social model of disability is a perspective of disability that has emerged as a response that challenges the medical model of disability.

[185] See Traustadóittir "Disability Studies, the Social Model and Legal Developments" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 3. Barnes ''A Legacy of Oppression: A History of Disability in Western Culture'' in Barton and Oliver (eds) *Disability Studies: Past, Present and Future* (Leeds: The Disability Press, 1997) pages 3-24, Barnes, Oliver and Barton (eds) *Disability Studies Today* (Cambridge: Polity, 2002), Baynton ''Disability as a Useful Category of Historical Analysis'' (*Disability Studies Quarterly*: 17 1997, page 85), Goggin and Newell *Disability in Australia: Exposing a Social Apartheid* (Sydney: UNSW Press, 2005), Meekosha and Dowse ''Enabling Citizenship: Gender, Disability and Citizenship in Australia'' (*Feminist Review*: 57, 1997, pages 49–72), Oliver *The Politics of Disablement* (London: Macmillan Education, 1990), Shapiro *No Pity: People with Disabilities Forging a New Civil Rights Movement* (New York: Times Books, 1994). It is in this respect that the environment disables and oppresses PWDs through societal attitudes and actions.

model of disability has emerged in different ways in different jurisdictions. In North America the social model of disability has been set out as a minority group approach to civil rights.[186] In the UK the social model of disability has provided a structural critique of the social barriers and social exclusion experienced by PWDs.[187] According to Oliver there are essentially two main approaches to understanding disability.[188] The first approach is to take an individual bio-medical view. The other approach is to adopt a social, structural and contextual view.[189] While this is an over simplification of a more complex debate within disability studies it does assist in understanding the tensions in relation to defendants and offenders with MHPs and ID from the perspective of the social model of disability.[190] Beresford notes that the social model had initially been used narrowly and more recently "more broadly to include a much wider range of groups, including mental health service users/survivors".[191] However, "mental health service users/survivors have never been central to the social model of

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[186] See Traustadóittir "Disability Studies, the Social Model and Legal Developments" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 4 and Albrecht "American Pragmatism, Sociology and the Development of Disability Studies" in Barnes, Oliver and Barton (eds) *Disability Studies Today* (Cambridge: Polity Press, 1996) at page 179-195.

[187] Barnes, Oliver and Barton *Disability Studies Today* (Cambridge: Polity Press, 1996) at page 179-195.

[188] Oliver "The Social Model in Action: If I had a Hammer" in Barnes and Mercer (eds) *Implementing the Social Model of Disability: Theory and Research* (The Disability Press, 2004) at pages 18-31.

[189] There is a growing body of literature that has criticised the social model of disability from different perspectives. It is not possible to consider these critiques within the scope of this thesis. However, see for example Crow "Renewing the Social Model of Disability" (*Coalition News*: July, 1996, pages 5-9); Goodley *Self-Advocacy In The Lives Of People With Learning Difficulties* (Buckingham: Open University Press, 2000); Gillespie-Sells, Hill and Robbins *She Dances To Different Dreams: Research Into Disabled Women's Sexuality* (London: King's Fund, 1998); Walmsley and Downer "Shouting the Loudest: Self-advocacy, Power and Diversity" in Ramcharan, Roberts, Grant and Borland (eds) *Empowerment In Everyday Life: Learning Disability* (London: Jessica Kingsley, 1997).

[190] In academia the social model of disability has emerged as part of what is now called disability studies. There has been a growing interest amongst academic and civil society in disability and the meaning of disability. There has been a clear emphasis on empowerment, normality of disability, the politics of difference and inclusion. See Bell "Introducing White Disability Studies: A Modest Proposal" in Davis (ed) *The Disability Studies Reader* (New York: Routledge 2nd ed, 2006).

[191] Beresford "Madness, Distress, Research and a Social Model" in Barnes and Mercer *Implementing the Social Model of Disability: Theory and Research* (The Disability Press, 2004) at pages 208-222.

disability".[192]

The social model has been used to criticise approaches to defendants and offenders with MHPs that involve treatment for a mental disorder.[193] It has been argued that diversion schemes "as an alternative to the punitive sentences" are not an "acceptable alternative" as penalties apply for "noncompliance with the prescribed treatment".[194] The other criticisms of diversion schemes from this perspective are that they do not benefit the person and are used as a method of "public safety".[195] In fact it is argued "irreparable harm is done by the coerced ingestion of mind-numbing drugs (the main modality of forced treatment), and by the narrative of incapability that removes a person from responsibility for, and confidence in, making deliberate choices to shape his/her own life".[196] This approach rejects and challenges many of the assumptions and rationales underlying diversion.

The anti-psychiatry approach also calls into question the use of treatment as part of the response to defendants and offenders with MHPs embroiled in the criminal justice system. The main thrust of the anti-psychiatry perspective is that psychiatric treatment is no better for a person with a mental illness than prison.[197] The anti-psychiatry school of thought argues that no one should ever be involuntarily detained in a psychiatric setting. Szasz for example suggested that involuntary detention and treatment constitutes the "gravest crime against

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[192] *Ibid*.

[193] Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012) and "Submission to Second Intergovernmental Expert Group Meeting on the Review of the Standard Minimum Rules on the Treatment of Prisoners" (United Nations: Submission by World Network of Users and Survivors of Psychiatry, 2012, UNODC/CCPCJ/EG.6/2012/NGO/5).

[194] Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012) at page 3.

[195] *Ibid*.

[196] *Ibid*.

[197] See Goffman *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Middlesex: Penguin, 1968).

humanity" and that mental illness is a myth.[198] He argued that mental illness simply labels the "problems of living" to which everyone is susceptible and as such psychiatry is "worthless and misleading".[199] The anti-psychiatry movement can be defined as "as a movement of criticism, focused on psychiatry" emerging from the 1960's and 1970's.[200] This critique can also be applied to the approach taken by the user and survivor movement in that there is a failure to engage with the issue of mental illness and this has significant implications for diversion.[201]

Defendants and offenders with MHPs and ID (and the issues and barriers that they experience) do not necessarily correspond to the issues faced by disability or mental health service user and survivor rights groups. As Beresford identifies there are a number of shared values and beliefs that run through the mental health service user/survivor movement.[202] However, there is no set of clear

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[198] Szasz *Myth of Mental Illness* (London: Paladin, 1972) at page 269.

[199] *Ibid*.

[200] Crossely "R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis" (*Social Science and Medicine*: 47(7), 1998, pages 877-889) at page 878. The main British anti-psychiatry commentators are; R. D. Laing, David Cooper, Aaron Esterson, Leon Redler, Morton Schatzman, Joseph Berk. The anti-psychiatry movement is composed of a number of different players. It included psychiatrists, the Church of Scientology and the user/ survivor movement. Crossely described the different groups in terms of "revolt' from ""within", "outside" and "below". See Crossely "R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis" (*Social Science and Medicine*: 47(7), 1998, pages 877-889) at page 878. The anti-psychiatry movement that emerged from the 1960's was different to the criticisms of psychiatry that predated that period. The main difference was that anti-psychiatry did not merely criticise aspects of psychiatry rather anti-psychiatrists questioned the entire basis of psychiatry. Anti-psychiatry questions the foundations of psychiatry and the understanding of the distinctions drawn between sanity and insanity. See Tantam "The anti-psychiatry movement" in Berrios and Freeman *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991) at pages 333-350. The anti-psychiatry analysis is based in a broader critique of society, which "requires the distortion, and repression of human potentialities for its effective functioning". See Crossely "R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis" (*Social Science and Medicine*: 47(7), 1998, pages 877-889) at page 878. at page 878. Anti-psychiatry commentators argue that there is no mind and therefore there can be no disease of the mind.

[201] User/survivor groups tend to see mental illness as being socially constructed and subscribe to the anti-psychiatry analysis of the myth of mental illness. This approach does not leave room to hear the voices of persons with mental illness who believe in psychiatry and who believe that psychiatric treatment is beneficial.

[202] Beresford "Madness, Distress, Research and a Social Model" in Barnes and Mercer *Implementing the Social Model of Disability: Theory and Research* (The Disability Press, 2004) at pages 208-222.

"philosophies or theories comparable to those of the social model of disability or independent living developed by the disabled people's movement… [t]he reasons for this appear to be various and complex".[203] However, two concerns have been identified as explaining this. The first is that service users / survivors seek to challenge the medical model as it relates to mental illness and they fear that such an approach will lead to them being viewed as simplistic or irrational and their voices being ignored.[204] The second reasons is that service users / survivors fear that subscribing "… to any kind of monolithic theory or set of principles … for fear that these [will] dominate and subordinate them and demand an orthodoxy in the same way as professional psychiatric thinking has done for so long."[205]

The agenda of the user and survivor movement is to oppose psychiatry, involuntary detention and to challenge stigma and discrimination faced by persons with MHPs, which are often based on perceptions of dangerousness. Given this agenda it is argued that opposition to diversion is inevitable as treatment is a response to risk, elements of coercion and direct links to the mental health system are central parts of diversion. Diversion then legitimatises laws, process and systems that are challenged and opposed by the user and survivor movement. This is illustrated by the position advocated by Hazen and Minkowitz.[206] They "contest the implied assumption that the presence of people with MHPs in prison is inherently shocking or problematic".[207] This position is at odds with the clear evidence-base and the need to address the over-representation of persons with MHPs in the prison population. This position also fails to see that diversion at its different points is a crucial mechanism for accessing community supports and services. The perspective of users and survivors of psychiatry on diversion is

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[203] *Ibid*.

[204] Campbell "The History of the User Movement in the United Kingdom" in Heller, Reynolds, Gomm, Muston and Pattison (eds) *Mental Health Matters: A Reader* (Basingstoke: Macmillan / Open University, 1996).

[205] Beresford "Madness, Distress, Research and a Social Model" in Barnes and Mercer *Implementing the Social Model of Disability: Theory and Research* (The Disability Press, 2004) at pages 208-222.

[206] Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012).

[207] *Ibid*, at page 1.

often articulated as representing the views of defendants and offenders with MHPs. However, this is unlikely to be the case as users and survivors of psychiatry generally advocate from the position of their experience of involuntary detention in civil mental health services, which largely have not involved contact with the criminal justice system. This an important point to make and is perhaps one that is conceded by users and survivors in recognising the need to consult with "prisoners with psychosocial disabilities" in developing and reforming policy.[208] The impact of the user and survivor perspective on involuntary detention and treatment and criminal responsibility has had a significant impact on our understanding of international human rights law in this area (the relevant provisions of the CRPD) and will be discussed in greater detail below.

8. Dangerousness, Risk and Diversion

A major criticism of diversion or a major argument for diversion, depending upon one's perspective is the role it plays in responding to perceptions of dangerousness and risk. One of the major developments in criminological research since the 1980s has been the commentary around the shift in the governance of crime. As O'Malley notes there has been a shift "from policing and crime prevention [to] a focus on reforming offenders towards preventing crime and managing behaviour using predictive techniques".[209] Criminologists suggested that the chief focus of the 20th century was "penal modernism", which involved understanding and scientifically correcting offenders, this approach was abandoned with the new focus on managing behaviour.[210] From the 1980s onwards there was little concern for the "motives and meanings" of offenders, the focus instead was on how to control offenders and minimise the perceived dangers.[211] Garland in his theory of culture of control identified a number of themes that characterise the crime complex.[212] These include the decline of the

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[208] *Ibid*, at page 6.

[209] O'Malley *Crime and Risk* (London: Sage, 2010) at page 1.

[210] See Cohen *Visions of Social Control* (London: Polity Press, 1985) and Simon "The Ideological Effects of Actuarial Practices" (*Law and Society Review*: 22, 1988, pages 771-800).

[211] O'Malley *Crime and Risk* (London: Sage, 2010) at page 1.

[212] See Garland *The Culture of Control: Crime and Social Order in Contemporary Society* (Oxford: Oxford University Press, 2001).

rehabilitative ideal; the re-emergence of punitive sanctions and expressive ideal; changes in the emotional tone of crime policy; the return of the victim; above all else the public must be protected; politicisation and the new populism; the reinvention of the prison; the transformation of criminological thought; the expanding infrastructure of crime prevention and community safety; civil society and the commercialisation of crime control; new management styles and working practices and a perpetual sense of crisis.[213]

The ability to predict dangerousness and risk has been the subject of much debate as it relates to persons with MHPs. The ability to predict dangerousness was called into question in the US in the 1970's following the release of Johnnie Baxtrom after serving a sentence for assault. Baxtrom was detained beyond his release date at the request of doctors who considered that he was dangerous and in need of psychiatric treatment. He successfully challenged his detention and as a result 967 similarly detained persons were released into the community.[214] Research conducted by a team of researchers revealed that only 2.7 % of the 967 released had behaved dangerously and were subsequently detained in prison or in a psychiatric facility. Litwack and Schlesinger estimate that forensic psychologists are correct in 50% of cases.[215] If this statistic is correct the probability of being accurate is the same as the toss of a coin and from a rights perspective that is of significant concern. Slobogin suggests a "jurisprudence of dangerousness" that requires a set of principles governing when and to what degree the state can deprive a person with a mental illness of their liberty on the basis of prediction of harm.[216] He notes that at present this jurisprudence is badly underdeveloped, particularly when compared to the literature around general deterrence and retribution.[217]

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[213] *Ibid*.

[214] Steadman "Follow-up on the Baxtrom Patients Returned to Hospitals for the Criminally Insane" (*American Journal of Psychology*: 3, 1973, pages 317-319).

[215] Litwack and Schlesinger "Dangerousness and Risk Assessments: Research, Legal, and Clinical Considerations" in Hess and Weiner (eds) *The Handbook of Forensic Psychology* (New York: Hohn Wiley and Sons, 2nd ed, 1999).

[216] Slobogin *Minding Justice Laws that Deprive People with Mental Disability of Life and Liberty* (Cambridge Massachusetts: Harvard University Press, 2006) at page 103.

[217] *Ibid*.

Hudson has expressed concern with the balance between "reducing risk" and "doing justice".[218] She suggests that, with the exception of some members of the judiciary, human rights scholars, legal theorists and civil libertarians, the importance of justice as a "regulatory ideal" is dissipating and questions whether established theories and institutions of justice are sufficient in resisting the challenges posed by the politics of risk and safety.[219] There appears to be a growing acceptance that justice is not owed to a person or categories of persons regarded as being a risk to public safety.[220] Fennell suggests that the pursuit by Government of " radical risk management policies … has affected and will continue to affect the legal framework of compulsory care for mentally disordered people".[221] He contends that this approach has altered the balance between therapy, retribution and social defence and in turn has affected the relationship between clinicians and patients.[222] The therapeutic strategies coming from the penal and psychiatric systems serve to converge both systems and facilitate indefinite detention, which has been more traditionally associated with the psychiatry system.[223] This indefinite detention does not require "treatability beyond the stipulation that behaviour consequent upon the disorder can be managed."[224] This means that risk management effectively becomes treatment. This is very much a medical model approach that raises specific human rights issues, particularly in respect of the CRPD, which will be discussed below. This approach also raises ethical issues in respect of drawing boundaries between therapy and preventive detention or "growing old in prison".[225]

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[218] Hudson "Balancing Rights and Risks: Dilemmas of Justice and Difference" in Gray, Lang and Noaks *Criminal Justice, Mental Health and the Politics of Risk* (London: Cavendish Publishing, 2002) at page 99.

[219] *Ibid*.

[220] *Ibid*, at page 100.

[221] Fennell "Radical Risk Management, Mental Health and Criminal Justice" in Gray, Lang and Noaks *Criminal Justice, Mental Health and the Politics of Risk* (London: Cavendish Publishing, 2002) at page 69.

[222] *Ibid*.

[223] *Ibid*, at page 95.

[224] *Ibid*, at page 96.

[225] *Ibid*.

It has been argued that indeterminate sentencing such as the provisions enacted in England and Wales in 2003 are examples of "reverse diversion".[226] This notion of "reverse diversion" refers to the idea that persons with MHPs who engage in criminal conduct are more likely to receive a prison sentence as a result of criminal justice legislation than benefiting from diversion to mental health services and that the use of indefinite detention rows away from a policy of diversion.[227] The rationale for "reverse diversion" is as a result of the dangerousness and risk discourse that focuses on identifying risk as opposed to MHPs.[228] As Thornicroft notes risk is a very complex concept that is dependant on many different elements:

> "Whether or not there is an additional risk depends upon the type of diagnosis, the nature and severity of the symptoms present, whether the person is receiving treatment and care, if there is a past history of violence by the individual, the co-occurrence of antisocial personality disorder and substance misuse and social, economic and cultural context in which an individual lives".[229]

The literature on the deinstitutionalisation movement and the rise of institutionalisation is relevant here. Some of the literature has examined whether there has been a reverse in the deinstitutionalisation process. One study suggested that in a number of European jurisdictions the number of beds and places in supported housing increased.[230] The study established that the number of psychiatric hospital beds were reduced in five countries, however, only in 2 countries the reduction outweighed the additional places in "forensic

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[226] Rutherford "Imprisonment for Public Protection: An example of Reverse Diversion" (*The Journal of Forensic Psychiatry and Psychology*: 20(1), 2009, pages 46-55).

[227] *Ibid*.

[228] *Ibid*.

[229] Thornicroft *Shunned: Discrimination Against People with Mental Illness* (Oxford: Oxford University Press, 2006) at page 139.

[230] Priebe, Badesconyi, Fioritti, Hansson, Kilian, Torres-Gonzales, Turner and Wiersma "Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries" (*British Medical Journal*: 330(15), 2005, pages 126-126). This study examined 6 European countries with different traditions of mental health care that have all undergone deinstitutionalisation since the 1970s; England and Wales, Germany, Italy, the Netherlands, Spain, and Sweden. The study found that changes in involuntary hospital admissions were inconsistent in these countries.

institutions and supported housing".[231] The research also identified that the general prison population also substantially increased in all of the countries examined in the study. While the study could not identify the precise reasons for this "reinstitutionalisation" it acknowledged that "attitudes to risk containment in a society" was an important issue and may be "more important than changing morbidity and new methods of mental healthcare delivery".[232]

Peay notes that "[v]isionary humanitarian aspirations" in respect of the treatment of "mentally disordered offenders" were commendable in intentions, however, they may have produced accidental consequences in the perception of the wider body of "mentally disordered people".[233] Detaining the mentally ill alongside mentally disordered offenders in mental hospitals may be more detrimental to the public's image of mental illness, than it is to their image of offenders as rational risk takers".[234] Regardless of the perspective on risk it is clear from the literature that while the research is inconsistent it has and will continue to play a central role in responding to defendants and offenders with MHPs and ID. In that regard diversion, which facilitates processes and mechanisms for assessing dangerousness and risk is likely to remain a key feature as the response to perceptions of dangerousness and risk.

9. Community Treatment Orders

The dissolution of the old institutions and asylums brought about an expectation that "psychiatric practice based on coercion and exclusion" would end.[235] However, the trend over the past decade throughout the Western world has been the increased use of compulsory admission.[236] The other "perhaps more troubling trend" has been the provision of community treatment orders, which extend the powers of psychiatrists

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[231] *Ibid*.

[232] *Ibid*.

[233] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at page 40.

[234] *Ibid*.

[235] Sullivan and Mullen "Mental Health and Human Rights in Secure Settings" in Dudley, Silove and Gale (eds) *Mental Health and Human Rights: Vision, Praxis, and Courage* (Oxford: Oxford University Press, 2012) at page 283.

[236] *Ibid*.

into the community.[237] These powers mean that coercion is now no longer restricted to the hospital and have resulted in practices "equally coercive and dehumanizing when compared to the days of the asylums".[238] This is all the more troubling as the evidence as to the effectiveness of these orders is uncertain, with recent research from England and Wales calling to question their effectiveness in reducing hospital admission.[239]

10. Therapeutic Jurisprudence and Diversion

This section considers the emergence of therapeutic jurisprudence, a philosophy that has become dominant and influential in criminal justice policy and advocates for the diversion of persons with MHPs from the criminal justice system. A key feature of therapeutic jurisprudence is the creation of problem-solving courts. Mental health courts based on principles of therapeutic jurisprudence have emerged as a prevailing feature of diversion at the pre-trial stage of the criminal justice system.

It is clear from the literature in North America and elsewhere that therapeutic jurisprudence has provided a new momentum for policy initiatives through the provision of interventions for persons with MHPs (and to a lesser extent persons with ID) when they come into contact with the criminal justice system. The literature reveals that therapeutic jurisprudence has a process-based and multidisciplinary approach to the law. The overarching approach seems to be aimed at addressing the underlying factors that are considered to cause crime and deal with them through effective remedial responses. While the literature is generally supportive of the therapeutic jurisprudence approach to mental health, some of the literature opposes the approach as it conflicts with established concepts of justice. In particular, there is concern that the therapeutic jurisprudence approach conflicts with concepts of deterrence, punishment and public protection and that it may discredit the criminal justice system.[240] It has also been argued

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[237] *Ibid*.

[238] *Ibid*.

[239] See Burns et al "Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial" (*The Lancet*: 381(9878), 2013, pages 1627-1633).

[240] See Casey "When Good Intentions are Not Enough: Problem Solving Courts and the Impending Crisis of Legitimacy" (*SMU Law Review*: 2004, 57, 1459); Davis "Special Problems for Special Courts" (*ABA Journal*: 2003, 32, 89); Nolan "Redefining Criminal Courts: Problem-

that the "therapeutic state" and the medical model of psychiatry minimise the need for persons to take responsibility for their own lives and make the necessary changes.[241] The medical model of psychiatry it is argued provides for "extralegal social control"[242] and in taking this perspective mental health courts can be seen as part of the expansion of social control in the community over persons considered to be "strange, threatening or dangerous".[243]

While the literature on mental health court programmes is voluminous, the literature does not give a clear identification of what constitutes best practice, as it is mainly descriptive as opposed to evaluative. There is a lack of evaluative research on mental health court programmes, which may be explained by the relatively recent arrival of this type of diversion process. As mental health court programmes operate with limited funding there may be insufficient resources to collect and analyse data. There has been little research on the effectiveness of mental health courts in actually reducing the participation of persons with mental illness in the criminal justice system. However, the research that has been produced indicates that they can be an effective response to defendants and offenders with MHPs.[244]

Solving and the Meaning of Justice" (*American Criminal Law Review*: 40(4), 2003, page 1541); Slobogin "Therapeutic Jurisprudence: Five Dilemmas to Ponder" (*Psychology Public Policy and the Law*: 1(1), 1995, page 193).

[241] See Leifer "The Medical Model as the Ideology of the Therapeutic State" (T*he Journal of Mind and Behavior*: 11(3), 1990, pages 247-258).

[242] *Ibid*.

[243] *Ibid*.

[244] A study indicated that persons under the supervision of the San Francisco Behavioral Court (18 months in) were at a 26% lower risk of new criminal charges and a 55% lower risk of charges for violent crimes to comparable persons processed through the County jail system. On these findings see McNiel and Binder "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (*American Journal of Psychiatry*: 164, 2007, page 1395). Research on the Broward County (Florida) Mental Health Court suggested that defendants were two times more likely than comparable defendants to receive services and treatment for their mental illness. The research also indicated that they were no more likely to commit a new crime, even though they spent on average 75 % fewer days in prison (in contrast to comparable defendants). See Boothroyd, Poythress, McGaha and Petrila "The Broward Mental Health Court: Process, outcomes and service utilization" (*International Journal of Law and Psychiatry*: 26, 2003, pages 55-71).

Mental health courts have been an increasing feature in North America (Canada and the US) and in Australia.[245] These courts take a "problem solving" approach to offenders with MHPs and provide for diversion from prison to supervision in the community. User and survivors of psychiatry groups criticise these initiatives as their philosophy espouses medical model approaches to MHPs such as psychiatric treatment.[246] It can be argued that the use of mental health courts does not fit easily with the social model of disability, the agendas of disability rights groups and user and survivor organisations. Particularly, as the dangerousness and risk discourse around mental illness is directed at defendants and offenders with MHPs.

The merits of therapeutic jurisprudence have been questioned by Irish academics. Cooney and O'Neill, commenting on the development of therapeutic jurisprudence in the early 1990s questioned the soundness of its development as it "seems to question the validity and priority of a rights based approach" to persons with MHPs.[247] Cooney and O'Neill further argued "therapeutic jurisprudence research does not attempt to resolve conflicts among competing values. Instead, it seeks to gather the data or information about the therapeutic or anti-therapeutic effects of laws, rules, processes, institutions, functions and so forth".[248]

While a defendant is required to have mental capacity to participate in a mental health court programme there is concern about the lack of safeguards to ensure that a person retains capacity after being accepted onto a programme.[249] The research indicates that participants in mental health courts may lack capacity to waive constitutional rights and make "informed decisions" relating to issues

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[245] See Schneider and Heerema *Mental Health Courts: Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007) and "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Melbourne: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010).

[246] See Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012).

[247] Cooney and O'Neill *Psychiatric Detention: Civil Commitment in Ireland* (Dublin: Baikonur, 1996) at page 49.

[248] *Ibid*, at page 58.

[249] See Stafford and Wygant "The Role of Competency to Stand Trial in Mental Health Courts" (*Behavioral Sciences and the Law*: 23, 2005, pages 245-258).

required as a participant in a programme.[250] The benefits to participation in mental health court programmes is that a person otherwise would be sentenced or given "standard probation" without any services.[251] Treatment as an aspect of participation is a real concern even though participation in a programme is (theoretically) voluntary. As Lurigio and Snowden note persons who participate in a mental health court programme "typically experienced several failed treatment attempts and incarcerations".[252] Even though participation is voluntary the true extent of this is questioned, as participation in a programme requires close supervision and "stringent conditions of supervision".[253]

These concerns are shared with user and survivors of psychiatry, who see the development of diversion from the court to "coerced mental health treatment … proceeding apace".[254] User and survivor groups question the validity of defendants and offenders voluntarily participation. It has been suggested that while "… participation … is voluntary at the outset"; mental health courts "induct individuals into coerced compliance with treatment, in exchange for suspension of prison sentence".[255] The involuntariness of participation is further evidenced with the requirement to plead guilty, comply with court supervised treatment and the threat a custodial sanction if compliance is considered inadequate.[256] Ryan and Whelan consider that the main opposition to mental health courts is the concern that participation is not truly voluntary and the failure to protect due process rights.[257]

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[250] *Ibid*.

[251] See Lurigio and Snowden "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (*Justice System Journal*: 30, 2009, pages198-218) at page 207.

[252] *Ibid*.

[253] *Ibid*.

[254] Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012) at page 3.

[255] *Ibid*. See also Sarteschi, Vaughn and Kim "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review" (*Journal of Criminal Justice*: 39, 2011, pages 12–20) at page 13.

[256] *Ibid*.

[257] Ryan and Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (*Web Journal of Current Issues*: 1, 2012).

The idea that mental health courts force treatment is rebuffed to some extent by research that showed a "noticeable trend" in that a "considerable portion of individuals … opted not to participate in the mental health court program".[258] While the literature is not clear why there is a refusal to participate, the trend suggests that persons with MHPs exercise their legal capacity and decide not to participate and their decision-making is respected. The description of participation of persons with MHPs in these diversionary programmes as involuntary could be interpreted as undermining their decision-making. The trend of refusal should be explored further to see what amendments to the programmes would facilitate participation. Another criticism of mental health courts are that they are considered "reactionary" in nature and treatment is only made available after a crime has been committed and they are charged with criminal offences.[259] Other concerns include that participation in programmes very often does not result in avoidance of a criminal record, even when a person graduates from a programme and complied fully with the terms of the programme.[260] Gender and racial bias have also been identified in the research.[261]

The advantages of mental health courts are essentially the same as other diversion schemes, in that they supposedly link persons to services, reduce recidivism, reduce costs in the criminal justice system and they decriminalise persons with MHPs.[262] This argument of "decriminalisation" suggests that mental health court programmes focus on "rehabilitation and treatment instead of punishment".[263] There is strong evidence for some of these suggested advantages. The first major study that sought to synthesise the available research on mental health courts suggested the effectiveness of mental health courts in reducing recidivism.[264]

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[258] Sarteschi, Vaughn and Kim "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review" (*Journal of Criminal Justice*: 39, 2011, pages 12–20) at page 18.

[259] *Ibid*, at page 13.

[260] *Ibid*, at page 14.

[261] *Ibid*.

[262] For a discussion on the advantages of mental health courts see Sarteschi, Vaughn and Kim "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review" (*Journal of Criminal Justice*: 39, 2011, pages 12–20) at page 13.

[263] *Ibid*.

[264] *Ibid*.

There is a lack of research on the experience and views of participants in mental health court programmes. As such it is important that the views of mental health court participants who are supportive of mental health court initiatives and positive about their experience of participation should not be misrepresented or lost. While users and survivor groups are critical of mental health courts and consider treatment plans as forced medication this analysis may not hold up to the experience and views of mental health court participants. At any rate mental health courts are developing as a popular policy initiative throughout the common law world in responding to persons with MHPs in contact with the criminal justice system. They are controversial and the research indicates many issues supporting and opposing mental health courts. Mental health courts are nonetheless likely to remain for the foreseeable future a key feature of the response to persons with MHPs and the research should focus on making recommendations that address concerns and resolve tensions identified.

While mental health courts are not the "panacea" they are considered to have potential to partly solving the issues.[265] Of course the principles of therapeutic jurisprudence require application "in a careful manner" to avoid interference with the constitutional rights of defendants.[266] It is suggested that procedural safeguards could involve appointing a solicitor early in the process to ensure that the defendant made an informed decision to participate in the programme. Ryan and Whelan considered that any system should ensure that guilty pleas should not be a requirement for admission onto a programme.[267]

It has been noted that therapeutic jurisprudence has been underexplored in international human rights law, which Perlin considers unfortunate as the principles could inform each other.[268] Indeed the central principle of therapeutic jurisprudence is a commitment to treating persons with dignity and respect.[269] In addition Ronner

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[265] Ryan and Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (*Web Journal of Current Issues*: 1, 2012).

[266] *Ibid*.

[267] *Ibid*.

[268] Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) at page 217.

[269] See Winick "Therapeutic Jurisprudence and Problem Solving Courts" (*Fordham Urban Law*

considers that therapeutic jurisprudence positively contributes the "three Vs": voice, validation and voluntariness.[270] The "three Vs" are predicated on the notion that the person ought to have an opportunity to tell their side of a story to the decision-maker, and if the person feels that the court listened to their voice they have a sense of validation.[271] This sense of voice and validation serves to create a sense of "voluntary participation" in the proceedings, which as a result are considered less coercive.[272] It is suggested that the "three Vs" allow persons to flourish as they feel they are participating in their own decisions.[273] Perlin takes the view that the CRPD and its philosophy resonates with principles of therapeutic jurisprudence, in particular Ronner's "three Vs".[274]

Indeed therapeutic jurisprudence has now expanded beyond persons with MHPs, presenting itself as "a new model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences".[275] In a sense therapeutic jurisprudence operates like reasonable accommodation, in determining if legal rules procedures and the roles of lawyers can be adjusted to "enhance their therapeutic potential" while "not subordinating due process principles".[276] In addition therapeutic jurisprudence principles contain elements of the recovery ethos, in examining "the law's influence on emotional life and psychological well-being".[277]

Journal: 30(3), 2003, 1055-1103) and Perlin "A Therapeutic Jurisprudence Inquiry Into the Roles of Dignity and Humiliation in the Law" (New York: Workshop on Humiliation and Violent Conflict, Columbia University, 2009).

[270] Ronner "Songs of Validation, Voice and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles" (*University of Cincinnati Law Review*: 71, 2002, pages 89-120) at pages 94-95.

[271] *Ibid*.

[272] *Ibid*.

[273] *Ibid*.

[274] Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) at pages 209-2010.

[275] *Ibid*, at page 203.

[276] *Ibid*.

[277] Perlin "Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study" (*Psychology, Public Policy & Law*: 9, 2003, pages 183-208) at page 203.

Perlin notes that the literature is "strangely silent" as to whether practice in the forensic mental health system "meets human rights standards".[278] In addressing human rights deficits in the forensic system he considers that therapeutic jurisprudence principles can assist lawyers and mental health professionals in "addressing and resolving human rights issues".[279] This suggestion is based on viewing human rights, therapeutic jurisprudence and forensic psychiatry as "normative, humanistic (with a concern for well-being), and interdisciplinary".[280] Therapeutic jurisprudence then offers a "potentially redemptive solution" by addressing the human rights violations in forensic mental health services by "maximizing the core values of freedom and well-being… for prisoners and detainees with a mental health illness".[281]

11. Criminal Responsibility

As is evident from the foregoing discussion the issue of criminal responsibility is an important aspect of the discourse on diversion. A perception of reduced culpability on the basis of a MHP or impaired mental capacity underlies the accommodations afforded to defendants and offenders considered to fall into these categories. This approach is not without it conceptual difficulties. Dhanda argues that the "unqualified acceptance of the illness explanation has further reinforced the legal attribution of incapacity to persons of unsound mind. It is this unquestioning acceptance of the bio-medical articulation of disorder which needs to be challenged".[282]

However, while an examination of criminal responsibility and the link to the mental disorder or ID may be examined in detail for some serious crimes (EG homicides), the issue may not a material consideration in diverting offenders for less serious crimes.[283] There is a significant amount of confusion around the status of defendants and offenders

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[278] Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) at page 205.

[279] *Ibid*.

[280] *Ibid*, at page 206.

[281] *Ibid*.

[282] Dhanda *Legal Order and Mental Disorder* (New Dehli: Sage Publications, 2000) at page 313.

[283] See Chapter 4: England and Wales.

with MHPs and ID. They are considered neither wholly culpable offenders nor "wholly incapacitious" offenders.[284] If they were "wholly culpable" they would have the full protection of due process and procedural rights. However, if they were "wholly incapacitious" special procedures could be used under mental health laws for treatment and detention where consent could not be obtained.[285] As defendants and offenders fall between these categorisations responses to perceived impairments or reduced mental capacity is problematical.

A person who was responsible at the time of the commission of an offence is considered to be a "responsible agent" when they are called to answer for their crimes at a later stage (normally a short time later).[286] A person who is not responsible at the time of the commission of the offence generally will not be considered to have the capacity to answer for the crime at a later stage.[287] However, the criminal law has been adapted to provide for circumstances where a person who was not responsible at the time of the action "can be restored to rational competence, whilst someone who was responsible at the time of the action can become non-responsible."[288] The adaptations made in the criminal law include the provision of the insanity defence, available to defendants considered to be so "disordered" at the time of the commission of the offence that they are considered not responsible. Other manifestations include the provision of unfitness for trial procedures, which prohibit the trial of a defendant considered to lack capacity. Duff suggests that "responsibility as answerability requires a capacity to respond to reasons and then to answer for oneself".[289] It is outside the scope of this thesis to explore the rich literature on areas such as excuses in criminal law and the wider debates that surround *mens rea*.

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[284] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at page 105.

[285] *Ibid*.

[286] Duff *Answering for Crime Responsibility and Liability in the Criminal Law* (Oxford: Hart Publishing, 2009) at page 40.

[287] *Ibid*.

[288] *Ibid*.

[289] *Ibid*, at page 41.

12. The Insanity Defence

Connected inextricably to the issue of criminal responsibility is the defence of insanity. The terminology, stigma and consequences of "successfully" raising the insanity defence (diversion in the sense of involuntary detention in a forensic hospital as opposed to a prison) are hugely controversial issues. Dhanda suggests that "[m]odern Criminal Law (strict liability offences excepted) is premised on the belief that human beings are morally responsible and not harm-causing agents".[290] However, the "successful" invocation of the insanity defence "results in acquittal not discharge".[291]

In a sense the insanity defence can be considered to be one of the oldest forms of diversion and one of the most consistently replicated throughout the common law world. In all common law jurisdictions there is provision for what we understand to be the insanity defence or some derivative of it.[292] The insanity defence is probably the most controversial of all of the defences in criminal law. The defence when raised successfully results in a defendant being deemed not guilty of the criminal offences they are charged with and as such punishment in theory is not administered. It is also argued that the "insanity defence is

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[290] Dhanda *Legal Order and Mental Disorder* (New Dehli: Sage Publications, 2000) at page 105.

[291] *Ibid*, at page 126.

[292] An examination of the operation, reform and different formats of the insanity defence is outside the scope of this thesis. For further reading on the insanity defence across different jurisdictions see Simon and Ahn-Redding *The Insanity Defence the World Over* (Lexington Books, 2006). The ongoing controversy in the field of disability studies - the definition of disability - is also a controversy in the area of the insanity defence. There is no of definition of mental defect or mental disease and insanity legislation has tended not to provide a statutory definition of insanity. The US Federal Courts have held that "[t]he definition of mental disease or mental defect is essentially a factual, medical question, not a legal issue. The court should not encroach upon the jury's function of resolving possibly competing psychiatric views of this definition." See Government of the *Virgin Islands v Fredricks* 578 F.2d 927, 932 (3rd Cir. 1978); *Wade v United States* 426 F.2d 64, 41 (9th Cir. 1970). While the final determination on insanity will be assigned to jurors the lack of a definition of these terms has meant that it is open to mental health experts to provide their own definitions. Here the US definitions are based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM*).* (The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders. Mental health professionals in the US and throughout the world use the DSM. It is used by a wide range of health and mental health professionals; including psychiatrists, physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counsellors.)

a mark of the maturity and humanity of the criminal law."[293] The insanity defence covers the most serious of criminal offences including homicide. The consequences of successfully using the insanity defence is that the defendant will be required to undergo psychiatric treatment and will in almost all cases, will be detained in a psychiatric facility while that treatment is being provided. In practice a person found not guilty by reason of insanity will be detained usually for a longer period than had they been convicted and served the sentence for the crime.[294] There has been a lot of discourse around the insanity defence over the past number of decades. The proponents of the insanity defence argue that it is fundamental to the criminal justice system as it bars the punishment of persons whose mental condition meant that they were not responsible for their acts.[295] It is on this basis that "… although the insanity defence has been the subject of much judicial and legislative tinkering for centuries, and especially in recent decades, to this day it remains an honored, if sometimes tarnished, fixture in Anglo-American law."[296]

Opponents of the insanity defence on the other hand argue that while the underlying rationale is laudable in reality the defence is open to abuse and does not deliver on its goals.[297] The verdict of not guilty by reason of insanity is unpredictable. Critics of the defence argue that the verdict turns on factors such as the nature of the crime, the defendants' lawyer, the expert that testified for or against the defendant and not on the criminal responsibility or mental status of the defendant at the time of the commission of the offence.[298] The studies that have examined the public perception of the insanity defence have revealed that the public see the insanity defence as a legal loophole

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[293] Editorial "Reforming the Insanity Defence" (*Criminal Law Review*: 2003, Mar, 139-140) at page 139.

[294] Ewing *Insanity: Murder, Madness and the Law* (Oxford: Oxford University Press, 2008), Parry *Criminal Mental Health and Disability Law, Evidence and Testimony:* (ABA Commission on Mental and Physical Disability Law: Criminal Justice Section, 2009).

[295] Ewing *Insanity: Murder, Madness and the Law* (Oxford: Oxford University Press, 2008) at page xvii.

[296] *Ibid.*

[297] *Ibid*.

[298] *Ibid*.

used by defendants to escape punishment for their crimes.[299] However, the insanity defence is only raised in a small number of criminal cases and when the defence is raised it is seldom successful. Different studies across many jurisdictions that provide for the insanity defence have demonstrated that when the defence is used in less than 1% of cases and when raised it has a success rate of less than 25%.[300] Other research has indicated that positive attitudes toward capital punishment in the US and misperceptions about overuse of the insanity defence were directly related to negative attitudes toward the insanity defence.[301]

The New Zealand Law Commission in its Report on the reform of the insanity defence engaged with the deeper philosophical questions associated with the insanity defence.[302] The Commission questioned why a person whose moral beliefs result from their "mental impairment" be treated differently. The Commission suggested that the question of incapacity was a possible explanation for this different treatment.[303] The New Zealand Law Commission suggested that the link with incapacity may assist in explaining the existence of a "certain amount of latitude about the insane person's understanding of morality, by contrast to the 'normal' person's: it follows from the incapacity concept that normal standards simply cannot be applied".[304] The Commission noted that if incapacity is "the essence of the defence", it remains unclear as to why "incapacity to reason morally is necessarily the right test for determining when it is not proper to hold the person responsible".[305] The Commission did note that the defence of insanity or similar defences varied from jurisdiction to jurisdiction and that the

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[299] See for example: Silver, Cirincione and Steadman "Demythologizing Inaccurate Perceptions of the Insanity Defense" (*Law and Human Behavior*: 18(1), 1994, pages 63-70).

[300] Ewing *Insanity: Murder, Madness and the Law* (Oxford: Oxford University Press, 2008) at page xxii.

[301][301] Bloechl, Vitacco, Neumann and Erickson "An Empirical Investigation of Insanity Defense Attitudes: Exploring Factors Related to Bias" (*International Journal of Law and Psychiatry*: 30, 2007, pages 153–161).

[302] For a discussion on this see "Mental Impairment Decision-Making and the Insanity Defence" (Wellington: New Zealand Law Commission, Report 120, 2010) at page 44.

[303] *Ibid*.

[304] *Ibid*.

[305] *Ibid*.

connection between incapacity and insanity was not as clearly drawn in some jurisdictions.[306] Dhanda notes other problems with the defence in that the "unchallenged rationale for the legal regulation of insanity is … the deviance dimension" and the defence servers to render persons "dangerous by reason of insanity" and in need of control by the law.[307]

The problems with the insanity defence are numerous and there is an emerging recognition that the defence in seeking to absolve persons from criminal liability while at the same time mitigating against risks is "unprincipled and, in practice, the defence does not serve either of its purposes particularly well".[308] The insanity defence is a chaotic field of study[309] and the debate around abolition is not "a simple question of abolishing or not abolishing the defence".[310] It would appear that at the present time the "moral arguments in favour of retaining the defence far outweigh those for abolishing it".[311]

One of the most honest accounts of the reform of the insanity defence emanated from the Law Commission for New Zealand, which concluded that the options for reform were abolition of the defence or its reformulation.[312] The Commission's view was "regardless of what the rules may say, in the end, the question jurors will put to themselves when they retire is simply … Is this man mad or not?"[313] The Commission did not recommend any reform to the defence in New Zealand even though it considered the problems with the defence not to be "insignificant".[314] Nevertheless the Law Commission considered

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[306] *Ibid*. The Commission used the example of laws enacted in Australia and New Zealand in making this point, suggesting that the laws in Australia on the insanity defence (or equivalent defences) were more amenable to drawing the connection between incapacity and insanity.

[307] Dhanda *Legal Order and Mental Disorder* (New Dehli: Sage Publications, 2000) at page 313.

[308] "Mental Impairment Decision-Making and the Insanity Defence" (Wellington: New Zealand Law Commission, Report 120, 2010) at page 5.

[309] See Glueck *Mental Disorder and the Criminal Law* (Little Brown: Boston, 1925) at page 188.

[310] See Hathaway "The Moral Significance of the Insanity Defence" (*Journal of Criminal Law*: 73(4), 2009, pages 310-317) at page 310.

[311] *Ibid*, at page 317.

[312] See "Mental Impairment Decision-Making and the Insanity Defence" (Wellington: New Zealand Law Commission, Report 120, 2010).

[313] *Ibid*, at page 7.

[314] *Ibid*.

that abolition would "diverge too far from community norms".[315] Certainly abolition of the insanity defence is possible as is evidenced by some of the law reform in the US. The consequences would be that defendants who lacked *mens rea* would be acquitted while persons who possessed the *mens rea* would be convicted.[316] However, for those acquitted in the absence of the insanity defence it would inevitably be the case that perceptions of dangerousness would be addressed by the use of civil commitment.[317] The debate on the insanity defence will be revisited below in light of the evolving understanding that Article 12 of the CRPD requires repeal and replacement of the insanity defence with a disability neutral alternative.

13. Intellectual Disability

This section considers the experience of persons with ID in the criminal justice system separately. The rationale for this is that many of the diversion initiatives have been specifically developed to respond to persons with MHPs. Persons with ID may not be able to participate in a mental health court programme as they fall short of the eligibility criteria (unless they have a co-occurring MHP). The deinstitutionalisation movement (discussed above) has had a significant impact on defendants and offenders with ID who are now more visible in the community.[318] There is no clear evidence as to whether persons with ID are over-represented or under represented in the "offender population".[319] The increased visibility of persons with ID in the community means that any "anti-social" or "offending behaviour" is also more visible, and is increasingly being dealt with in the criminal justice system.[320]

While "generic" ID services have been responding to "complex and risky cases" it has been suggested that a more appropriate response

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[315] *Ibid*, at page 5.

[316] *Ibid*, at page 5.

[317] *Ibid*.

[318] See Taylor and Lindsay "Understanding and Treating Offenders with Learning Disabilities: A Review of Recent Developments" (*Journal of Learning Disabilities and Offending Behaviour*: 1(1), 2010, pages 5-16).

[319] *Ibid*, at page 12.

[320] *Ibid*, at page 13.

would involve the development of specialised services with "structured care plans" that are "underpinned by risk assessment procedures".[321] This medical approach to offending behaviour also envisages the development of specialised treatments (EG cognitive-behavioural therapies) for persons with ID.[322] Diversion then in the absence of appropriate services is likely to become an increasingly important issue for policy makers. It has suggested that the failure to develop dedicated services for offenders with ID has been stifled as they fell between different services and the lack of dedicated funding.[323]

The literature suggests that persons with ID enter the criminal justice system in the same way as other offenders, meaning that diversion processes are necessary to respond to their needs.[324] However, the experiences of defendants and offenders with ID within the criminal justice system are dependent upon recognition of their disability.[325] The literature on defendants and offenders with ID suggests that the rationale for diversion is based on perceptions of vulnerability in conjunction with an "increased risk of victimisation" within prison.[326] This has been endorsed in law and policy, which recognises that defendants and offenders with ID should be detained in the "least restrictive environment" available and alternative supports and supervision in the community should provided where possible.[327] It has been suggested that there is an "emerging trend" of criminalisation of the persons with ID as a result of "limited resources and funding in the community".[328]

A review of the literature also suggests that traditional therapeutic approaches of the criminal justice system are inappropriate and

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[321] *Ibid*.

[322] *Ibid*.

[323] Myers "On the Borderline? People with Learning Disabilities and/ or Autism Spectrum Disorders in Secure, Forensic and other Specialist settings" (Edinburgh: Scottish Development Centre for Mental Health, 2004).

[324] Jones "Persons With Intellectual Disabilities in the Criminal Justice System" (*International Journal of Offender Therapy and Comparative Criminology*: 51(6), 2007, pages 723-733).

[325] *Ibid*.

[326] *Ibid*.

[327] *Ibid*.

[328] *Ibid*.

ineffective for persons with ID and they face the risk of being rejected by mainstream services, as their needs are considered "too difficult and awkward to treat".[329] Persons with ID who engage in offending behaviour also face rejection from services for persons with ID as they are considered to pose an unacceptable risk to others in the service.[330]

When a person with an ID enters the criminal justice system they are faced with many barriers and obstacles. While there is no consensus on the over-representation or under-representation it has been suggested by some that persons with ID are greatly over-represented in the "criminal justice system as a whole, although their involvement at different stages is not consistent."[331] Research from the US indicates that 10% of the prison population have an ID.[332] Research from the UK suggests that persons with ID are not over-represented in the prison population rather they are over-represented in the other stages of the criminal justice system.[333] It has been suggested that offences committed by persons with ID are less serious than those committed by non-disabled persons.[334] However, persons with ID are suggested to have "… an exaggerated presence in the criminal justice system because they are more likely to be apprehended, confess the crime, incriminate themselves, be led by the interviewer, plead guilty, waive their rights without full comprehension of the process, and less likely to

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[329] *Ibid*, at page 7.

[330] See Murphy "Policy and service development trends: Forensic mental health and social care services" (*Tizard Learning Disability Review*: 5, 2000, pages 32-35); Lindsay, Law, and Macleod "Intellectual disabilities and crime: Issues in assessment, intervention and management" in Needs and Towl (eds) *Applying psychology to forensic practice* (Oxford: British Psychological Society Books / Blackwell Publishing, 2002) and Hayes "Pathways for offenders with intellectual disabilities" in Lindsay, Taylor and Sturmey (eds) *Offenders with developmental disabilities* (Chichester: Wiley, 2004) at pages 68-89.

[331] Marinos, Griffiths, Gosse, Robinson, Olley and Lindsay "Legal Rights and Persons with Intellectual Disabilities" in Owens and Griffiths (eds) *Challenges to the Human Rights of Persons with Intellectual Disabilities* (Philadelphia: Jessica Kingsley Publishers, 2009) at page 130.

[332] Petersilia *Doing Justice? Criminal Offenders with Intellectual Disabilities* (Berkeley: California Policy Research Centre, 2000).

[333] See McBrien, Hodgetts and Gregory "Offending and Risky Behaviour in Community Services for People with Intellectual Disabilities in one Local Authority" (*The Journal of Forensic Psychiatry and Psychology*: 41(2), 2003, pages 280-297).

[334] Marinos, Griffiths, Gosse, Robinson, Olley and Lindsay "Legal Rights and Persons with Intellectual Disabilities" in Owens and Griffiths (eds) *Challenges to the Human Rights of Persons with Intellectual Disabilities* (Philadelphia: Jessica Kingsley Publishers, 2009) at page 130.

plea bargain or appeal judgement, understand the implications of their statements and afford defence counsel".[335] Nonetheless it should be recognised that the criminal justice system has sought to address the "vulnerability" of persons with ID through creating safeguards around questioning in police stations and in policies on prosecution. There is a suggestion that the available statistics on the involvement of persons with ID is "falsely low" due to interaction with other agencies in the criminal justice system, diversion programmes, placement in restrictive community residential services and supervised community settings.[336] Defendants being considered not fit for trial may also explain this.

There is other evidence that persons with ID are less likely to fully understand their legal rights and to comprehend the operation of the criminal justice system.[337] Research in England and Wales has revealed the difficulties faced with suspects in detention and their counterparts in the general population in understanding written police cautions, which details important information on the right to silence.[338] Other research has revealed that persons with ID have greater difficulty in comprehending written information concerning their legal rights when compared to offenders without ID.[339] Research has also indicated that persons with ID are more vulnerable to suggestive questioning and to agree with statements during the course of police interviews.[340]

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[335] *Ibid*.

[336] *Ibid*.

[337] See Baroff "The Mentally Retarded Offender" in Jacobson and Mulick (eds), *Manual of* D*iagnosis and Professional Practice in Mental Retardation* (Washington: American Psychiatric Association, 1996) at pages 311-321; Baroff, Gunn and Hayes "Legal Issues" in Lindsay, Taylor and Sturmey (eds) *Offenders with Developmental Disabilities* (Chichester: Wiley, 2004) at pages 38-65; Hayes "Early Intervention or Early Incarceration? Using a Screening Test for Intellectual Disability in the Criminal Justice System" (*Journal of Applied Research in Intellectual Disabilities*: 15, 2002, 120-128); Jones "Persons With Intellectual Disabilities in the Criminal Justice System" (*International Journal of Offender Therapy and Comparative Criminology*: 51(6), 2007, pages 723-733).

[338] Fenner, Gudjonsson and Clare "Understanding of the Current Police Caution (England and Wales) Among Suspects in Police Detention" (*Journal of Community and Applied Social Psychology*: 12, 2002, pages 83-93).

[339] Clare, Gudjonsson and Harari, "Understanding of the Current Police Caution (England and Wales)" (*Journal of Community and Social Psychology*: 8, 1998, pages 323-329).

[340] See Clare and Gudjonsson "Interrogative Suggestibility, Confabulation and Acquiescence in People with Mild Learning Disabilities (mental handicap): Implications for Reliability During Police Interview" (*British Journal of Clinical Psychology*: 32, 1993, pages 295-301).

Research also suggests that persons with ID are more likely to misunderstand fundamental principles of law such as "guilty" and "not guilty" and to be under the impression that a false confession is obvious and can be withdrawn.[341]

There is also a human rights issue in that persons with ID embroiled in the criminal justice system may be required to live in institutional settings indefinitely for rehabilitation purposes and there are no formal processes of redress or adequate safeguards.[342] A number of jurisdictions have sought to address the difficulties facing persons with ID through the creation of diversion programmes and specific procedures.[343] Fitness for trial procedures available in most common-law jurisdictions is often used to stay criminal prosecutions against persons with ID.[344] The Codes of Practice associated with the *Police and Criminal Evidence Act 1984* (PACE) in England and Wales provide guidance for police officers when dealing with suspects that they know or suspect have a "mental handicap".[345] For defendants with ID the assessment of competency and culpability is particularly important,

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[341] Clare and Murphy "Working with Offenders or Alleged Offenders with Intellectual Disabilities" in Emerson, Caine, Bromley and Hatton (eds) Clinical Psychology and People with Intellectual Disabilities" (Chichester: Wiley, 1998) at pages 154-176.

[342] See Fedoroff, Griffiths, Marini and Richards "One of Our Clients have been Arrested for Sexual Assault: Now What? – The Interplay Developmental and Legal Delay" in Poindexter (ed) *Bridging the Gap Proceedings of the 17th Annual NADD Conference* (Kingston: NADD, 2000).

[343] In New Zealand the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 links to the Criminal Procedure (Mentally Impaired Persons) Act 2003, and permits the New Zealand court to order individuals with mental impairment who have been charged with or convicted of an offence meriting imprisonment to accept compulsory care and rehabilitation under the Act, or in the case of persons with a mental illness, under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

[344] The underlying rationale of fitness for trial procedures is rooted in the idea that at it would defeat justice to permit a trial to proceed where a defendant was unfit to undergo the process and is essentially a due process right. For a discussion on fitness for trial in Ireland see Whelan *Mental Health: Law and Practice* (Dublin: Thomson Reuters, 2009) at pages 482-504. Whelan suggests that unfitness for trial in Ireland is narrowly defined and that the courts at present do not generally use the power on their initiative. He suggests that there is an argument for using the power more frequently, particularly in trials where a defendant insists on self-representation and is acting irrationality.

[345] For a discussion on this see Gendle and Woodhams "Suspects Who Have a Learning Disability: Police Perceptions Toward the Client Group and Their Knowledge About Learning Disabilities" (*Journal of Intellectual Disabilities*: 9(1), 2005, pages 70-81).

however, assessment is difficult due to "cognitive deficits and limited problem-solving abilities".[346]

Review of the literature on criminality with ID has been associated with particular criminal offences such as fire setting and sexual offences.[347] The literature on offenders and accused persons with ID suggests that as a group they face a number of different challenges in particular challenges around comprehension of the criminal justice system and their rights.[348] Research indicates that persons with ID face difficulties in understanding cautions and comprehending their rights at the time of arrest and interrogation and that this can lead to miscarriages of justice.[349] There is also a visibility issue in relation to offenders with ID. The suggestion is that there is a need for more effective assessments and therapies with a particular need for risk assessments to identify "unique characteristics of this population" to better inform sentencing and treatment planning.[350] As discussed above in order for defendants and offenders with MHPs to have access to supports, services and reasonable accommodations in the criminal justice system, it is essential that the disability is identified and disclosed. This is essential for persons with ID, when they face police questioning as suspects, and is necessary to protect their rights. The need to raise awareness about offenders and accused persons with ID through education in the legal

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[346] Jones "Persons With Intellectual Disabilities in the Criminal Justice System" (*International Journal of Offender Therapy and Comparative Criminology*: 51(6), 2007, pages 723-733) at page 727.

[347] See for example Prins *Offenders, Deviants or Patients? The Study of Socio-Forensic Problems* (London: Tavistock Publications, 1980) and Cullen "The treatment of people with learning disabilities who offend" in Howells and Hollin (eds) *Clinical Approaches to the Mentally Disordered Offender* (Chichester: Wiley, 1993), pages 145-164; both citied in Carson et al "Referrals Into Services for Offenders with Intellectual Disabilities: Variables Predicting Community or Secure Provision" (*Criminal Behaviour and Mental Health*: 20, 2010, pages 39-50).

[348] See Baroff "The mentally retarded offender" in Jacobson and Mulick (eds) *Manual of diagnosis and professional practice in mental retardation* (Washington DC: American Psychiatric Association, 1996); Baroff, Gunn and Hayes "Legal issues" in Lindsay, Taylor and Sturmey (eds) *Offenders with developmental disabilities* (Chichester: Wiley, 2004) and Jones "Persons With Intellectual Disabilities in the Criminal Justice System: Review of Issues" (*International Journal of Offender Therapy and Comparative Criminology*: 51(6), 2007, pages 723-733) at page 726.

[349] See Clare, Gudjonsson and Harari "Understanding of the current police caution (England and Wales)" (*Journal of Community and Social Psychology*: 8, 1998, pages 323-329).

[350] *Ibid*.

system has been identified.[351]

The use of therapeutic jurisprudence principles in responding to persons with ID involved with the criminal justice system has been criticised.[352] The criticism of the problem-solving approach is that it reduces an understanding of disability and situates the problem within the person with the ID. The consequence of this is the adoption of "health-based, interventions which concentrate on the internal, psychological causes of offending to the detriment of a thorough consideration of the role of environmental factors".[353] A further criticism of the diversion approach is that it takes an individual approach and transforms a social issue that ought to be the responsibility of the community and resolved in the community into "an individualised, legal and criminal issue".[354]

As discussed above review of the literature has explained that diversion of persons with ID from the criminal justice system is based on perceptions of vulnerability and to counter the person's increased likelihood of being victimised within the criminal justice system. This rationale again while not couched or explained in terms of reasonable accommodation is essentially a reasonable accommodation response that seeks to minimise discrimination flowing from imprisoning a person with a disability. The de-institutionalisation movement and increased visibility of persons with ID in the community is resulting in increased contact with the criminal system. Given this trend, diversion provisions, processes and initiatives seeking to divert persons with ID from the criminal justice system to supports and services in the community. As such they are likely to become more important in the future.

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[351] Jones "Persons With Intellectual Disabilities in the Criminal Justice System: Review of Issues" (*International Journal of Offender Therapy and Comparative Criminology*: 51(6), 2007, pages 723-733) at pages 730-731.

[352] See "Enabling Justice: A Report on Problems and Solutions in Relation to Diversion of Alleged Offenders with Intellectual Disability from the New South Wales Local Courts System" (Intellectual Disability Rights Service, 2008) at page 18 citied in "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 41-42.

[353] *Ibid*.

[354] *Ibid*.

14. Conclusions

The foregoing discussion has revealed that persons with MHPs have been historically the subjects of much discrimination. Connections between disability and criminality have been drawn for centuries, despite the lack of a sound basis for the conflation. Policy and regulatory responses to persons with MHPs saw the creation of large institutions that segregated persons with disability from their communities. However, the deinstitutionalisation movement has, since the 1970s, seen greater visibility of persons with MHPs and ID in the community. Nonetheless, the deinstitutionalisation movement has corresponded to an increase in the prevalence of persons with MHPs in the criminal justice system. While there are inconsistencies in the literature explaining this increase, there is a consensus that persons with MHPs are over-represented in the prison population when compared to the general population. The literature suggests that increased visibility of persons with ID in the community has resulted in greater contact with the criminal justice system. Therefore, diversion is becoming increasingly important for persons with ID.

Diversion has emerged in different guises at different points of the criminal justice system; it is now a common tool in seeking to address the over-representation of persons with MHPs in the criminal justice system. The literature review identified 5 categories of diversion; diversion in the community; diversion following arrest; diversion before the trial; diversion at the court and diversion following conviction. It identified that diversion in the community has great potential to connect persons with services and avoid contact with the criminal justice system in the first place. However, the procedures, processes and provisions for diversion at this stage are very under developed. The literature review revealed that more reactionary responses, later in the criminal justice system, are the norm.

The literature reveals that there are many advantages to diversion; chief amongst them is that it addresses the over-representation of persons with MHPs in the criminal justice system or at least gives the perception that something is being done. Diversion is also considered to facilitate bail for persons with MHPs and ID, accommodates perceptions of reduced culpability and other disadvantages arising from disability and yields savings in public expenditure. In addition diversion avoids the harmful impact of prison on persons with MHPs and ID, who are

considered to be particularly vulnerable for a variety of reasons in the prison setting. The other main benefit to diversion is that it is effective in reducing recidivism of persons benefiting from participation.

However, a number of disadvantages to diversion are outlined in the literature. Disadvantages include, the ineffectiveness of diversion, its processes are stigmatising in connecting MHPs to crime and espousing a medical model of disability. Users and survivors of psychiatry also criticise diversion initiatives such as mental health courts, on the basis that participation is not voluntary and they enable social control through forced psychiatry in the community.

The available literature on mental illness and crime is very fragmented with many contradictions. It is clear that there has been a move towards managing risk and responding to perceptions of dangerousness posed by persons with MHPs and ID. It is suggested that the dangerousness and risk considerations are now the dominant theoretical perspective informing law and policy. It is suggested that while there is much attention given to the therapeutic jurisprudence approach the concerns with risk and dangerousness prevail as evidenced by the proliferation of indeterminate sentencing, which has been described in terms of "reverse diversion".

Chapter 2: Literature Review, Part 2

1. Introduction

Certain Articles of the CRPD have been interpreted in ways that challenge the legitimacy of diversion provisions, processes and initiatives. This part of the chapter critically explores the background to this development. There is also a consideration of how these interpretations sit with existing human rights law and whether our evolving understanding of the CRPD can be reconciled with corresponding provisions of the ECHR and case law of the ECtHR. Following this, consideration of how the CRPD can embed human rights based approaches to diversion provisions; processes and initiatives outlined above will be addressed.

2. The CRPD

The United Nations (UN) since its establishment in the wake of World War II to the end of the last millennium created 7 core human rights Conventions.[355] The CRPD was the first UN Convention of this millennium. It was felt that a specific Convention was needed to deal with the human rights of PWDs as the existing UN human rights treaties were not specifically inclusive of disability and were considered insufficient in challenging national laws that excluded the rights of PWDs.[356] The purpose of the CRPD was to clarify the existing human

[355] The core human rights instruments include the International Covenant on Civil and Political Rights (New York, 16 December 1966); International Covenant on Economic, Social and Cultural Rights (New York, 16 December 1966); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (New York, 10 December 1984); Convention on the Elimination of All Forms of Discrimination against Women (New York, 18 December 1979); International Convention on the Elimination of All Forms of Racial Discrimination (New York, 7 March 1966); International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (New York, 18 December 1990); Convention on the Rights of the Child (New York, 20 November 1989). The International Convention for the Protection of All Persons from Enforced Disappearances (New York, 20 December 2006) was adopted but is awaiting one more signatory before it enters into force (as of 19 October 2010).

[356] Quinn, Degener et al "Human Rights and Disability: The Current Use of the Potential of United Nations Human Rights Instruments in the Context of Disability" (Office of the United Nations High Commissioner for Human Rights, 2002).

rights law as it relates to PWDs as opposed to the creation of new law.[357] The new vision of disability espoused by the social model of disability has been very influential in impacting policymaking at the domestic and international level. There is no doubt that the CRPD has adopted the approach of the social model of disability.[358]

The requirement that State Parties to the CRPD ensure "full and effective participation and inclusion in society" and "respect for difference and acceptance of PWDs as part of human diversity and humanity" are very important aspects of CRPD. Of course they are not new revolutionary concepts, they are as Quinn describes, the legacy of human rights theory and law.[359] However, the application of these principles in the context of disability is revolutionary.[360] The CRPD represents a sea change in how PWDs are seen.[361] PWDs are no longer

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[357] See Quinn "Resisting the 'Temptation of Elegance': Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour?" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 215; Quinn, Degener et al "Human Rights and Disability: The Current Use of the Potential of United Nations Human Rights Instruments in the Context of Disability" (United Nations: Office of the United Nations High Commissioner for Human Rights, 2002).

[358] Mexico the State Party that is widely seen as the driving force behind the initial proposal for a disability rights Convention, was committed proponent of the social model of disability. Mexico was also committed to ensuring that PWDs and the organisations that represent them were included in the Convention process. See de Burca "The European Union in the negotiation of the UN Disability Convention" (*European Law Review*: 2010, 35(2), 174-196) at page 183 and 188. de Burca notes that the European Union was supportive of stakeholder participation in the negotiation of the Convention but that it was not "an active proponent and campaigner on behalf of the stakeholder participation during the negotiations" in the same way as the delegations from New Zealand and Mexico. The preamble to the Convention recognises "… that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others". Article 3 sets out the general principles of the Convention. It states that it "… is fundamental to the crafting of any national-level law and policy framework insofar as it catalogue's the Convention's general principles that guide its application and interpretation". See Lord and Stein "The Domestic Incorporation of Human Rights Law and the United Nations Convention on the Rights of Persons with Disabilities" (*University of Washington Law* Review: 83, 2008, pages 449-479).

[359] Quinn "Resisting the 'Temptation of Elegance': Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour?" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at pages 215-216.

[360] *Ibid*, at page 216.

[361] *Ibid*.

to be viewed as "objects" requiring charity and care, rather as "human subjects" enjoying human rights on an equal basis with everyone.[362]

So while the CRPD has had an immediate impact in "reconceptualising disability as a human rights issue" its implications remain unclear in respect of PWDs embroiled in the criminal justice system.[363] After all, the issues faced by this category of persons are not the same as the issues faced by PWDs facing barriers to employment or access to justice in the civil context. The commission or alleged commission of criminal offences has consequences that can legitimately mandate punishment and restrict liberty and indeed go beyond that in terms of policies that address the perceived dangerousness and risk of offenders with MHPs as discussed above. Indeed defendants and offenders with MHPs and ID under the current approach of the criminal justice system will not be treated on an equal basis with others as they have committed crimes. Their conduct may result in care and treatment or supervision and control in the community.

The origins and conceptualisation of the social model, was not developed to address the issues and barriers facing persons with MHPs and ID, in contact with the criminal justice system (see above). The preamble to the CRPD states that it seeks to redress "… the profound social disadvantage of PWDs and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities in both developing and developed countries".[364] It is within this context that is difficult to reconcile the goals and rationales of the CRPD with offenders with MHPs. Offenders with MHPs, like all criminals, face stigma and are seen as having little to contribute through participation in the civil, political, economic, social and cultural spheres of a state. So the difficulties with reconceptualising disability as a human rights issue are problematic when addressing the rights of persons claiming that their disability negates their responsibility for their conduct in criminal law.

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[362] *Ibid*.

[363] Stein and Lord "Future Prospects for the United Nations Convention on the Rights of Persons with Disabilities" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 18.

[364] See Preamble to the CRPD at paragraph y.

3. Abolition of the Insanity Defence

Following the negotiation of the CRPD and its opening for signature the UN Office of the High Commissioner for Human Rights (OHCHR) in 2007 opined that the CRPD requires State Parties to reconsider how domestic laws deal with the criminal responsibility of PWDs. The OHCHR stated

> "It must be noted here that the recognition of the legal capacity of PWDs on an equal basis with others in all aspects of life has a bearing on the issue of criminal responsibility and the insanity defence clauses in many legal systems."[365]

The OHCHR subsequently in 2009 formed a more certain view on the action required by State Parties to the Convention in respect of the insanity defence. The OHCHR submitted a Report to Human Rights Council pursuant to Resolution 7/9 entitled "Human rights of persons with disabilities".[366] The first debate held by the Council focused on the "key legal measures for ratification and effective implementation of the Convention, including with regard to equality and non-discrimination".[367] The Council requested the OHCHR to "… prepare a thematic study to enhance awareness and understanding of the CRPD, focusing on legal measures key for the ratification and effective implementation of the Convention, such as those relating to equality and non-discrimination, in consultation with States, civil society organizations, including organizations of PWDs, and national human rights institutions …" in order to support this debate. In preparing the thematic study the OHCHR called for written submissions from the different stakeholders. These included State Parties, intergovernmental organisations, national human rights institutions, NGOs and representative disability groups. The OHCHR also organised "a one-

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[365] "Dignity and Justice for Detainees Week: Persons with Disabilities" (Office of the United Nations High Commissioner for Human Rights (OHCHR), Information Note No. 4, 2007) at page 3.

[366] This Resolution followed a decision of the Human Rights Council to hold an annual interactive debate on the rights of PWDs. See "Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights On Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities" (United Nations, UN doc A/HRC/10/48, 26 January 2009) at page 15.

[367] *Ibid.*

day open-ended consultation" on the thematic study and organised meetings with other relevant experts.[368] The recommendations and discussions that emerged from this process informed the content of the OHCHR's Report. The OHCHR stated:

> "In the area of criminal law, recognition of the legal capacity of PWDs requires abolishing a defence based on the negation of criminal responsibility because of the existence of a mental or intellectual disability. Instead disability-neutral doctrines on the subjective element of the crime should be applied, which take into consideration the situation of the individual defendant. Procedural accommodations both during the pretrial and trial phase of the proceedings might be required in accordance with article 13 of the Convention, and implementing norms must be adopted."[369]

This statements challenge the very basis upon which diversion is based. As noted above in Part 1 the underlying rationale for diversion is based in perceptions of reduced culpability and impaired mental capacity. Of course the conflation of disability and reduced mental capacity is problematical. [370] Peay proposes the provision of better mental condition defences that are more effective is deciphering who is fit to plead and who is not.[371] Such a situation would facilitate a more robust use of the human rights framework, allowing the issues of culpability to be more easily resolved. Peay considers that the bulk of offenders with MHPs are not lacking capacity in contrast to persons who are considered to be "of unsound mind" and are able to independently challenge the legality and circumstances of their detention and treatment and will have access to lawyers.[372] It is suggested that offenders with MHPs are not as helpless or vulnerable when compared

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[368] This was held in Geneva Switzerland on 24 October 2008.

[369] "Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights On Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities" (United Nations: UN doc A/HRC/10/48, 26 January 2009) at page 15. Available at: http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf. <Last accessed 10 November 2013>

[370] Peay *Mental Health and Crime* (Oxford: Routledge, 2011), at page 105.

[371] *Ibid*.

[372] *Ibid*, at page 106.

to persons detained involuntarily under the civil mental health regime.[373] This is perhaps what the OHCHR is getting at but, perceptions of lack of legal capacity are incorrect and vulnerability can be addressed by way of accommodations as required by Article 13 of the CRPD.

The statements of the OHCHR are novel given that the link between deprivation of legal capacity and loss of liberty. The implications of these statements are not to any great extent being explored and challenged in the academic literature. As we will see below diversion provisions in England and Wales, NI, Scotland and Australia include or have included the use of guardianship as part of the framework of responding to defendants and offenders with MHPs and ID. These provisions are very much based on notions of mental capacity and the literature has not engaged with the implication of these provisions in restricting the legal capacity of defendants or offenders.

The law on fitness to plead (or unfitness to plead) is an area of law that seeks to respond to the specific needs of persons who are considered to be vulnerable as a result of a MHP or ID. As discussed above for the purposes of this thesis a broad approach is taken to the meaning of diversion and in a very loose sense fitness to plead can be considered as part of the processes of diversion. In general the law on fitness to plead seeks to remove from the criminal justice system the defendant, either briefly or permanently. Unlike the insanity defence the law around fitness to plead is not concerned with the state of mind of the defendant at the time of the commission of the defence. Rather rules on the fitness to plead safeguard against disadvantage flowing from a MHP or ID at the time of the criminal proceedings. The concern here is ensuring that the right to a fair trial is guaranteed. There is a view that persons with a MHP or ID might be better off being diverted from the criminal justice system as opposed to being accommodated with reasonable accommodations to facilitate standing trial and that a "care and treatment disposal, rather than exposure to disposals which are focused on sentencing and rehabilitation".[374] This raises the issue that the provision of what are effectively reasonable accommodations to

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[373] *Ibid*.

[374] See for example, "Report: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC16, 2013) at page 86.

offenders with MHPs and ID might serve to lead them away from access to health and social supports and into the custodial disposals. However, the statements of the OHCHR challenge the basis on which these accommodations are made. While it might be better to respect recognition of their legal capacity in the abstract, it could serve to deprive persons of their right to access services, live in the community and lose their liberty and subject them to exploitation violence and abuse in the prison setting.

Very often laws on fitness to plead are based on a functional test of the defendant's mental capacity. However, there is an element of the outcome approach in the law around fitness to plead, as recognition of the legal capacity of the accused person can be restricted on the basis of the outcome of a miscarriage of justice if the accused person would be wrongly convicted. The current approach in common law jurisdictions to fitness to plead is to ensure the right to a fair trial requires procedural safeguards for persons who are considered to have impaired mental capacity.[375]

In *R v Walls*, Lord Justice Thomas recognised that the court should consider special measures (effectively reasonable accommodation) in assisting the accused person in participating in their trial.[376]

> "Plainly consideration should be given to the use of these powers or other ways in which the characteristics of a defendant evident from a psychological or psychiatric report can be accommodated with the trial process so that his limitations can be understood by the jury, before a court takes the very significant step of embarking on a trial of fitness to plead."

While the insanity defence (and related defences) and the law on fitness to plead have a benevolent goal it can serve to aversely affect the rights of persons determined not have be fit for trial. On this point Dhanda notes that the "benefit of postponement granted to the insane is a double-edged sword. It may ideally aid the fair trial of the accused but in reality may indefinitely postpone trial and result in lifelong

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[375] *Ibid*.

[376] [2011] EWCA Crim 443.

incarceration".[377] While stalling of the trial is considered essential to protect the rights of defendants considered unfit, Dhanda argues that the provisions for postponement also "ensures the smooth functioning of criminal justice" which is not impeded by unsoundness of mind.[378] In fact the "legislative management" results in "indefinite postponement of the criminal trial and prolonged incarceration of the person of unsound mind".[379] This disadvantage, Dhanda notes, has not been addressed adequately in legislation on fitness to plead.[380] The statements of the OHCHR on the implications of restriction of legal capacity of defendants and offenders with disability (whether they be thought defences or unfitness provisions) may provide the impetus for addressing these concerns in the relevant legislations.

4. Article 14 CRPD

Before the CRPD there was little consideration of the lawfulness of mental health laws under international human rights law provided that the legislative frameworks provided for due process rights and regular review. Much of the focus was on improving mental health legislation through exploring the advantages and disadvantages of different approaches such as "dispersed" mental health laws over "consolidated" legislative frameworks.[381] The WHO considered that dispersed legislation reduced stigma and facilitated community living, while consolidated legislation was easy to enact and adopt.[382] The view of the WHO was that a "combined approach of dispersed and consolidated legislation is preferable".[383] The CRPD deals with general liberty-style rights as provided for in Articles 14 (liberty), 20 (personal mobility) and 18 (nationality). These rights connect up with broader human rights and seek to take the extra step of addressing the different obstacles in the disability context with appropriately tailored obligations.

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[377] Dhanda *Legal Order and Mental Disorder* (New Dehli: Sage Publications, 2000) at page 89.

[378] *Ibid*, at page 315.

[379] *Ibid*.

[380] *Ibid*.

[381] See "Mental Health and Human Rights" (Geneva: World Health Organization, Mental Health Policy and Service Guidance Package, 2003) at page 10.

[382] *Ibid*.

[383] *Ibid*.

Article 14 reiterates the general right to liberty, which cannot be removed unlawfully or arbitrarily. Article 14 provides "disability shall in no case justify a deprivation of liberty". It was initially thought that Article 14 added little to international law, as disability is not a sole justification for loss of liberty. Rather the combination of disability with a perception of danger to you or to others justified deprivation of liberty. It was thought that Article 14 merely required a narrowing of the criteria for loss of liberty. Article 14(2) of the CRPD provides that if PWDs are deprived of their liberty through any process (which presumably embraces both the criminal process and the civil involuntary detention process) they are entitled to all the due process guarantees available to others under international human rights law, and shall be treated in conformity with the objectives and principles of the CRPD. However, it has emerged that the implications of Article 14 are much more significant than the tightening of the criteria upon which loss of liberty can occur. The OHCHR in its Thematic Report also made a number of other significant statements on action required by States Parties in order to comply with the Convention.

Under the heading "right to liberty and security of the person" the OHCHR stated Article 14 of the Convention means that involuntary detention and or treatment based on mental disability or a mental disorder is not permitted. The Report states that a "particular challenge in the context of promoting and protecting the right to liberty and security of PWDs is the legislation and practice related to health care and more specifically to institutionalization without the free and informed consent of the person concerned".[384] The OHCHR went on state that Article 14 means that legislation authorising the institutionalisation of PWDs on the grounds of their disability without their free and informed consent must be abolished.

> "This must include the repeal of provisions authorizing institutionalization of PWDs for their care and treatment without

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[384] "Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights On Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities" (United Nations: UN doc A/HRC/10/48 26 January 2009) at paragraph 48. Available at: http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf. <Last accessed 10 November 2013>

> their free and informed consent, as well as provisions authorizing the preventive detention of PWDs on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness".[385]

The OHCHR explained that this statement "should not be interpreted to say that PWDs cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis".[386] This has profound and far-reaching implications for diversion, as treatment for MHPs is a core aspect of many of the diversion provisions, processes and initiatives discussed above (see Part 1 of this chapter). The UN Committee on the Rights of Persons with Disabilities has followed the approach outlined by the OHCHR.[387]

The position adopted by the OHCHR reflects the position of disability rights groups who lobbied the UN on this point. For example, the International Disability Alliance (IDA) advocated for these positions.[388]

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[385] *Ibid,* at paragraphs 49.

[386] *Ibid.*

[387] For example in its concluding observations on Tunisia, the Committee stated that it was "concerned that having a disability, including an intellectual or psychosocial disability, can constitute a basis for the deprivation of liberty under current legislation". On that basis the Committee recommended that Tunisia "repeal legislative provisions which allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disability". Furthermore, until new legislation is enacted all cases of PWDs who are deprived of their liberty and detained in hospitals and specialized institutions should be reviewed, and the review process should provide for an appeal. Concluding observations on Tunisia, paragraphs 24-25. In its concluding observations on Spain, the Committee noted the legal regime allowing the institutionalisation of PWDs, including persons with intellectual and psychosocial disabilities' and expressed concern with the "reported trend of resorting to urgent measures of institutionalization which contain only ex post facto safeguards for the affected individuals". The Committee expressed equal concern at the abuse of PWDs who are institutionalised in residential centres or psychiatric hospitals. In light of these concerns the Committee recommended that Spain review its laws that allow for the deprivation of liberty on the basis of disability; repeal provisions that authorise involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services are based on the informed consent of the person concerned. Concluding observations on Spain, paragraphs 35-36.

[388] The IDA states that its goal is to promote the effective and full implementation of the CRPD worldwide. It also seeks to realise compliance with the Convention within the UN system,

The World Network of Users and Survivors of Psychiatry (WNUSP) took a similar position to that of the International Disability Alliance (IDA) in relation to the implications of the Convention for the insanity defence.[389] The WNUSP in its manual refers to concepts mentioned in the preamble, which do not reappear in the "binding articles" in the actual text of the Convention.[390] The WNUSP state that "[t]he application of these principles will radically alter the lives of persons with psychosocial disabilities" and the consequences include "the abolition of mental health commitment laws, guardianship, and the insanity defense".[391] The WNUSP went on to state that abolition of the insanity defence requires the replacement of "disability-neutral standards for adjudicating criminal responsibility… actual criminal intent, taking account of the circumstances of the crime, motivation".[392] In setting out its position calling for abolition of the insanity defence the WNUSP stated that they are unconvinced by arguments that abolition would result in mentally ill offenders facing the death penalty.[393] They stated that Article 14 of the Convention requires reasonable accommodation for persons with psychosocial disability. They also acknowledge "we must seek the reform of the whole criminal justice system to fully realize reasonable accommodation for persons with

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through the active and coordinated involvement of organisations that represent PWDs at national, regional and international levels. "The UN Standard Minimum Rules on the Treatment of Prisoners states that persons found to be "insane" should not be held in prison, but removed to a mental institution. To the extent this refers to insanity as a defence to immutability of a criminal offense, it is superseded by CRPD Article 12, which requires the recognition of legal capacity in all aspects of life, and is not limited to civil matters. (In doing away with the insanity defense, it is important to simultaneously abolish the death penalty and other harsh measures that have traditionally been avoided by means of this defense, at least by some defendants). The provision on removing persons found to be "insane" to a mental institution is also superseded by Articles 14 and 19, which do not permit compulsory institutionalization based on disability." See "Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and other Instruments" (International Disability Alliance, 25 April, 2008).

[389] The WNUSP "… is an international organization of users and survivors of psychiatry advocates for human rights of users and survivors speaks internationally for users and survivors promotes the user/survivor movement in every nation around the globe links user/survivor organizations and individuals throughout the world". See http://wnusp.rafus.dk/. <Last accessed 10 November 2013>

[390] *Ibid*.

[391] "Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities" (World Network of Users and Survivors of Psychiatry, February 2008) at pages 10-11.

[392] *Ibid*, at page 16.

[393] *Ibid*, at page 38.

psychosocial disabilities. Furthermore, we support alternatives to incarceration and the discretion to refrain from prosecution where appropriate, so long as these measures do not involve compulsory psychiatric treatment."[394] The WNUSP, while stating that it "cannot agree with the insanity defense in principle", did concede that "as a practical option" the insanity defence needs to be left open as long as the death penalty and other harsh measures are being used in the penal system."[395] Therefore, the WNUSP sought abolition of the insanity defence as part of a broader comprehensive penal reform agenda, while still criticising compulsory psychiatric detention and treatment of persons acquitted by reason of insanity.[396]

5. Critique of Article 12 CRPD

It is clear that the OHCHR's calls for abolition of the insanity defence is based on Article 12 of the Convention, which provides for equal recognition of PWDs before the law. Article 12 of the Convention deals with the capacity of persons to have rights and also with the exercise of those rights. An interpretation of Article 12 as requiring abolition of the insanity defence is problematic as the rationale actually deprives a person with a MHP of raising the defence. If the insanity defence is viewed as a type of reasonable accommodation, the application of suggested meaning of Article 12, equal recognition before the criminal law, makes it difficult to reconcile as it arguably erodes the rights and options of defendants with MHPs. The OHCHR's interpretation of the Convention as requiring the stripping away of the insanity defence (and other similar offences) fails to appreciate the underlying rationale of the insanity defence. The underlying rationale is that it would be wrong to hold a person with a mental illness responsible in criminal law in circumstances where their illness meant that they could not control or appreciate the consequences of their actions at the time that they committed the criminal offence. Of course as we have seen above the evidence between criminality and mental illness is contested and unclear.

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[394] *Ibid*, at page 38-39.

[395] *Ibid*, at page 39.

[396] *Ibid*.

The way in which the OHCHR has presented the issue is also problematical as it fails to connect the abolition of the insanity defence with the overarching human rights concern with the insanity defence – the indefinite detention of persons in a psychiatric facility following acquittal by reason of insanity. The failure to make this connection is problematical for State Parties trying to understand their obligations under the Convention. There was a significant time delay for the OHCHR to develop its conclusion (not that the thinking is evident from its 2009 Report) that Article 12 requires abolition of the insanity defence.

The submissions from the IDA and the WNUSP demonstrate some engagement and understanding of this overarching human rights concern with the insanity defence (EG indefinite detention in a psychiatric facility). However, there is a failure to engage in a discussion of the rationale underlying the insanity defence. The IDA and the WNUSP have adopted a social model of disability and are applying it to issues that affect offenders with MHPs. It is important to note that these bodies are not necessarily representative of the views of defendants and offenders with MHPs. This raises the issue of the visibility of offenders with MHPs and raises the question of whether these groups are representative of the views of offenders with MHPs.

The OHCHR and the representative disability rights groups mentioned above failed to engage with the debate, central to diversion and the insanity defence, the perceived reduced culpability of persons on the basis of a MHP or ID. It seems to interpret the Convention, as requiring abolition of a reasonable accommodation available to persons who have a disability and it is arguable that it runs counter to the principles of the Convention. The concern of some of the disability rights groups is focused on the stigma of the insanity defence and the presumption of incapacity that goes hand in hand with the defence. Reform of the insanity defence or even a discussion of reform and refinement of the insanity defence would be a more sensible and helpful approach for the OHCHR and for disability rights groups and user and survivor groups to take. Such an approach would engage with the human rights concerns in relation to the indefinite detention of defendants acquitted under the insanity defence. However, such an approach fails to advance the agendas of disability rights organisations whose preference is to see the abolition of the insanity defence and the invisibility of offenders with MHPs. This approach is short sighted as it

fails to engage with a discussion on the rationale and understanding of the insanity defence. Discussion of these issues is essential to identifying potential solutions.

In Chapter 3: Ireland the insanity defence has been recently reformed by way of the *Criminal Law (Insanity) Act 2006*. During the course of the Dáil debates on the legislation one of the proposed amendments to the Bill was aimed at addressing the politically incorrect and stigmatising term insanity. The proposed amendment suggested changing "insanity" to "mental disorder" in the Short Title. However, the Minister of the Justice, Equality and Law Reform at the time Michael McDowell stated:

> "[A]mendment cannot be accepted because corresponding changes would have to be made to the rest of the Bill's terminology. It would also be undesirable because the use of the less pejorative terminology, "mental disorder" instead of "insanity", may result in a widespread use of the plea on a mischievous basis. It might also give the misleading impression that any mental disorder, no matter how trivial, would justify returning a verdict of not guilty. The word "insanity"; signifies a threshold of disorder which cannot be regarded as trivial or minor. If one claims a person is insane in ordinary parlance, it does not just mean the person is a bit odd."[397]

The rationale of the Minister was that the focus of the Bill was criminal law and the term "insanity" was used in connection with the criminal law. He felt that an amendment of the nature suggested could introduce "doubt or uncertainty into the area".[398] The Minister stated "I do not want to wake up some morning, even after a restless night, to discover a judge has interpreted it in a way which was not originally envisaged by the House. This is an attempt to give direction to the courts as to how they should deal with these matters. Throwing up untried and vague language will prejudice, rather than advance, the

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[397] See McDowell " "Criminal Law (Insanity) Bill 2002" [Seanad]: Report and Final Stages" (Dáil Éireann: 616, 23 March, 2006) at 17. Available at: http://historical-debates.oireachtas.ie/. <Last accessed 10 November 2013>

[398] *Ibid*.

administration of justice."[399] The reluctance of the Minister for Justice to even consider using a less offensive term than the insanity defence is indicative of the significant obstacles faced in replacing the insanity defence with a disability neutral defence. Given the level of scepticism surrounding the insanity defence the OHCHR's recommendation for a broader all encompassing defence seems an unrealistic proposition that is unappealing to legislators. The recommendation of a disability neutral defence fails to engage with a consideration of the underlying rationale of the defence.

There are no guarantees that the values and principles set out in the CRPD will be realised by State Parties to the Convention. An examination of the experiences in implementing the obligations contained in the pre-existing body of human rights instruments reveals the difficulties in translating human rights obligations into practice at domestic level. There will be resistance particularly when the changes and reforms required by the Convention clash with established practices.[400] This will inevitably be the case with the proposed abolition of the insanity defence. As discussed above the insanity defence, while probably the most controversial of the defences in criminal law, is nonetheless seen as important and has been reviewed, reformed and recalibrated as an important component of criminal justice systems across the world. An ambiguous paragraph from the OHCHR on the need to abolish the defence is unlikely to be effective in convincing State Parties to the Convention to abolish the insanity defence.[401]

Reading the text of the CRPD would not lead a reader to conclude it required removal of the insanity defence. It will be difficult for State Parties to see such a fundamental amendment to their criminal justice systems as necessary without a developed and comprehensive understanding of the consequences of the removal. The failure of the UN and the bodies advocating for this reform to engage with the

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[399] The rationale of the Minister was that the focus of the Bill was criminal law and the term "insanity" was used in connection with criminal law.

[400] Quinn "Resisting the 'Temptation of Elegance': Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour?" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 216.

[401] This analysis is supported with reference to the recent review of the NSW Law Reform Commission on the insanity defence (see below).

practicalities of the proposed reform means that even the consideration by State Parties of abolition of the insanity defence is unlikely. International human rights law has had limited success in challenging national sovereignty and state control over domestic policies, which are inconsistent with human rights norms.[402] In that regard it is unlikely that the Convention will coerce or convince State Parties "… to do what they otherwise would not do… is unlikely as international law rarely has that effect and usually only where there is a court to make authoritative and binding pronouncements. Even then, such a court would need time to build its institutional legitimacy."[403] Other views of how international law works see international human rights law as having a persuasive effect and will be adopted by State Parties.[404] It remains to be seen whether the CRPD will have a persuasive effect on Member States through ratification and signature of the Convention.[405] Given the way in which the reform of the insanity defence has been framed it seems unlikely that the OHCHR interpretation of the CRPD will be successful in persuading State Parties to remove the defence from their statute books.

The advent of the UN Convention on the Elimination of Discrimination Against Women (CEDAW) did not result in women's rights groups campaigning for the abolition of the defences of infanticide or the use of the doctrine of self-defence for women who were in abusive relationships. Nor did any children rights organisations suggest that the provisions in the UN Convention on the Rights of the Child (CRC) required the repeal of the doctrine of *doli incapax* (or other similar defences) that limits the responsibility of children for their actions in criminal law. This analogy is very problematical as there are obvious differences with the situation as it relates to the insanity defence.

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[402] See for example Krasner "Sovereignty" (Foreign Policy: 2001, 122 January-February, 20-29).

[403] Quinn "Resisting the 'Temptation of Elegance': Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour?" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 218.

[404] Goodman and Jinks "How to Influence States: Socialization and International Human Rights Law" (*Duke Law Review*: 54, 2004, page 621).

[405] For a discussion on this see Quinn "Resisting the 'Temptation of Elegance': Can the Convention on the Rights of Persons with Disabilities Socialise States to Right Behaviour?" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009) at page 218.

Nevertheless, it is worth noting that it would be difficult to imagine a women's or children's rights group advocating a reform that seemed to erode or could be considered to erode the rights of the groups for whom they represent.

6. Draft General Comment Article 12 CRPD

The recently published Draft General Comment of the UN Committee on the Rights of Persons with Disabilities seeks to address "a general misunderstanding of the exact scope of the obligations of States Parties under Article 12".[406] The Committee acknowledged the confusion between the concepts of legal capacity and mental capacity, and the tendency of State Parties to conflate the two. Nonetheless it emphasised the shift in thinking from "substitute decision-making" to "supported decision-making", declaring that schemes based on status, outcome and functional approaches that restrict legal capacity are prohibited. Similarly, the Committee confirmed that Article 12 required mental health laws to be abolished in order to restore "full legal capacity".[407] Interestingly the Committee's description of Article 12(3) did not engage with the costs of providing supports when needed for the exercise of legal capacity.[408] The Committee's discussion of Article 12 as a gateway right (to the enjoyment of other rights) is of note, having implications for PWDs involved in the criminal justice system. The Committee asserted the centrality of reasonable accommodation, although it acknowledged that compliance was limited by the imposition of a disproportionate or undue burden.[409]

The Committee distilled its jurisprudence on forced psychiatric treatment, stating that it amounted to breaches of Articles 17, 15 and 16 and indeed Article 12.[410] Additionally, the Committee emphasised

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[406] "Draft General Comment on Article 12 of the Convention-Equal Recognition Before the Law" (United Nations: UN Committee on the Rights of Persons with Disabilities, Adopted by the Committee at its tenth session, 2-13 September 2013) at page 2.

[407] *Ibid*, at page 3.

[408] *Ibid*, at page 4.

[409] *Ibid*, at page 8. The acknowledgement of the limitation of the disproportionate or undue burden may be inconsistent with the Committee's classification of Article 12 as a civil and political right, requiring State Parties to take immediate steps to "support the exercise of legal capacity" (see page 7).

[410] *Ibid*, at pages 9-10.

that Article 12(3) read in light of Article 19 required a "community based approach", an interpretation that supports community disposal of defendant and offenders with MHPs or ID.[411] Regrettably the Committee did not address the impact of Article 12 on criminal responsibility, defences in criminal law, or on diversion.[412] The extent to which the final version of the general comment resolves "a general misunderstanding of the exact scope of the obligations of States Parties under Article 12" remains to be seen. Unless a specific section on the implication of Article 12 for criminal responsibility (and the related issues) is developed, a "general misunderstanding" will inevitably continue. Indeed the failure to clarify the previous statements of the OHCHR (regarding the abolition of the insanity defence.) calls into question the accuracy of OHCHR's interpretation of Article 12 in 2009.

7. The ECHR and CRPD and the Insanity Defence

There is a body of literature that has questioned whether the insanity defence is compliant with international human rights law on a different basis than that set out by the OHCHR.[413] This section considers this literature and argues that the position of the OHCHR, disability rights groups and user and survivor groups would be strengthened if reference were made to this body of work. This section also considers how the CRPD conflicts with regional international human rights law on the insanity defence and on involuntary detention of persons with MHPs.

The public perception of the insanity defence as a legal loophole to avoid criminal culpability is at variance with the reality that a defendant who successfully raises the defence will almost certainly not walk free from court. Inevitably the person receiving a not guilty by reason of insanity verdict will be subject to some form of detention and the relevant procedures and processes vary from jurisdiction to

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[411] *Ibid*, at page 10.

[412] However, the Committee suggested that it was permissible to restrict legal capacity in certain circumstances, including bankruptcy and following a criminal conviction (at page 7).

[413] See Ashworth *Principles of Criminal Law* (Oxford: Clarendon Press, 3rd ed. 1999) and Hopper and McSherry "The Insanity Defence and International Human Rights Obligations" (*Psychiatry, Psychology and Law*: 2001, 8: 2, 161-173).

jurisdiction.[414] The detention will normally be mandatory and for an indefinite period of time with the defendant having no say or control over the process and he / she will be detained until such time as they are not considered dangerous. There are legitimate human rights considerations with this process. The underlying rationale of the insanity defence is not to punish a person who meets the requirements of the insanity defence. However, the result of successfully raising the insanity defence is indefinite detention normally in a forensic psychiatric hospital with a curtailment on the right to liberty.

Article 5 of the European Convention of Human Rights (ECHR) provides for the right to liberty and security "[e]veryone has the right to liberty and security of person". A number of exceptions are set out in Article 5(1) the relevant restriction on persons with mental illness is contained in Article 5 1(e) where it states "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants". In the seminal case in this area *Winterwerp v The Netherlands* the European Court of Human Rights (ECtHR) held that the Dutch national should not have been deprived of his liberty unless it was shown that he was of "unsound mind".[415] The court went on to say in its judgment that a person detained must have a mental disorder, and that the mental disorder needed to be established before the relevant national court or tribunal, and needed to be supported with objective medical evidence. The ECtHR held that the evidence needed to be of the kind and degree that required compulsory confinement and that the detention could only be considered lawful in circumstances where the mental disorder persists.[416] In *Winterwerp* the ECtHR developed criteria to assist States in avoiding arbitrary and unlawful detention of persons considered to be of "unsound mind".

The problem of definition was evident in *Winterwerp* and the ECtHR stated a "person of unsound mind" could not be given a definitive

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[414] See Ewing *Insanity: Murder, Madness and the Law* (Oxford: Oxford University Press, 2008) at page xxii-xxiii and Simon and Ahn-Redding *The Insanity Defence the World Over* (Lexington Books, 2006).

[415] (1979) 2 EHRR 387.

[416] The European Court of Human Rights did not rule that treatment was a necessary requirement in order to make the detention lawful.

interpretation. According to Ashworth the *Winterwerp* decision has implications for the insanity defence, as requiring; a close relationship between expert opinion and the definition of the mental state required in satisfying the defence; the court's decision on the impairment must be based on objective medical evidence and the court must have discretion available to it in deciding whether the mental state is "of a kind or degree warranting compulsory confinement".[417]

The insanity defence in many jurisdictions is based on the *M'Naghten Rules in* whole or part.[418] A key rule developed in the judgment is the requirement that an accused person suffers from a "defect or reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or that he did not know what he was doing was wrong."[419] Ashworth has argued that the concept of the "disease of the mind" is not consistent with the criteria set down by the ECtHR in *Winterwerp*, as the courts have ruled that medical conditions such as hyperglycaemia, sleepwalking and epilepsy under certain circumstances constitute "diseases of the mind".[420] The problem here is that these conditions unlike mental disorder cannot be considered to require involuntary detention. In England and Wales (as indeed elsewhere) the human rights issues and criticisms of the insanity defence are not with the defence *per se* but rather the consequence of the defence, namely the mandatory indefinite detention. It is also clear that indefinite detention of a person who successfully raises the insanity defence is not consistent with the decision of the ECtHR in *Winterwerp*, particularly in relation to the court, which must have discretion available to it in deciding whether the mental state is "of a kind or degree warranting compulsory confinement".[421]

The conception of lawful detention as understood from the ECtHR

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[417] (1979) 2 EHRR 387. Ashworth *Princlies of Criminal Law* (Oxford: Oxford University Press, 2009).

[418] *M'Naghten Rules* (1843) 8 ER 718. For a comprehensive discussion of the different forms of the Insanity defence see Simon and Ahn-Redding *The Insanity Defence the World Over* (Lexington Books, 2006).

[419] *M'Naghten Rules* (1843) 10 CL & Fin 200.

[420] Ashworth *Principles of Criminal Law* (Oxford: Clarendon Press, 3rd ed, 1999) at page 216. See also and Hopper and McSherry "The Insanity Defence and International Human Rights Obligations" (*Psychiatry, Psychology and Law*: 8(2), 2001 pages 161-173).

[421] (1979) 2 EHRR 387.

jurisprudence is at odds with the interpretation of the OHCHR. The ECtHR requires that a mental disorder is present in order to be involuntarily detained, that independent medical evidence is provided and that the evidence demonstrates that the compulsory confinement is justified. Given the profound implications of the position adopted by the OHCHR it is unfortunate that it did not engage in a more comprehensive explanation of its position. Particularly, as it conflicts with the current body of human rights law and case law that informs State Parties of their human rights obligations. Similarly, the UN Committee on the Rights of Persons with Disabilities have in its concluding observations to State Parties not provided guidance on resolving the conflicting perspectives in international human rights law.

8. The ECHR and the CRPD

Fennell and Khaliq examined in detail the conflicts between the CRPD and English domestic law focusing on the conflicts in the area of legislation on mental health law and guardianship.[422] They did not specifically deal with the conflict between the CRPD and the insanity and other similar defences. In their article they discussed recent law reform by way of the English *Mental Health Act 2007*, which sought to bring the domestic law into compliance with the ECHR. However, they noted that these provisions "clearly risk falling foul" of Article 14 of the CRPD. Similarly, they note that the provisions introduced in the 2007 Act to give effect to the ECtHR judgment in *HL v United Kingdom* through the introduction of Deprivation of Liberty Orders under the *Mental Capacity Act 2005*, which seek to satisfy the requirements of Article 5 of the ECHR (but are in breach of Article 14 of the CRPD as interpreted by the UN Committee on the Rights of Persons with Disabilities). The UK unlike other jurisdictions did not enter "reservations to the CRPD to take account of the conflict between art.5 of the ECHR and art.14 of the CRPD".[423] It is envisaged the UK would be open to the "risk that a communication will be lodged so as to use

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[422] Fennell and Khaliq "Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law" (*European Human Rights Law Review*: 6, 2011, pages 662-674) at page 673.

[423] *Ibid*. The States Parties who have made a reservation or an interpretive declaration with respect to Article 12 include: Canada, Egypt, France, Syria and Australia. For declarations and reservations, see: http://www.un.org/disabilities/default.asp?id=475. <Last accessed 10 November 2013>

the petition system to seek redress before the Disability Rights Committee" and that the UK would be required to square its obligations under the Convention or if unable to do so would have to "accept that it will … be in breach of either the European Convention or the CRPD".[424]

Fennell and Khaliq concluded that while the "CRPD represents a radical approach to the rights of people with psychosocial disabilities, by comparison with the ECHR, it suffers a number of shortcomings".[425] A major shortcoming is that the type of petition and reporting systems provided for under the CRPD, which cannot provide effective protection against arbitrary detention of persons with MHPs.[426] It is also considered that deserting the *Winterwerp* requirements represents "a major shift in approach" that is not necessarily positive.[427] The current ECtHR jurisprudence affords "extensive discretion" to both psychiatrists' and national courts and the ECtHR is "reluctant to question clinical judgment the safeguards of medical expertise and medical ethics" it would be unwise to lightly dismiss the procedural safeguards "without some credible alternative".[428] Perhaps the CRPD will in time lead the ECtHR to take a more challenging approach.

Peay also notes the problems with Article 5 of the ECHR, which provides for the right to liberty and security of person subject to a number of exceptions.[429] The exceptions include deprivation of liberty in circumstances involving the commission of crime and in addition Article 5(1)(e) provides for "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants". Peay regards the inclusion of lawful deprivation of liberty on the basis of mental disorder or involvement in criminality as the persistence of the same tendencies that existed in the 19th century to create causal links

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[424] *Ibid*, at page 673.

[425] *Ibid*, at page 673.

[426] *Ibid*, at page 673.

[427] *Ibid*, at page 674.

[428] *Ibid*, at page 674.

[429] Peay *Mental Health and Crime* (Oxford: Routledge, 2011) at page 40.

between criminality and mental disorder.[430] Peay also notes while the *Winterwerp* requirements are "not very demanding" they have "proved relatively fertile ground for a raft of challenges".[431]

It is suggested then that "it is not beyond the realms of possibility that the EU States, such as the UK, might be obliged to give effect to the CRPD in domestic law through the prism of EU law and find themselves having to try and reconcile EU obligations with the European Convention and the CRPD".[432] They conclude that faced with "hard choices between the EU, ECHR and the CRPD, or even just the ECHR and the CRPD, the one with the least political and, probably, legal costs is the latter".[433] They also suggest that it is not "politically realistic" to expect any of the Council of Europe (COE) Member States to repeal specialist mental health legislation that provides for the detention on grounds of unsoundness of mind.[434] In addition it is not "politically realistic" to suppose a complete move away from the "institutional care of people with psychosocial disabilities".[435] It is suggested that the more likely and realistic impact of the CRPD will be that practitioners bringing cases before national courts and the ECtHR will use the CRPD to support the development and extension of the European Convention rights and rights provided for in national law.[436] This is a view that is shared by Perlin who considers that the potential of the CRPD lies in facilitating greater access to independent counsel to vindicate the rights of persons with MHPs through the courts.[437]

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[430] *Ibid*. See Chapter 2: Literature Review, Part 1.

[431] *Ibid*, at page 115. If an offender is detained on the basis of unsound mind following successfully raising a not guilty by reason of insanity defence the European Court of Human Rights has held that the person has to be detained in a hospital setting (*Aerts v Belgium* (Application No. 25357/94, Judgment 30 June 1998). However, if a person is being detained partially on the basis of punishment then it is permissible for that person to be detained in a prison setting.

[432] Fennell and Khaliq "Conflicting or Complementary Obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law" (*European Human Rights Law Review*: 6, 2011, pages 662-674) at page 674.

[433] *Ibid*, at page 674.

[434] *Ibid*.

[435] *Ibid*.

[436] *Ibid*.

[437] See Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) at pages 148-149.

It is also of note that States are obliged to protect the integrity of the individual particularly under Articles 2 and 3 of the ECHR. The ECtHR have held that States have a positive duty to maintain and apply in practice an "adequate legal framework affording protection against acts of violence by private individuals".[438] This well developed principle in the jurisprudence of the ECtHR would likely pose a significant barrier to the repeal of mental health laws. The ECtHR in its recent judgments involving disability issues have referenced the CRPD.[439] While this is encouraging, it unclear what substantive impact the CRPD will have on the jurisprudence of the ECtHR. Nevertheless the references to the CRPD and its use as an interpretative aid offers much potential to develop the ECtHR's approach to cases taken by defendants and offenders with MHPs and ID. There seems to be potential in particular to develop the jurisprudence of the ECtHR on reasonable accommodation as evidenced by some of the recent case law.[440]

9. Existing International Human Rights Law and Diversion

The discussion above reveals that Articles 12 and 14 of the CRPD are at odds with the provisions of the ECHR and the case law of ECtHR. Diversion then in the broad sense as defined for the purpose of this

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[438] See the recent judgment of *Söderman v Sweden* (Applicatin No 5786/08, Judgment 12 November 2013) at paragraph 80. See also *X and Y v The Netherlands* (Application No 8978/80, Judgment 26 March 1985), *Costello-Roberts v United Kingdom* (Application No 13134/87, Judgment 25 March 1993), *Osman v The United Kingdom* (Application No 87/1997/871/1083, Judgment 28 October 1998), *DP v The United Kingdom* (App No 38719/97, Judgment 10 October 2002), *MC v Bulgaria* (Application No 39272/98, Judgment 4 December 2003), *A v Croatia* (Application No 55164/08, Judgment 14 October 2010) and *Hajduová v Slovakia* (Application No 2660/03, Judgment 30 November 2010).

[439] See for example *Glor v Switzerland* (Application No 13444/04, Judgment 30 April 2009), *Alajos Kiss v Hungary* (Application No 38832/06, Judgment 20 May 2010), *Seal v The United Kingdom* (Application No 50330/07, Judgment 7 December 2010), *Jasinskis v Latvia* (Application No 45744/08, Judgment 21 December 2010), *Kiyutin v Russia* (Application No 2700/10, Judgment 10 March 2011), *Stanev v Bulgaria* (Application No 36760/06, Judgment 17 January 2012), *Pleso v Hungary* (Application No 41242/08, Judgment 2 October 2012), *DD v Lithuania* (Application No 13469/06, Judgment 14 February 2012), *ZH v Hungary* (Application No 28973/11, Judgment 8 November 2012), *Lashin v Russia* (Application No 33117/02, Judgment 23 January 2013). It is of note that the CRPD was not referenced in other recent judgments. See for example *Kędzior v Poland* (Application No 4502607/07, Judgment 16 October 2012) and *Bureš v The Czech Republic* (Application No 37679/07, Judgment 18 October 2012).

[440] *Ibid*.

thesis is called into question as it operates on the basis of impaired mental capacity, reduced culpability and the facilitation of treatment of persons with MHPs. User and survivor groups, in opposing diversion provisions, processes and initiatives (EG mental health courts) have relied upon the CRPD to bolster their position.[441] This section will consider the existing human rights framework, which is argued supports diversion.

There are a number of different sources of international human rights law that support the notion of diversion from the criminal justice system and prison.[442] International human rights standards that were developed prior to the CRPD, such as the MI principles, permit the involuntary treatment and detention of persons with MHPs provided that certain safeguards are complied with.[443] At the regional level most if not all COE countries have specialised systems "for people whose mental disability is a direct cause of their criminal behaviour".[444] The ECtHR is clear that where the justification of a person's detention is based on the existence of a mental disorder, they need to receive treatment in a therapeutic environment such as a hospital.[445] The ECtHR requires that when prisoners with MHPs are detained in prisons appropriate treatment has to be provided.[446] The case law of the ECtHR does not require diversion of persons with MHPs from the prison to a psychiatric or hospital environment, even if their MHP is treatable, provided that the treatment is available in the prison.[447] The failure to

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[441] See Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012) and "Submission to Second Intergovernmental Expert Group Meeting on the Review of the Standard Minimum Rules on the Treatment of Prisoners" (United Nations: Submission by World Network of Users and Survivors of Psychiatry, 2012, UNODC/CCPCJ/EG.6/2012/NGO/5).

[442] For an overview see "Toolkit on Diversion and Alternatives to Detention: International Human Rights Instruments Relevant to Diversion and Alternatives to Detention – Summary Of Provisions And Commentary" (United Nations: UNICEF, 2009).

[443] See "United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health" (United Nations: GA Res 46/119, A/RES/46/119, 17 December 1991), principle 11 "Consent to Treatment" and Principle 16 "Involuntary Admission".

[444] Bartlett, Lewis and Thorold *Mental Disability and the European Convention on Human Rights* (Leiden: Martinus Nijhoff Publishers, 2007).

[445] See *Aerts v Belgium* (Application No. 25357/94, Judgment 30 June 1998).

[446] See *Keenan v United Kingdom* (Application No. 27229/95, Judgment 3 April 2001).

[447] Bartlett, Lewis and Thorold *Mental Disability and the European Convention on Human Rights*

provide access to treatment has been found to be a violation of the ECHR. In May 2012 the ECtHR issued a judgment in a case entitled *MS v United Kingdom*.[448] The ECtHR held unanimously that there had been a violation of Article 3 of the ECHR on prohibition of inhuman or degrading treatment. This case related to the detention of a man with a MHP in police custody for more than three days. The Court found that the applicant's prolonged detention without appropriate psychiatric treatment had diminished his human dignity, even though there had been no intentional neglect on the part of the police, and amounted to degrading treatment.

The MI Principles since the 1990s have been an important source of soft law relating to the rights of persons with MHPs.[449] However, their standing has been called into question in light of the CRPD and the fact that the principles endorse a medical model view of mental illness, is as we have seen above at odds with the social model of disability embedded in the CRPD. The application of the MI Principles have been firmly rebuffed by some commentators as they are non-binding and mandate "the imposition of coercive measures in the supposed 'best interests' of an adult person with a disability".[450] Nonetheless the MI Principles are still regarded as a useful source of soft law in interpreting the rights of persons with MHPs.[451] Principle 20 deals with

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(Leiden: Martinus Nijhoff Publishers, 2007) at page 14.

[448] *MS v United Kingdom* (Application no. 24527/08, judgment 3 May 2012). This case concerned a man who had been arrested and detained under section 136 of the Mental Health Act 1983. Following his arrest he was assessed by a psychiatric specialist who determined he was suffering from a mental illness of a nature or degree that warranted detention in hospital in the interests of his health and safety and for the protection of others. The local psychiatric intensive care unit was unable to admit him and there was an attempt to place the applicant in a clinic with a medium secure unit. The applicant remained in police custody for more than 72 hours, locked up in a cell where he was very distressed shouting, removing his clothing, banging his head on the wall, drinking from the toilet and smearing himself with food and feces. On the second day of his custody, the prosecution service concluded that there was insufficient evidence to charge him. After more than three days in detention and on the advice of the consultant forensic psychiatrist the applicant was taken in handcuffs to the clinic where he received treatment.

[449] See "United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health" (United Nations: GA Res 46/119, A/RES/46/119, 17 December 1991).

[450] For example see Minkowitz "Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 151.

[451] See "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011).

criminal offenders and suggests that diversion of persons with MHPs from prison is a human rights norm. Principle 20 applies to persons serving imprisonment for criminal offences or who are detained in the course of criminal proceedings who are considered to have a mental illness.[452] Principle 20(2) provides that persons detained under these set of circumstances should receive "the best available mental health care". Principle 20(3) provides that domestic law could empower a "court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons is admitted to a mental health facility".[453] While the contents of Principle 20 is clearly at odds with our evolving understanding of Article 14 of the CRPD *inter alia* it is important to note that diversion from prison to treatment is expressly required.

At the regional level the work of the CPT is relevant in understanding the obligations of COE Member States in respect of persons detained in institutions throughout Europe. The CPT operates off a set of standards that peculiarly they do not publish publicly, opting instead to make a concise version available to the public.[454] The CPT standards relating to persons with MHPs in prison focus on accessing medical treatment and recording their "physical and mental condition" and in particular on providing for equivalence of medical care in the prison and the community and transfer for treatment as soon as possible.[455] In terms of providing for equivalence of care the CPT require that a "mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff".[456] There is no requirement that the facility be provided in the community, rather the facility can be a "civil mental hospital" or a "specially equipped psychiatric facility" located within the prison system.[457] Given the oppressive environment of the prison and the

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[452] See Principle 20(1).

[453] However, treatment of persons determined to have mental illness was to be done in accordance with the consent of the person in line with principle 11.

[454] See "European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT): CPT Standards" (Strasbourg: CPT/Inf/E (2002) 1, revised 2011) at page 29.

[455] *Ibid*, at pages 20 and 41.

[456] *Ibid*, at page 41.

[457] *Ibid*.

impact it has on the wellbeing and mental health of prisoners it is arguable that equivalence of care and recovery is not possible if the "psychiatric facility" is located in the prison. In fact the CPT state that the provision of care in the prison or the community is an "ethical" decision left to the discretion of the State Party.[458] Moreover the CPT legitimises the arguments for care in the prison as it "enables care to be administered in optimum conditions of security, and the activities of medical and social services intensified within that system".[459]

From an examination of these standards, which were revised in 2011 there is little reference to any requirement to divert persons with MHPs or ID from the criminal justice system or reference to the trend of trans-institutionalisation, reinstitutionalisation or the vulnerability of persons with MHPs to be over represented in the prison population. This is a missed opportunity and the CPT could play an enhanced role in critiquing policies or laws that result in this over-representation in prison populations across Europe. However, the CPT, in a revision to its standards in 2011, acknowledged the trend across Europe in reducing the number of psychiatric beds and in their stead the development of community based mental health services. Commenting on this development that CPT stated that this was "very favourable development, on condition that such units provide a satisfactory quality of care".[460] The CPT went on to state that it is

> "widely accepted that large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff, the more so if they are situated in isolated locations. This can have a detrimental effect on patient treatment. Care programmes drawing on the full range of psychiatric treatment are much easier to implement in small units located close to the main urban centres".[461]

While these statements from the CPT are welcomed they are still lukewarm in terms of taking a more robust view on institutionalisation. It

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[458] *Ibid*.

[459] *Ibid*.

[460] *Ibid*, at page 57.

[461] *Ibid*.

is noteworthy that the COE Office of Commissioner for Human Rights in a recent issue paper on institutionalisation adopted a more robust approach.[462] The CPT expressly recognise that psychiatric hospitals are a common feature in prisons across Europe, therefore failure to question why this is the case is unfortunate. The CPT standards underscore the important role diversion can play in avoiding institutionalisation. The standards do not challenge but rather support the use of involuntary detention. This situation indicates that Articles 12 and 14 of the CRPD are having little impact at the regional and national level.

Indeed the evolving understanding of Article 14 of the CRPD has been contested by the UN Human Rights Committee, which in a recent draft of a General Comment on "Liberty and Security of the Person" endorsed the use of laws to detain persons on the grounds of mental health (subject of course to procedural safeguards).[463]

> "States parties should explain in their reports what they have done to revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention. Any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the person in question or preventing injury to others, must take into consideration less restrictive alternatives, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the patient, and should ensure that any guardian or representative genuinely represents and defends the wishes and interests of the patient. States parties must provide programmes for institutionalized persons that serve the purposes that are asserted to justify the detention. Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity. Patients should be assisted in

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[462] "The Right of People with Disabilities to Live Independently and be Included in the Community" (Strasbourg: Issue Paper, Council of Europe Commissioner for Human Rights, 13 March 2012, CommDH/IssuePaper(2012)3).

[463] See "Draft General Comment No. 35 Article 9: Liberty and Security of Person" (United Nations: Human Rights Committee, CCPR/C/107/R.3, 2013) at paragraph 19. For a critique of the draft text of the general comment see "Submission to the Human Rights Committee in Response to Paragraph 19 of its Draft General Comment on Liberty and Security of the Person" (World Network of Users and Survivors of Psychiatry, 2013).

> obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to ensure conditions of detention consistent with the Covenant."

Later in the Draft General Comment it states that detention on the basis of mental health is lawful provided it is reviewed every "few days".[464] The Draft General Comment is based on the Committee's existing jurisprudence and highlights the reality that within the realm of the UN framework for the protection of human rights the CRPD is having little immediate impact and the implications of Article 14 are likely to be contested ideas for the foreseeable future.

10. Diversion: The Potential of the CRPD

The Optional Protocol to the CRPD provides "new entry points for claimants with disabilities and their representative organizations with the opportunity to enrich human rights advocacy through the application of reasonable accommodation across all spheres of life".[465] The Optional Protocol may well provide opportunities for the UN Committee on the Rights of Persons with Disabilities to elaborate on how the CRPD requires of State Parties to respond to defendants and offenders with disabilities. This section considers how the CRPD can inform and positively augment diversion provisions, processes and initiatives.

Perlin in his book on mental health law and international human rights did not discuss the implications of Articles 12 and 14 for the legitimacy of mental health legislation, which again calls into question the implications of the CRPD for diversion and criminal responsibility.[466] Nonetheless, he suggested that the CRPD was the "most important development – ever – in institutional human rights law for persons with mental disabilities".[467] In this regard he considers that the potential of

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[464] *Ibid*, at paragraph 48.

[465] Lord and Brown "The Role of Reasonable Accommodation in Securing Substantive Equality for Persons with Disabilities: The UN Convention on the Rights of Persons with Disabilities" (SSRN Paper, 2010) at page 1.

[466] Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) see chapters 7 and 8.

[467] *Ibid*, at page 158.

the CRPD lies in equipping counsel representing persons involuntarily detained, to develop and expand upon existing procedural and substantive due process rights.[468] This reflects the view that the CRPD needs to be seen as part of a broader human rights framework. [469]

10.1. Reasonable Accommodation CRPD

Reasonable accommodation' is a key non-discrimination tool in comparative disability discrimination law.[470] It effectively "sweeps in some action going beyond merely abstaining from discrimination".[471] The concept is now a key feature of the CRPD with discrimination defined as specifically including a "denial of reasonable accommodation" and the obligation not to discriminate is contained in every right in the CRPD.[472] The concept of reasonable accommodation has not been explored in the literature to any great extent as it relates to defendants and offenders with MHPs and ID. As Lawson notes "relatively little attention has been paid to disability equality issues in the monitoring" *inter alia* of police stations and prisons.[473] Reasonable accommodation responds directly to the person, is tailored to them and failure to provide the reasonable accommodation may result in a

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[468] *Ibid*, at chapter 8.

[469] Donnelly *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge: Cambridge University Press, 2010) at page 57.

[470] See Jolls "Accommodation Mandates" (*Stanford Law Review*: 53, 2000, pages 223-306).

[471] Quinn and O'Mahony ''Disability and Human Rights: A New Field in the United Nations'' in Krause and Scheinin (eds) *International Protection of Human Rights: A Textbook* (Turku: Åbo Akademi University Institute for Human Rights) at page 277.

[472] For a discussion on reasonable accommodation and reasonable accommodation see Kayess and French "Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities" (Human Rights Law Review: 8, 2008, pages 1-34), Lawson "The UN Convention on the Rights of Persons with Disabilities and European Disability Law: A Catalyst for Cohesion?" in Aranardóittir and Quinn (eds) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives* (Martinus Nijohoff, 2009), Lawson "People with Psychosocial Impairments or Conditions, Reasonable Accommodation and the Convention on the Rights of Persons with Disabilities" (*Law in Context*, 26, 2008, pages 60-84) and Lawson *Disability and Equality Law in Britain: The Role of Reasonable Adjustment* (Oxford: Hart Publishing, 2008).

[473] Lawson "Disability Equality, Reasonable Accommodation and the Avoidance of Ill-Treatment in Places of Detention: The Role of Supranational Monitoring and Inspection Bodies" (*The International Journal of Human Rights*: 16(6), 2012, pages 845–864) at page 854.

legal action.[474] As such there is potential to use reasonable accommodation to navigate barriers faced by PWDs in the criminal justice system and other places of detention. Indeed the case law of the ECtHR demonstrates that barriers can led to breaches of human rights, in particular Article 3 of the ECHR.[475]

10.2. Article 13 (Access to Justice) CRPD

Persons with MHPs and ID face many barriers in the criminal justice system.[476] Article 13 of the CRPD can play a very important role in removing these barriers. The idea of access to justice is a theme that has received a lot of consideration academically over the past number of years. However, the literature on access to justice examining disability is relatively sparse by comparison. Nonetheless Perlin singles out Article 13 of the CRPD suggesting that the success of the Convention for persons with "mental disabilities" hinges upon the extent to which State Parties honour Article 13, in particular, through the provision of independent counsel.[477]

The barriers facing persons in interacting with the criminal justice system have only recently begun to attract some serious academic consideration.[478] This consideration is perhaps being spurred by the

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[474] Quinn and O'Mahony ''Disability and Human Rights: A New Field in the United Nations'' in Krause and Scheinin (eds) *International Protection of Human Rights: A Textbook* (Turku: Åbo Akademi University Institute for Human Rights) at page 277.

[475] For a discussion on the ECtHR case law and other regional human rights jurisprudence see Lawson "Disability Equality, Reasonable Accommodation and the Avoidance of Ill-Treatment in Places of Detention: The Role of Supranational Monitoring and Inspection Bodies" (*The International Journal of Human Rights*: 16(6), 2012, pages 845–864). See for example *Price v The United Kingdom* (Application No 33394/96, Judgment 10 July 2001), *Stanev v Bulgaria* (Application Ni 36760/06, Judgment 17 January 2012), *Keenan v The United Kingdom* (Application No 27229/95, Judgment 3 April 2001), *Mouisel v France* (Application No 67263/01, Judgment 14 November 2002) and *Jasinskis v Latvia* (Application No 45744/08, Judgment 21 December 2010).

[476] See Chapter 2: Literature Review, Part 1.

[477] Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) at pages 148-149.

[478] See Flynn and Lawson "Disability and Access to Justice in the European Union: Implications of the United Nations Convention on the Rights of Persons with Disabilities" (*European Yearbook of Disability Law*: 4, 2013, pages 7-44) and Ortoleva "Inaccessible Justice: Human Rights, Persons with Disabilities and The Legal System" (*ILSA Journal of International & Comparative Law*: 17(2), 2003, pages 282-320).

arrival of Article 13 of the CRPD, which for the first time set outs clearly a right to access to justice in international human rights law. The notion of "Access to Justice" has a wide meaning that encompasses access in real terms to the different systems, information, procedures, processes and locations involved in the administration of justice.[479] Some of the issues that arise regionally can be dealt with under Article 6 of the ECHR on access to fair trial procedures. While it is clear that Article 13 applies to both victims of crime and defendants there has been little consideration of the barriers facing PWDs subject to the criminal justice system through the prism of access to justice. Article 13 nonetheless is "an innovative provision in an innovative treaty".[480]

However, it has been noted that the barriers that face PWDs (and children) may result in them being "singled out from others for diversion from the court system into alternative programmes such as those designed to facilitate restorative justice".[481] Hazen and Minkowitz have suggested that part of the reason for the over-representation of persons with MHPs in the criminal justice system is due to discrimination in access to justice:

> "Given the traumatic backgrounds of people who end up in prison and the relationship of trauma to MHPs, the prevalence of MHPs by any measures should not be surprising. Trauma may be common among prisoners for reasons including discrimination in access to justice, discrimination in the definition of crime and in the establishment of penalties for different crimes, as well as factors influencing the commission of criminal acts."[482]

Article 13 of the CRPD then has the potential to remove barriers facing persons with MHPs and ID embroiled in the criminal justice system.

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[479] See Ortoleva "Inaccessible Justice: Human Rights, Persons with Disabilities and The Legal System" (*ILSA Journal of International & Comparative Law*: 17(2), 2003, pages 282-320).

[480] *Ibid*, at page 43.

[481] See Flynn and Lawson "Disability and Access to Justice in the European Union: Implications of the United Nations Convention on the Rights of Persons with Disabilities" (*European Yearbook of Disability Law*: 4, 2013, pages 7-44) at page 11.

[482] Hazen and Minkowitz "A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System" (Center for the Human Rights of Users and Survivors of Psychiatry, 2012) at page 1.

Some commentators suggest that Article 13 effectively "draws together a range of important principles which have traditionally been dealt with separately and in a more fragmented manner".[483] Article 13 is much broader in encompassing not only procedural and due process rights such as the right to a fair trial it goes further than that in requiring removal of barriers at all stages of the criminal system through policing to imprisonment. In that regard Article 13 could prove to be a powerful tool in requiring diversion, in circumstances where current barriers in the built environment or in the criminal justice processes itself, cannot be removed or adjusted to overcome the perceived disadvantage.

While there is no express reference to reasonable accommodation in Article 13 there is reference to the need for State Parties to "ensure effective access to justice for PWDs on an equal basis with others … through the provision of procedural and age-appropriate accommodations".[484] It has been suggested that the difference between "accommodations" and "reasonable accommodations" is significant and that it might mean that the responses may "be more generic and less individualised".[485] Nonetheless it is suggested that the obligation on the State Party to make the accommodations "cannot be mitigated by arguments about reasonableness and the extent of the burden they would place on the duty-bearer".[486] Perhaps one of the most important elements of Article 13 is its potential to underscore the importance of reasonably accommodating persons with MHPs and ID in contact with the criminal justice system. In requesting accommodations defendants and offenders can argue that a failure to provide accommodations amounts to discrimination. There is little evidence to suggest that this is being done but there is potential, which can be facilitated by the UN Committee on the Rights of Persons with Disabilities through its concluding observations, adjudication on individual complaints under the optional protocol or indeed through development of general comments.

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[483] *Ibid*, at page 42.

[484] See Article 13(1) of the CRPD (2006).

[485] Flynn and Lawson "Disability and Access to Justice in the European Union: Implications of the United Nations Convention on the Rights of Persons with Disabilities" (*European Yearbook of Disability Law*: 4, 2013, pages 7-44) at page 25.

[486] *Ibid*.

10.3. Article 25 (Rights to Health), Article 26 (Habilitation and Rehabilitation) and Recovery CRPD

The literature suggests that access to a universal health care system, facilitates greater access to community services. This has been identified as part of the reason why fewer persons with MHPs detained in Canadian prisons compared to prisons in the US.[487] As discussed in Part 1 of this chapter diversion facilitates connection to services and supports in the community. For persons with MHPs in contact with the criminal justice system, diversion is key to accessing treatment, particularly when there are barriers to accessing services in the community. Achieving equivalence of health care between prisoners and persons in the community is an established human rights norm.[488] James has questioned the validity of the principle of equivalence and whether it is a "sufficiently ambitious aim" as the "needs of the prison population are greater than those of the general population in terms of mental health care".[489] De Vaggiani argues that there is a need for a fundamental change in the approach to prison health, an approach "that lifts the debate from the traditional orthodoxy based on medical, psychiatric and security imperatives to a new public health agenda that addresses key social and structural determinants of health".[490]

The right to health is a "key human right in the context of mental health care" and barriers to accessing services is a challenge for persons with MHPs in contact with the criminal justice system.[491] The CRPD has

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[487] Davis "Assessing the 'criminalization' of the mentally ill in Canada" (*Canadian Journal of Psychiatry*: 37, 1992, pages 532-538).

[488] See for example the "Basic Principles for the Treatment of Prisoners" (United Nations: A/RES/45/111, 14 December 1990); "Guidelines on HIV Infection and AIDS in Prisons" Geneva: World Health Organization, 1993) and "Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules" (Strasbourg: Council of Europe Committee of Ministers, 11 January 2006). For a discussion on this see Lines "From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons" (*International Journal of Prisoner Health*: 2(4), 2006, pages 269-280) and Wilson "The Principle of Equivalence and the Future of Mental Health Care in Prison" (*The British Journal of Psychiatry*: 184, 2004, pages 5-7).

[489] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, pages 241–248) at page 244.

[490] de Vaggiani "Unhealthy Prisons: Exploring Structural Determinants of Prison Health" (*Sociology of Health and Illness*: 29(1), 2007, pages 15-135).

[491] Backman, Bueno and Mesquita "Right to Health" in Dudley, Silove and Gale (eds) *Mental*

potential to access services for persons with MHPs. This view is shared by Perlin who sees the potential for the CRPD to be used as a vehicle for access to "positive rights" such as the right to treatment in the community.[492] Article 25 of the CRPD provides for a substantive right to health that could play an important role in removing these barriers. States Parties to the Convention are obliged to "provide PWDs with the same range, quality and standard of free or affordable health care". In addition to this requirement Article 25(b) requires the provision of supplementary services that specifically, on account of disability, are key (EG early identification, intervention as appropriate and services designed to minimise and prevent further disabilities). Article 25 has avoided placing an emphasis on prevention, as that would run counter to the CRPD, which is not about prevention; Article 25 is couched in terms of preventing "further disabilities". The realisation of the right to health through provision of treatment for MHPs needs to be critically considered in light of recent research. A recent study called into question the effectiveness of psychiatry reporting that jurisdictions that have "better psychiatric services experience higher suicide rates".[493] In order to address its findings it was suggested that population-based public health strategies could have a better impact on national suicide rates than "curative mental health services for individuals".[494]

Building on Article 25, Article 26 of the CRPD makes provision for the right of "habilitation and rehabilitation". Although there is such a right in the European Social Charter (Revised) it is not firmly enshrined elsewhere in international human rights law.[495] Given that the CRPD was not intended to create new rights, Article 26 was included as it was considered necessary to give effectiveness to other more general human rights such as liberty. This dependence on general human rights is evident from Article 26(1), which states that the right is a method to

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Health and Human Rights: Vision, Praxis, and Courage (Oxford: Oxford University Press, 2012) at page 583.

[492] Perlin *International Human Rights and Mental Disability Law: When the Silenced Are Heard* (Oxford: Oxford University Press, 2012) at page 167.

[493] See Rajkumar, Brinda, Duba, Thangadurai and Jacob "National Suicide Rates and Mental Health System Indicators: An Ecological Study of 191 Countries" (*International Journal of Law and Psychiatry*: 36, 2013, pages 339-342).

[494] *Ibid*. The researchers did acknowledge a number of limitations to their study.

[495] See Quinn "The European Social Charter and EU Anti-Discrimination Law in the Field of Disability: Two Gravitational Fields with One Common Purpose" in de Burca and de Witte (eds), *Social Rights in Europe* (Oxford: Oxford University Press, 2005) at pages 279-304.

"attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life".

Allied to the notion of the right to health and habilitation and rehabilitation is the notion of recovery in mental health law and policy. Recovery is an increasingly prominent aspect of mental health policy; the philosophy is now contained in mental health policies and strategies in the US, UK, New Zealand, Ireland and in many other countries.[496] Recovery has been identified as a new way of thinking about mental health "formulated by people with lived experience of mental distress".[497] The term recovery is not a new term in the area of mental health, however, it has in more recent times come to the "forefront of the policy agenda".[498] Bonney and Stickley have identified that service users, health care providers and policy makers are committed to recovery although it is a "contested concept" and there is no agreed definition of what recovery is. Despite the lack of a consensus or a universal definition of recovery there is a consensus in the literature in the UK that recovery involves provision of good quality care to service users to promote recovery both as inpatient or in the community. Studies in the 1980s as well as personal narratives "demonstrated that people who were diagnosed with severe mental illness could reclaim or recover meaningful lives"; this momentum gave rise to the concept of the "recovery oriented services".[499]

Recovery is a concept that has been developed outside of the criminal justice system, developed by service users. As such it has great potential to develop mental health services and supports that respects the autonomy and legal capacity of the person using services. Recovery is considered to have originated in the US in the 1970s and 1980s. The following have been identified as key themes in defining;

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[496] See Davidson, O'Connell, Tondora, Staeheli and Evans "Recovery in Serious Mental Illness: Paradigm Shift or Shibboleth?" (Program for Recovery and Community Health of Yale University and the Connecticut Department of Mental Health and Addiction Services, 2005) and "A Vision for Change" (Dublin: Stationery Office), 2006.

[497] See "Mental Health Europe Newsletter" (Bruxelles: No. 5, 2013) at page 2.

[498] See Bonney and Stickley "Recovery and Mental Health: A Review of the British Literature" (*Journal of Psychiatric and Mental Health Nursing*: 15, 2008, pages 140–153) at page 140.

[499] Higgins "A Recovery Approach within the Irish Mental Health Services: A Framework for Development" (Dublin: Mental Health Commission, 2008).

"being able to live a meaningful life, both personally and in the community; redefining a positive sense of identity; making certain life adjustments; overcoming symptoms, stigma and discrimination; and living with hopefulness for the future. It needs to be acknowledged that recovery means different things for different people, and that it can be viewed as both a process and an outcome".[500] The protection of human rights, recognition of legal capacity and the other principles in the CRPD around equality form part of the principles of recovery.[501]

Therapeutic jurisprudence also involves the notion of recovery. Therapeutic jurisprudence has developed specifically to respond to persons with MHPs in contact with the criminal justice system. As seen from the discussion above the criticisms of therapeutic jurisprudence and mental health courts are that they have the potential to intrude on the rights of the individual subject to the diversion process. If recovery is embedded within therapeutic jurisprudence and within diversion procedures, processes and initiatives it could resolve many of the tensions with the CRPD. This in conjunction with recognition of the right to health and the right to habilitation and rehabilitation have much potential to remove barriers that prevent persons with MHPs and ID from accessing supports and services in the community. The provision of services in the community is also supported by a recent Finnish study. The study reported that outpatients (diagnosed with schizophrenia at first onset) had better recovery than patients that were hospitalised.[502]

10.4. Article 17 (Protecting the Integrity of the Person) CRPD

Article 17 of the CRPD is closely connected to Article 25 of the CRPD with regards to consent for treatment.[503] Given that treatment for a

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[500] "Developing a Recovery Oriented Service Provider Resource for Community Mental Health Organisations: Literature Review on Recovery" (Sydney: NSW Consumer Advisory Group, 2009) at pages 2-3.

[501] *Ibid.*

[502] See Kiviniemi, Suvisaari, Isohanni, Saarento, Hakkinen, Pirkola and Hakko "The Characteristics and Outcomes of Hospitalised and Outpatient-Treated First-Onset Schizophrenia Patients: A 5-Year Register Linkage Study" (*International Journal of Clinical Practice*: 67(11), 2013, pages 1105–1112).

[503] For a discussion of Article 17 CRPD see "Involuntary placement and involuntary treatment of persons with mental health problems" (Vienna: EU Agency for Fundamental Rights, 2012) at page 22.

MHP is very often a requirement for participation in a diversion programme the issue of informed and freely given consent is a significant issue. Article 17 the right to integrity of the person requires that the "physical and mental integrity" of the persons with a disability should be respected "on an equal basis with others". The CRPD Committee have expressed concern with regards to the consent of PWDs within health and mental health services. In its concluding observations to Tunisia for example the Committee has expressed concern around the lack of clarity with the legislation protecting "PWDs from being subjected to treatment without their free and informed consent, including forced treatment in mental health services".[504] The UN Special Rapporteur has also expressed similar concerns and has emphasised the mental and physical integrity of PWDs.[505] Article 17 then requires that all diversion programmes operate in a way that respects the mental and physical integrity of the participant. As such full and informed consent is essential and support and reasonable accommodation should be provided for.

10.5. Articles 19 (Independent Living) Article 16 (Freedom from Exploitation Violence and Abuse) CRPD

Article 19 of the CRPD sets out the right to live independently and to be included in the community and is one of the key provisions in the CRPD that seeks to restore autonomy, choice and independence for PWDs.[506] Article 19 requires State Parties to the CRPD to take action to facilitate PWDs to fully enjoy inclusion and participation in the community. While there is no precise definition of independent living in Article 19, it is understood to reflect the principles of autonomy and choice and reflects the social model of disability. Article 19 makes it clear that the placement of PWDs in institutions constitutes a "pervasive violation" of

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[504] See "Concluding Observations of the Committee on the Rights of Persons with Disabilities: Tunisia" (Geneva: UN doc. CRPD/C/TUN/CO/1, 13 May 2011) at paragraphs 28 and 29.

[505] See Mendez "Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment" (United Nations: UN doc A/66/268, 5 August 2011) and Mendez "Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment"(United Nations: UN doc A/HRC/22/53, 1 February 2013).

[506] For a discussion on Article 19 see Clements and Parker "The UN Convention on the Rights of persons with Disabilities: A New Right to Independent Living?" (*European Human Rights Law Review*: 4, 2008, pages 508-523).

the CRPD.[507] Despite this acknowledgement that placement of PWDs in institutions "is a pervasive violation" there are approximately one million persons living in institutions across Europe.[508] Given the risk of institutionalisation and the complicated and uncertain relationship between disability, criminality and institutionalisation, diversion can be argued as a tool of ensuring community living (see above).

It has been noted that there has been a greater focus "to the fundamental question of how to move away from policies and systems which place disabled people into social care homes, psychiatric hospitals and other institutional living arrangements separated from the life of mainstream society".[509] However, despite "… efforts to ensure that disabled people have opportunities to live independently and participate in the life of their communities" comparatively little consideration has been given to "disability equality issues in the monitoring of such places of detention".[510] Lawson notes that the implications of neglecting disability equality issues in monitoring places of detention have "serious implications for disabled detainees and result in levels of suffering amounting to cruel, inhuman or degrading treatment and possibly even torture".[511]

The importance of tools of community living is evident when the dangers of institutionalisation are considered. The WHO Report on Disability found that adults with disabilities are at greater risk of violence than those without disabilities and abuse against PWDs has been reported to be 4–10 times greater than that against people without disabilities.[512] Similarly, the prevalence of sexual abuse against PWDs has been shown to be higher especially for institutionalised men and women with ID,

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[507] See '"The Right of People with Disabilities to Live Independently and be Included in the Community" (Strasbourg: Issue Paper, Council of Europe Commissioner for Human Rights, 13 March 2012, CommDH/IssuePaper(2012)3).

[508] *Ibid*.

[509] Lawson "Disability Equality, Reasonable Accommodation and the Avoidance of Ill Treatment in Places of Detention: The Role of Supranational Monitoring and Inspection Bodies" (*The International Journal of Human Rights*: 16(6), 2012) pages 845–864, at page 845.

[510] *Ibid*, at pages 845-846.

[511] *Ibid*, at page 846.

[512] "World Report on Disability" (Geneva: World Health Organization and the World Bank, 2011).

intimate partners and teenagers. The vulnerability of persons with MHPs and ID in prison is well recognised.[513] Given this context Article 16 (freedom from exploitation, violence and abuse) of the CRPD is a very novel provision, which is relevant to the notion of diversion as defined in this thesis. Article 16 of the CRPD represents a reasonable expression of general human rights standards as applied in the context of disability.[514] As discussed above persons with a disability are vulnerable, especially in institutional settings such as prisons. Article 16 then requires States Parties to take all appropriate measures to protect PWDs including in the prison from all forms of exploitation, violence and abuse.[515] It effectively requires lifting the veil surrounding institutions by demanding effective monitoring and it is argued, where necessary, requires the release of persons with MHPs and ID from prison where they are at risk of exploitation violence and abuse. The CRPD requires States Parties to put in place effective recovery and rehabilitation programmes in cases where violence and abuse have taken place and robust action in the form of investigation and prosecution.

In an interim report of July 2008, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment devoted considerable attention to the matter of protecting PWDs from torture.[39] Similarly, an interim report in 2011 from the Special Rapporteur on torture considered the protection of PWDs from abuse and exploitation.[516] Reportedly, the Committee against Torture is considering

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[513] See "Handbook on Prisoners with Special Needs" (Vienna: United Nations Criminal Justice Handbook Series, United Nations Office On Drugs And Crime, 2009).

[514] Quinn and O'Mahony ''Disability and Human Rights: A New Field in the United Nations'' in Krause and Scheinin (eds) *International Protection of Human Rights: A Textbook* (Turku: Åbo Akademi University Institute for Human Rights) at pages 282-283.

[515] There is explicit inclusion of "home" in Article 16, which means that States Parties will have to develop appropriate tools to investigate abuse within the family setting. Article 16 goes on to require States Parties to prevent all forms of exploitation and abuse by providing assistance and supports including information on how to recognise and report instances.

[39] Nowak "Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment" (United Nations: UN doc A/63/175, 28 July 2008).

[516] Mendez "Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment" (United Nations: UN doc A/66/268, 5 August 2011). Importantly the Special Rapporteur found that where the physical conditions and solitary confinement cause severe mental and physical pain or suffering (when used as a punishment, during pre-trial detention, indefinitely, prolonged) on juveniles or persons with mental disabilities, it can amount to cruel, inhuman or degrading treatment or punishment and even torture. He also found that the use of solitary confinement increases the risk that acts of torture

preparation of a general comment on disability and torture, inhumane and degrading treatment. A General Comment on this topic would be welcome in the context of institutional settings where PWDs are at their most vulnerable and a specific consideration of its implications for persons with MHPs and ID would bring clarity to this area.

11. Conclusions

While the insanity defence is only raised in a small number of cases it is an important component of the criminal law. The failure of the OHCHR to adequately explain its call for abolition is regrettable, particularly as the defence

> "is at the heart of debates about the effect of the accused's mental condition on criminal liability. It is also regrettable that the UN Committee on the Rights of Persons with Disabilities has failed to engage with the issue in its Draft General Comment on Article 12. The scope and limits of insanity are a major factor in shaping other defences founded on states of automatism, intoxication and diminished responsibility."[517]

While the law on diminished responsibility, the procedural rules on fitness to be tried and the law on the insanity defence have different rules (that vary from jurisdiction to jurisdiction) and are justified very often on different grounds they have common threads running through. The most obvious thread being the rationale for making concessions to defendants and offenders who commit criminal acts while experiencing some sort of impairment on account of their disability. As such the implications of abolition may have serious consequences that merit greater discussion and consideration than that provided thus far. These consequences have clear implications for the different diversion provisions, processes and initiatives discussed above.

There is a need to clarify the rationale for abolition of the insanity defence and how State Parties can meet their obligations. Similarly, the implications of Article 14 for mental health laws need to be clarified.

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and other cruel, inhuman or degrading treatment or punishment will go undetected and unchallenged.

[517] Editorial "Reforming the Insanity Defence" (*Criminal Law Review*: 2003, pages 139-140) at page 139.

Perhaps this can be most authoritatively done by the UN Committee on the Rights of Persons with Disabilities through General Comments. Policy makers, lawyers and psychiatrists might quickly disregard these interpretations of the CRPD as "absurd" and "adopt a hurt and somewhat defensive posture".[518] However, that approach would not be constructive. There is a legitimate human rights issue at the heart of the calls for the abolition of the insanity defence. Bartlett suggests "[i]f there are reservations about the approach propounded for the CRPD, it is for users, practitioners and others in the field to come up with an equally clear and intellectually defensible alternative."[519] It is argued here that the replacement of the insanity defence (and other similar defences) with a disability neutral defence runs counter to the rationale of the defence. As such State Parties to the CRPD are unlikely to consider the proposed amendments to their criminal law a realistic law reform option.[520] The repeal and replacement of the insanity defence with a disability neutral defence opens up the insanity defence in a way that would be repugnant to legislators and the public who often view the defence with much distrust and scepticism. Given the risk of institutionalisation faced by PWDs (see Part 1 above) it is argued that a disability neutral law aimed at managing risk may result in an upward trend in institutionalisation of person with disabilities in prisons. This unintended consequence is considered a real prospect with reference to the discussion on dangerousness and risk in Part 1 of this chapter.

It is concluded that a workable suggestion for law reform would be to address the core human rights concern with the insanity defence, the indefinite detention of persons who successfully raise the defence. Greater consultation beyond the narrower dialogue that has currently been generated is key to ensuring a greater understanding of the complex issues involved and in securing buy in from State Parties many

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[518] Bartlett "The United Nations Convention on the Rights of Persons with Disabilities the Future of Mental Health Law" (*Psychiatry*: 8(12), 2009, pages 496-498) at page 498.

[519] *Ibid*.

[520] The suggestion that the CRPD is unlikely to have a significant even within academic research is illustrated with reference to a recent study of involuntary treatment. In the study of 32 Commonwealth Mental Health Acts were compared using a framework developed from standards derived from the Universal Declaration of Human Rights. Nowhere in the study was there a reference to the CRPD and the requirements of Article 14 on State Parties to the CRPD. See Fistein, Holland, Clare and Gunn "A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions" (*International Journal of Law and Psychiatry*: 32, 2009, pages 147–155).

of whom are currently engaged in domestic law reform programmes aimed at bringing national law into compliance with the CRPD. The failure of the OHCHR to engage in a discussion about the implications of the abolition of the insanity defence is also evident in the lack of discussion around the defence of diminished responsibility. The UN Committee on the Rights of Persons with Disabilities is best placed to facilitate this dialogue through its work with civil society and reporting by State Parties.

It is of note that the UN Committee on the Rights of Persons with Disabilities to date in their concluding observations to State Parties have not addressed the implications of the CRPD in the area of criminal responsibility. Similarly, the COE Human Rights Commissioner in his Issue Paper on legal capacity did not engage with the issue of legal capacity and criminal responsibility, which supports the suggestion Article 12 of the CRPD is unlikely to lead law and policy reform for the foreseeable future.[521] This reflects the uncertainty of these interpretations, particularly in light of their direct conflict with established procedural rights contained in the ECHR. Nonetheless the CRPD will undoubtedly be instrumental in advancing the rights of PWDs and driving law reform agendas across the world that seek to bring domestic law of State Parties into conformity with the CRPD. One of the main rationales for the development of a CRPD was to provide greater clarity on the human rights of PWDs. The CRPD on the whole was successful in expressing this in the text of the Convention. However, the calls for the abolition of the insanity defence and mental health laws have resulted in confusion and uncertainty. This is most glaringly evident within the UN system itself where it endorses the old paradigm in its draft of the "General Comment on Liberty and Security of the Person". It is coming as a surprise for State Parties who negotiated the Convention that their compliance with the Convention now requires abolition of the insanity defence.

The rights of persons with MHPs are pursued "with verve", the rights of persons with MHPs "who straddle the disordered-offending spectrum,

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[521] See "Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities" (Strasbourg: 20 February 2012, CommDH/IssuePaper(2012)2). However, there was some discussion of the case law of the ECtHR on reasonable accommodation in the prison setting.

is a much less comfortable fit in a human rights context."[522] The submissions made by disability rights groups calling for abolition of the insanity defence highlight a theoretical divergence in how the social model of disability relates to defendants and offenders with MHPs. The social model has been very influential in impacting on policy and advancing equality as evidenced by its inclusion in the CRPD and its potential in achieving greater equality for PWDs is "incalculable".[523] However, there is a lack of research exploring the tensions between the social model and mental illness. In particular, there is a lack of research exploring the social model and its application to defendants and offenders with MHPs. The views advanced by disability rights groups and user and survivor groups may not represent the views of offenders with MHPs and there is a need to ensure that their voice is heard in this debate.

As we have seen in Part 1 of this chapter mental health courts and indeed other processes of diversion can be seen as "evolving models of practice".[524] As such they can be adapted to respond to the needs of PWDs in contact with the criminal justice system in a ways that comply with international human rights law. It is suggested that the CRPD (EG Articles 13, 16, 19, 25 and 26) can be used to reformulate diversion to address the concerns from the user and survivor groups. Diversion that is based on non-coercion and providing supports for persons in the community then can form an part of CRPD compliant model of diversion. The CRPD has underscored the unacceptability of institutionalisation; diversion it is argued can be reformulated to be a powerful tool in ensuring community living and inclusion for defendants and offenders with MHPs in contact with the criminal justice system.

It has been suggested that the strongest argument for adherence to human rights, is not that national or international law requires adherence.[525] Rather adherence to human rights standards works

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[522] *Ibid*.

[523] Crow "Renewing the Social Model of Disability" (*Coalition News,* July, 1996 at 5-9).

[524] Lurigio and Snowden "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (*Justice System Journal*: 30, 2009, pages 198-218).

[525] Zinger "Human Rights Compliance and the Role of External Prison Oversight" (*Canadian Journal of Criminology and Criminal Justice*: 48(2), 2006, 127) at page 127.

better than any other alternatives for "offenders for correctional staff, for society at large".[526] Zinger's contention is that compliance with human rights standards augments but does not guarantee "the odds of releasing a more responsible citizen".[527] As such he argues that a prison environment that is more respectful of human rights is "conducive to positive change, whereas an environment of abuse, disrespect, and discrimination has the opposite effect: Treating prisoners with humanity actually enhances public safety".[528] Similarly it is argued here that diversion and connection to supports and services better achieves public safety and safety of persons with MHPs and ID. A final point is the deprivation of legal capacity (EG by stripping away criminal responsibility) is not a feature of diversion, where most diversion cases relate to non-serious offending and participation is voluntary.

[526] *Ibid*.

[527] *Ibid*.

[528] *Ibid*.

Chapter 3: Ireland

1. Introduction

Formal diversion of defendants and offenders with MHPs and ID from the criminal justice system in Ireland was almost non-existent until recently. The purpose of this chapter is to explain why Ireland has not developed diversion at the different points of the criminal justice system. This chapter begins with a historical overview of the development of asylums and psychiatric hospitals, as this narrative is necessary to understanding the development of current law and policy in Ireland. An overview is provided of the existing law and policy and the informal processes of diversion that have developed. There is also a consideration of therapeutic jurisprudence approaches in the criminal justice system and the relevant criminal justice and penal policy and mental health policy.

2. Historical Development of Institutions in Ireland

The Brehon Laws were the early laws of Ireland that were codified around the 5th century. It is of note that Brehon Laws made special provision for five categories of persons who were considered vulnerable: idiots, fools, dotards, persons of no sense and mad men.[1] Persons falling into these categories were exempted from the punishments that applied to different crimes. The purpose of the Brehon law had a benevolent philosophy, seeking to protect idiots, fools, dotards, persons of no sense and mad men from exploitation.[2] However, there was little provision for vulnerable persons in medieval times, express provisions would not emerge until the poor laws were formulated.

The segregation of the insane "began quietly" in Ireland with the anticipated use of the asylum for a "miniscule proportion of the population" with a small number of institutions with a handful of beds to "clear the roads of wandering idiots and the gaols and houses of industry of troublesome lunatics".[3] In 1804 a Select Committee of the House of Commons recommended the provision of four provincial

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[1] "Report of the Commission of Inquiry on Mental Handicap" (Dublin: Stationary Office, 1965) at page 10.

[2] *Ibid*.

[3] Finnane *Insanity and the Insane in Post-famine Ireland* (Croom Helm, 1981) at page 13.

asylums for the treatment of the mentally ill and as a response to the numbers of persons detained in prisons and houses of industry.[4] The 1800s saw the introduction of legislation governing the civil and criminal compulsion of persons to asylums, which coincided with the introduction of inspection for psychiatric institutions.[5] At the same time a substantial number of public psychiatric hospitals known as "district asylums" were set up and this building programme continued into the 20th century in Ireland. The creation of these institutions facilitated increased admissions.[6]

By 1851 there were 3,234 persons detained in asylums in Ireland rising to 11,265 by 1891.[7] The expansion of the asylum is aptly illustrated by the construction of the Connaught Asylum built in Ballinasloe in 1833. The institution in Ballinasloe initially detained 150 persons and by the middle of the 19th century it detained 300, by the end of the 19th century over 1,000, in 1922 the time of independence 1,482.[8] In Connemara (the Irish speaking part of County Galway) references to the asylum in Ballinasloe to the east of the county entered the lexicon; common phrases still used to this day include *"cuireann tú soir me" "you drive me east" or "chur siad soir mé" "they drove me east".* While Ireland was not alone in the Western world in expanding asylums (see above), Ireland stands out for the demand for asylum places due to limited industrialisation and urbanisation and also because of declining population in the 1840s following the famine.[9]

It is clear from Prior's work that the use of "dangerousness" as a

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[4] Kelly "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (*Medico-Legal Journal*: 76(1), 2008, pages 19–25) at page 20.

[5] See Kelly "Mental Health Law in Ireland, 1945 to 2001: Reformation and Renewal" (*Medico-Legal Journal*: 76(2), 2008, pages 65-72).

[6] Williamson "The Beginnings of State Care for the Mentally Ill in Ireland" (*Economic and Social Review*: 10, 1970, pages 280-291) and Finnane *Insanity and the Insane in Post-famine Ireland* (Croom Helm, 1981).

[7] Kelly "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (*Medico-Legal Journal*: 76(1), 2008, pages 19–25) at page 21.

[8] O'Sullivan and O'Donnell C*oercive Confinement in Ireland: Patients, Prisoners and Penitents* (Manchester: Manchester University Press, 2012) at page 9.

[9] See Malcolm "Ireland's Crowed Madhouses: The Institutional Confinement of the Insane in Nineteenth Century Ireland" in Porter and Wright *The Confinement of the Insane: International Perspectives* (Cambridge: Cambridge University Press, 2003).

discourse within criminal justice discourse is not a new issue and that in the second half of the 19th century there was "excessive use" of "dangerous lunacy" legal procedures in admissions to the asylum.[10] The lunacy system in Ireland in the 19th century was set up with a view to controlling "vagrancy and in the classification and division of the 'deserving' from the 'undeserving poor'".[11] It originated in the report of the select committee on the "Aged and Infirm Poor of Ireland" in 1804 and was enacted through the *Lunacy Act 1821*.[12] This was an era when "insurrection laws" were vigorously enforced, for example, through forced transportation to Australia of persons suspected of revolting against the British colonial administration.[13] The laws that regulated the Irish asylum system were different to those that operated in England. One of the main differences was that prisons were authorised "to receive lunatics for the first half of the century".[14] Before the opening of the Criminal Lunatic Asylum in Dundrum in 1850 there was no special facility for criminal lunatics in Ireland.[15]

In the early years of the 19th century admission to the new "district asylums" was "fairly straightforward and simple", persons considered to be of "unsound mind" were admitted under the legislation from 1821 and 1826.[16] However, this changed when the increased demand for places exceeded the supply and new legislation known as the *Dangerous Lunatics (Ireland) Act 1838*, was enacted that permitted the direct committal to prison of persons designated as "dangerous lunatics".[17] The law permitted transfer to a "district asylum" without any review from local magistrates when places became available.[18] While persons continued to be admitted to "district asylums" as "ordinary lunatics" as the 19th century moved in the number of "dangerous

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[10] Prior "Dangerous Lunacy: the Misuse of Mental Health Law in Nineteenth-Century Ireland" (*Journal of Forensic Psychiatry and Psychology*: 14, 2003, pages 525-541).

[11] *Ibid*, at page 528.

[12] *Ibid*.

[13] *Ibid*.

[14] *Ibid*.

[15] *Ibid*.

[16] *Ibid*, at page 529. See Lunacy Act 1821 and Lunacy (Ireland) Act 1826.

[17] *Ibid*.

[18] *Ibid*.

lunatics" increased significantly.[19]

One explanation for the increase of "dangerous lunatics" in the "district asylums" was that the asylums could not refuse the admission of persons from the prison system.[20] However, the numbers of persons waiting for transfer amassed as the years went by with statistics showing that there were 441 dangerous lunatics in 1864 waiting for places in the "district asylum system" with 505 in 1865 and 495 waiting in 1866.[21] The Report "Commission of Inquiry into Lunatic Asylums in Ireland" in 1857 resulted in law reform, ten years later by making it illegal to admit "dangerous lunatics" requiring instead direct admission to the asylum.[22] However, in spite of the transfer of decision-making on admission from the prison system to the asylum system, the upward trend in the number of persons admitted as "dangerous lunatics" continued.[23] The research indicates that despite the law reform this trend continued and "only a very small percentage of admissions to district asylums were 'ordinary' admissions (of unsound mind)" with most of the admissions being classified as "dangerous".[24] There were of course advantages (from the family perspective) flowing from having a relative admitted, as a "dangerous lunatic", namely they were guaranteed admission and members of the police force would transport "the patient from home to the asylum regardless of the distance".[25]

The history of mental health services in the 19th century Ireland tells us a number of interesting things that are relevant to the current discourse on mental health law and policy. As Prior points out "large-scale structures" suit the professional classes and this can lead to "organizational expansion even in the face of obvious flaws".[26] It was suggested that everyone working in the lunacy system in 19th century Ireland was aware that the legislation was being exploited and that the

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[19] *Ibid*.

[20] *Ibid*, at page 530.

[21] *Ibid*.

[22] *Ibid*, at page 531.

[23] *Ibid*.

[24] *Ibid*.

[25] *Ibid*.

[26] *Ibid*, at page 537.

majority of persons detained in asylums were not in fact "dangerous lunatics".[27] Despite this knowledge the law did not change in Ireland until the 1940s.[28] The suggested explanations for this inertia in reform range from the economic – the asylum business was "lucrative for many professionals (legal and medical) and for officials working in this highly bureaucratized system".[29] It is contended that the interests of the professionals' remains an issue today in pushing back against reform as mental health care systems remains a big employer for professionals with "significant amount of lucrative work for the legal profession through the work involved in tribunals and judicial reviews".[30] Under this set of circumstances it is suggested that reforming the system and implementing new policies poses difficulties.[31] Control and influence of professionals and their representative bodies over policymaking in relation to defendants and offenders with MHPs and ID may go some way to explaining the failure to deliver any meaningful reform or proactive responses such as diversion programmes.

At the beginning of World War I the rate of detention in psychiatric hospitals was 490 per 100,000 in Ireland, which compared to 298 in England and 283 in Scotland per 100,000.[32] The Irish Free State was found to have the highest rates of institutionalisation for the "insane and mentally defective".[33] The highest point in the rate of detention of persons in psychiatric hospitals was recorded in 1958 when 21,075 were detained at a rate of 742 per 100,000.[34] At the time of the founding of the state in 1922 there were no special services for persons with ID. 11,000 "itinerant beggars" were placed in "County Homes" formerly known as "Workhouses". Persons with "mental handicap" are amongst this population, which also included young offenders,

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[27] *Ibid*.

[28] *Ibid*.

[29] *Ibid*.

[30] *Ibid*.

[31] *Ibid*.

[32] Finnane *Insanity and the Insane in Post-famine Ireland* (Croom Helm, 1981) at page 224

[33] See Penrose "Mental Disease and Crime: Outline of a Comparative Study of Comparative Statistics" (*British Journal of Medical Psychology*: 18(1), 1939, pages 1-15).

[34] Walsh and Daly "Mental Illness in Ireland 1750-2002: Reflections on the Rise and Fall of Institutional Care" (Dublin: Research Health Board, 2004) at page 33.

prostitutes, "infirm" and older persons no longer able to support themselves, "idiots and imbeciles", the overflow from asylums, unmarried mothers, orphans and abandoned children and "illegitimate children".[35]

As Kelly notes there were many problems with Irish psychiatric institutions such as overcrowding and a failure to provide for voluntary admission to the institutions.[36] Problems echo on-going debates in Ireland today such as over-crowding in Irish prisons and debates surrounding mental health legislation and the status of voluntary patients.[37] The Irish prison population remained low and declined until the 1950s; the low prison population has been explained by two main factors migration patterns and the use of other institutions other than prison "to regulate dangerous, deviant, damaged troubled and troubling individuals".[38] However, social control achieved through the use of these other institutions went into decline by the end of the 1960s, which led to the use of the prison as the main response to "deviance".[39] Essentially from the end of the 1960s the use of non-state penal institutions went into "terminal decline", which resulted in a dramatic increase in the use and size of the state penal system in "managing deviance".[40] The prison became centrally important from the 1970s onwards, which is also explained in terms of increased secularisation in Ireland. Important also were changing ideas about what constituted moral and immoral behaviour, increasing crime rates and the growth in the number of professionals working within the criminal justice system.[41]

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[35] See Robbins *From Rejection to Integration: A Century of Service by the Daughters of Charity to Persons with Mental Handicap* (Dublin: Gill and Macmillan, 1992) at pages 2-3.

[36] Kelly "Mental Health Law in Ireland, 1945 to 2001: Reformation and Renewal" (*Medico-Legal Journal*: 76(2), 2008, pages 65-72).

[37] See "IPRT Briefing on: Overcrowding in Irish Prisons" (Dublin: Irish Penal Reform Trust, October 2011) and "Interim Report of the Steering Group on the Review of the Mental Health Act 2001" (Dublin: Department of Health, 2012).

[38] Kilcommins, O'Donnell, O'Sullivan and Vaughan *Crime, Punishment and the Search for Order in Ireland* (Dublin: Institute of Public Administration, 2004) at page 87.

[39] *Ibid*.

[40] *Ibid*.

[41] Ibid, at page 88.

As discussed in Chapter 2: Literature Review a study on Penrose's law showed the number of persons in Irish psychiatric units and hospitals decreased from 19,801 to 3,658 approximately a five-fold decrease (between 1963 and 2003).[42] During the same period the Irish prison population increased from 534 to 3,176 (an increase of 2,642).[43] These statistics demonstrate a significant reverse connection between the number of people in Irish psychiatric units and hospitals and the day-to-day average number of prisoners in Irish prisons during the period of the study.[44] The study suggests that there has been a continual decline in the number of psychiatric inpatients and a continual increase in prisoners between the 1960s and the 2000s.[45]

Given the large-scale use of institutions it is not surprising that a number of inquiries into institutional care in Ireland published in the 1960s. These inquiries are considered significant milestones in propelling the move from institutional care to the provision of care in the community.[46] The inquiries include a Report from the Commission of Inquiry on Mental Handicap (1965), a Report of the Commission of Inquiry on Mental Illness (1966) and the Report on Reformatory and Industrial Schools System (1970).[47] The Report from the Commission of Inquiry on Mental Handicap (1965) will be considered below and the Report of the Commission of Inquiry on Mental Illness (1966) will be considered now.[48]

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[42] Kelly "Penrose's Law in Ireland: An Ecological Analysis of Psychiatric Inpatients and Prisoners" (*Irish Medical Journal*: 100(2), 2007, pages 373-374). This study involved a review of date from the annual census of psychiatric patients and prison statistics between 1963 and 2003.

[43] *Ibid*.

[44] *Ibid*.

[45] *Ibid*. The study reveals that there has been a significant net deinstitutionalisation as the number of increased prisoners is still much lower than the rate of persons detained in psychiatric units and hospitals in the period. See Chapter 2: Literature Review.

[46] *Ibid*.

[47] "Report of the Commission of Inquiry on Mental Handicap" (Dublin: Stationary Office, 1965); "Report of the Commission of Inquiry on Mental Illness" (Dublin: Stationary Office, 1966) and "Reformatory and Industrial Schools System" (Dublin: Stationary Office, 1970).

[48] The Report on Reformatory and Industrial Schools System (1970), focuses on minors and as such falls outside the scope of this thesis (see Chapter 1: Introduction above).

3. Commission of Inquiry into Mental Illness

The Commission of Inquiry into Mental Illness, which issued its Report in 1966, examined the services that were available to persons with mental illness in Ireland.[49] The Commission concluded that the public psychiatric hospitals were a "legacy" of the past where there was an emphasis on security and custodial style care.[50] A key part of the Commission's terms of reference was "to consider and report on changes which they regard as necessary or desirable in the legislation dealing with the mentally ill (other than the legislation dealing with criminal lunatics and with the estates of persons under the care of the High Court or the Circuit Court)".[51]

However, the Commission of Inquiry into Mental Illness made a number of recommendations that are relevant to the discussion here. In particular, the Commission recommended that improved psychiatric services should be provided to prisoners who are not custody patients, but who nonetheless were in need of "psychiatric advice or treatment".[52] The Commission recommended that detention centres should also make arrangements with local health authorities to provide the necessary psychiatric services to prisoners. Retention of the Central Mental Hospital (CMH) was recommended as a "special hospital for those custody patients who cannot be suitably catered for in the ordinary range of psychiatric hospitals".[53] The criteria recommended by the Commission for deciding whether a patient should be sent to, or should be retained in, the CMH speak to the taboo of being resident in the CMH. A central factor to be considered by a district mental hospital in accepting a patient from the CMH was whether "his presence … would unduly stigmatise the hospital".[54]

The Commission of Inquiry into Mental Illness also highlighted problems at that time concerning persons with MHPs appearing before

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[49] "Report of the Commission of Inquiry on Mental Illness" (Dublin: Stationary Office, 1966).

[50] *Ibid*, at page 21.

[51] *Ibid*, at page xxli.

[52] *Ibid*, at page xxviii.

[53] *Ibid.*

[54] *Ibid.*

the courts. The Commission asserted, "[c]rime in adults may be a symptom of emotional disturbance or other psychiatric disorder" and made a number of recommendations to address this symptom.[55] One of the main recommendations was that the court should be in a position to obtain a full psychiatric report. The Commission also recommended the suspended sentences should be used to facilitate the person obtaining psychiatric treatment if "stipulated by the Court".[56]

4. The Henchy Report

The recommendations of the Commission of Inquiry into Mental Illness were not enacted. The "Interdepartmental Committee on Mentally Ill and Maladjusted Persons" was subsequently set up and unlike the Commission of the Inquiry into Mental Illness focused solely on issues in the criminal law. The "Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons: Treatment and Care of Persons Suffering from Mental Disorder Who Appear Before the Courts on Criminal Charges" also known as the Henchy Report was published in 1978.[57] The terms of reference for the Interdepartmental Committee was as follows:

> "To examine and report on the provisions, legislative, administrative and otherwise, which the Committee considers to be necessary or desirable in relation to persons (including drug abusers, psychopaths and emotionally disturbed and maladjusted children and adolescents) who have come, or appear likely to come in conflict with the law and who may be in need of psychiatric treatment".[58]

In its Report the Committee set out in an extraordinarily detailed manner a draft bill containing legislative changes that would be needed to give effect to its recommendations. The Report in fact ran to

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[55] *Ibid*, at page xxix.

[56] *Ibid.*

[57] "Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons: Treatment and Care of Persons Suffering from Mental Disorder Who Appear Before the Courts on Criminal Charges" (Dublin: Stationary Office, Prl 8275, 1978).

[58] *Ibid*, at page 3.

less than 5 pages with the Committee forming the view that it "thought it desirable to state its conclusions in the form of a draft bill, not so much to give finite form to its recommendations as to enable the scope and effect of those recommendations to be viewed and appraised as components of a legislative pattern".[59]

The Henchy Report sought to expand the scope of using mental illness as a defence acknowledging that "judges and juries are debarred from tasking into account mental illness or personality disorder" unless it is sufficiently serious to amount to the insanity defence.[60] The Report noted that mental illness or personality disorders were only taken into account for the purposes of sentencing and it only became a factor when raised by the defence.[61] The Henchy Report considered that mental illness may reduce criminal responsibility (see Chapter 2: Literature Review), concluding that many persons were dealt with in the courts as "normal offenders" even though they may not be responsible or fully responsible for the conduct for which they are facing criminal charges and that they may be in need of "psychiatric or other special treatment".[62]

This Henchy Report considered the inability or restricted ability of the Irish criminal law to facilitate "appropriate psychiatric treatment" was a "grave defect" with the law.[63] The Report acknowledged that the courts had no power to send a person convicted of a crime to a psychiatric setting as opposed to imposing a custodial sentence. The lack of options available to members of the judiciary it was concluded resulted in "a not inconsiderable number of persons, either before or after conviction" passing "unnecessarily and undesirably into prisons or kindred places of detention".[64] The Committee considered the lack of provisions meant "an appreciable number of accused persons" in need of in-patient or outpatient psychiatric treatment are dealt with by the

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[59] *Ibid*. The Bill was annotated with extremely useful explanatory notes throughout.

[60] *Ibid*.

[61] *Ibid*.

[62] *Ibid*.

[63] *Ibid*.

[64] *Ibid*.

Irish courts "without due regard to the need for such treatment".[65] The bill drafted by the Committee provided that in circumstances where the court was of the view that an accused person may be suffering from a mental disorder, they would have the powers to order an assessment and make an order on foot of that at "earliest possible opportunity".[66]

The Committee expressed concern that the old formulation of "guilty but insane" tended to "conceal the fact that it is a verdict of not guilty".[67] In addition the Committee was of the view that the exclusion of a defence of insanity at the District Court was a "serious shortcoming. If a person is not responsible for his conduct because of insanity, it is but a fortuity that his conduct amounts to an indictable rather than a summary offence".[68] As such the Committee considered that it was in the interests of the accused and the public that the issue of "non-responsibility" be judicially determined. The rationale for this was that even if it was a summary offence a problem solving approach could be taken to address the accused person's "psychiatric condition".[69] The view expressed in the Henchy Report did not reference an *obiter dicta* statement by Walsh J in a case reported in 1967 that suggested even through there was no verdict provided for in statute in the District Court the common law governed the court and that the verdict should be one of acquittal.[70]

Flowing from this rationale the Henchy Report proposed amendments to the substantive criminal law and recommended "wide powers" that permitted the courts "in varying circumstances" both before and following conviction to refer or commit an accused person to a "designated centre".[71] The Committee stated that it would be a matter

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[65] *Ibid*.

[66] *Ibid*, at page 4.

[67] On the issue of fitness to plead the Committee recommended that the District Court would have a limited role (summary offences) in deciding on issues of fitness to plead and that the Circuit Court and Central Criminal Court would have jurisdiction over fitness to plead.

[68] *Ibid*.

[69] *Ibid*.

[70] *State (C) v Minister for Justice* [1967] IR 106. For a discussion on this see Whelan *Mental Health: Law and Practice* (Dublin: Thomson Reuters, 2009) at page 462.

[71] "Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons: Treatment and Care of Persons Suffering from Mental Disorder Who Appear Before the Courts on Criminal Charges" (Dublin: Stationary Office, Prl 8275, 1978) at page 4.

of policy for the Minister of Health to designate what would be a "designated centre" for the "reception, treatment and care of persons or classes of persons, or persons or classes of persons from particular areas, committed under the Bill".[72] The Committee envisaged that this reform would mean that many more persons currently detained as prisoners would be in future detained as patients in "designated centres". [73] Interestingly and progressively the Henchy Report expressed the view that the courts making orders under its proposed Bill placed in "outpatient treatment" and in "community care" as the "primary consideration" and only those "whose condition" required detention in a "designated centre" would be detained there.[74] The Report very much acknowledged that if its Bill were to be implemented there would be a change in how offenders were treated they would no longer be "prisoners" rather they would be "patients".[75] As such the draft Bill contained a series of provisions regulating reception, transfer and release. In addition the Committee envisaged that regulations would need to be developed by the Minister for Justice in consultation with the Minister for Health in order to implement the provisions of the Bill.[76]

The Henchy Committee recommended the creation of a special detention unit for "psychopaths or sociopaths".[77] The Committee considered that there would be a small number of persons under this heading that would have a "propensity to cause injury to themselves or to others" who were not amenable to treatment in "designated centres" or detention in prison.[78] This category of persons would be referred to as "suffering from a persistent disorder or disability of personality" were not amenable to "conventional psychiatric therapy" and required the special unit, as they did not "qualify for exemption from criminal liability by reason of mental disorder".[79]

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[72] *Ibid*.

[73] *Ibid*.

[74] *Ibid*.

[75] *Ibid*, at page 5.

[76] *Ibid*, at pages 5-6.

[77] *Ibid*, at page 6.

[78] *Ibid*.

[79] *Ibid*.

The Henchy Committee also made recommendations as to the reform of the substantive criminal law. Specifically it recommended a reformulation of the insanity defence; which was subsequently realised in the *Criminal Law (Insanity) Act 2006*. The other main recommendations related to the introduction of the defence of diminished responsibility, which was subsequently introduced in the 2006 Act.[80] The Committee was critical of the legal position as it was then that the trial judge was unable to give effect to the circumstance where an accused was not insane "his responsibility for his conduct was substantially diminished".[81] The Committee envisaged that a person convicted of murder, who raised the defence successfully (by verdict of a jury) would be able punished for manslaughter or be committed to a "designated centre" indefinitely until a judge made further orders in respect of the offender.

In line with what was to become the *Mental Health Act 2001* the draft Bill proposed by the Henchy Committee excluded drug and alcohol addicts from the scope of its provisions as they were concerned only with offenders who were in need of "psychiatric treatment".[82] However, the Committee recommended a further study on responses to offenders with drug and alcohol addictions.[83] The Committee also decided to exclude intoxication from the scope of its draft Bill.[84]

While the Henchy Committee acknowledged that the CMH was likely to remain as the primary place of detention, for persons who raised the insanity defence, it suggested that that the Minister for Health could designate any other public or private services as a "designated centre".[85] As will be seen later this was a recommendation that was not implemented in the *Criminal Law (Insanity) Act 2006*, which retained the CMH as the only "designated centre". The Minister for Health under section 3 of the 2006 Act after consultation with the Mental Health Commission (MHC) can make orders creating new designated

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[80] *Ibid*, at page 5.

[81] *Ibid*.

[82] *Ibid*.

[83] *Ibid*.

[84] *Ibid*.

[85] *Ibid*, at page 6.

centres. The Henchy Committee envisaged, rightly in light of the criticism of Sheehan J in *People (DPP) v B* (see below), that it should be possible for "a particular person be detained in such designated unit as is best calculated to meet his particular situation".[86] The Bill proposed to connect the civil and criminal law further by allowing for the transfer of patients detained in designated centres to other designated centres including the CMH. The Bill envisaged that the system of transfer would be flexible and respond to the needs of persons held under court orders.[87]

The Committee reported that the statutory basis of transfer from a district mental hospital (civil psychiatric hospitals) to the CMH under section 207 of the *Mental Treatment Act 1945* (as it was then) was fraught with difficulties.[88] The provisions it proposed in the draft Bill were hoped would create a "more workable system".[89] The Committee foresaw that for the purposes of its proposed Bill there would "be no essential difference between the CMH and district mental hospitals".[90] In that regard the Committee envisaged that the legislative repeals it proposed would address the "aura and stigma" of the CMH as a "criminal lunatic asylum" and would be "deemed and maintained" by the Eastern Health Board as an institution of "new standing and acceptability".[91]

In addition to the range of provisions recommended by the Committee to address the needs of defendants and offenders with MHPs a number of provisions in its proposed Bill sought to address the human rights issues around the detention of patients in "designated centres".[92] These measures were aimed at safeguarding against wrongful detention.[93] The Committee recommended that a permanent body called "Mental Care Review Body" be created. The role of this body

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[86] *Ibid.*

[87] *Ibid.*

[88] *Ibid.*

[89] *Ibid.*

[90] *Ibid.*

[91] *Ibid.*

[92] *Ibid*, at page 7.

[93] *Ibid.*

was to provide "regular and independent supervision of the welfare and the safety of persons so detained".[94] It was also anticipated that this body would provide the courts with expert advice in carrying out its functions under the legislation.[95] The Bill did not provide for automatic review, however, any person detained in the "special unit" or "designated centre" would be entitled to apply to the body to have their detention reviewed and the body was obliged to report its opinion to the court.[96]

A number of provisions in the draft Bill sought to address the perceived dangerousness of offenders with MHPs. The "chief medical officer" was required to report to the President of the High Court if they considered that a "convicted person" if released at the end of a period of detention posed a risk to themselves or others.[97] The Bill further provided that the President of the High Court or other nominated judge of the High Court should take the assessment of risk into consideration when making a subsequent order. Similarly, persons detained in the "special unit" the "Mental Care Review Body" would be required to report to the President of the High Court or nominee judge if they considered that the person posed a danger to themselves or others.[98] The draft Bill did provide for indefinite detention in circumstances where the court considered that an offender did pose such a danger. The rationale for indefinite detention was based on public protection but also on a paternalistic view of what would be in the "interest" of the prisoner.[99] As will be seen in the application of *Application of Gallagher (No 2)* case this recommendation is at odds with the judgment of the court on preventative detention.[100] While adopting a paternalistic and public protection approach to dealing with offenders with a "dangerous condition" the Committee in its Report went to pains to emphasise that the indefinite detention provisions proposed were "not without reservations in principle on the part of certain members of the

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[94] *Ibid.*

[95] *Ibid.*

[96] *Ibid.*

[97] *Ibid.*

[98] *Ibid.*

[99] *Ibid.*

[100] [1996] 3 IR 10.

Committee". [101] There was also an acknowledgement that this recommendation would give rise to "legal difficulties"; presumably they were referring to the Irish constitutional law principle of proportionality in sentencing (see below).[102]

At the end of the Committee's Report it again emphasised that despite the provision of "specified institutions" in its proposed Bill its recommendations should not be interpreted as implying that "non-institutional treatment" should not be an option for responding to an "offender's condition".[103] As such the Henchy Committee went to pains to point out that the Bill provided for the courts to have the power to mandate outpatient treatment and that any person released from a "designated centre" or "special unit" would have the "full benefit of appropriate community services".[104]

It is of note that the issue of accused or convicted persons with an ID was not referenced in the Report of the Henchy Committee. Of course that might have been a product of the narrow terms of reference for the Committee. The Report of the Henchy Committee in 1978 was a key moment in identifying that Ireland was out of step in not providing powers to the courts to connect persons with MHPs to mental health services. The recommendations in the Report could have been easily implemented (if there had been political capital) as the Bill expertly connected the proposed powers of diversion to the *Mental Treatment Act 1945*. While the Report contained provisions on the use of preventative detention can be regarded as regressive, it contained very positive provisions such as powers that would allow criminal courts for all matters summary and indictable to connect accused and convicted person to local mental health services.

5. The Whitaker Report

Despite the endorsement of the work of the Henchy Committee, its

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[101] "Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons: Treatment and Care of Persons Suffering from Mental Disorder Who Appear Before the Courts on Criminal Charges" (Dublin: Stationary Office, Prl 8275, 1978) at page 7.

[102] *Ibid*.

[103] *Ibid*.

[104] *Ibid*, at pages 7-8.

recommendations remained unimplemented and failed to raise awareness of the issues facing defendants and offenders with MHPs. This lack of awareness is illustrated by the Whitaker Report, a major report on the reform of the Irish penal system, which failed to engage in a meaningful way with the situation of defendants and offenders with MHPs.[105] However, the Whitaker Report considered that persons with "psychological/psychiatric difficulties" were offenders with "special cases" and endorsed the approach of the Henchy Report outlining the main recommendations in that Report.[106] In chapter 5 of the Report there was a discussion of alternatives to prison. It was suggested that community service, supervised probation were administered as frequently as prison sentences as penal sanctions. While the Henchy Report was citied in the bibliography, it was not comprehensively discussed in the chapter dealing with alternatives to prisons or in the chapter dealing with "special categories of offenders".[107]

There was reference in chapter 5 to the expanded use of diversionary programmes, conditional discharge and treatment orders. However, there was no specific discussion of defendants or offenders with MHPs or ID and it was not clear on what basis the Committee was making these observations. At any rate the Report viewed positively diversion and other similar programmes, particularly in relation to juvenile offenders, and endorsed attempts at early intervention particularly before court appearances.[108] The Report tacitly suggested that prison was used to deal with defendants and convicted persons as a way of "inducing conformity" and that specialised programmes were required as an alternative.

The lack of non-custodial options available to judges in Ireland was identified as a significant issue. The Whitaker Report was of the view that if alternative options to imposing prison sentences were available judges would use them. It was suggested that non-custodial options available at that time (EG fines and suspended sentences) were not used due to procedural defects as opposed to of an unwillingness of

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[105] See "Report of the Committee of Inquiry into the Penal System" (Dublin: Stationary Office, 1985), known as the Whitaker Report.

[106] *Ibid*, at pages 58-59.

[107] *Ibid*, see chapters 5 and 10.

[108] *Ibid*, at page 43.

the judiciary to use them.[109] Suspended sentences were considered an unsatisfactory alternative as they lacked a clear legal status, with no reporting mechanism where a person breached the terms of a suspended sentence.[110] The Whitaker Report identified that alternatives to prison sentences had implications for liberty as alternatives led to restrictions on freedom in the community.[111] Unfortunately there was no discussion of the use of community orders for persons with MHPs or ID. However, there was a reference to persons who may require therapy.[112] The Committee recommended that it would be preferable that services required for offenders receiving a non-custodial sanction should be provided in the community or centre that they should not be established exclusively for "offenders" rather they should be "facilities already operating for the general community".[113] The Whitaker Report while endorsing the Henchy approach to diverting persons with MHPs from the prison also made recommendations on the need to develop psychiatric services in the prison where diversion to community services was not possible.[114] It was envisaged that treatment of "high security risk prisoners" was a particular problem that ought to be addressed by the creation of a "small psychiatric unit" to be developed in Portloaise.[115] It was recommended that forensic mental health service for the Eastern Health Board (as it was then) would staff the Unit, assisted by local psychiatric services.[116]

6. Green Paper on Mental Health

The recommendations of the Henchy Committee remained unimplemented and the draft Bill was not enacted. This echoed a

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[109] *Ibid*, at page 45. The amount imposed for some fines were outdated, for example, the fines provided for under the Summary Jurisdiction over *Children (Ireland) Act 1884* provided for a maximum order of £2 for a child aged 7-15 o summary conviction; while a fine attaching for a indictable offence was £10.

[110] *Ibid*, at page 46.

[111] *Ibid*, at pages 48-49.

[112] *Ibid*, at page 49.

[113] *Ibid*.

[114] *Ibid*, see chapter 10 at pages 85-88.

[115] *Ibid*, at page 87.

[116] *Ibid*.

failure to progress with the recommendations on the reform of the penal system as envisaged in the Whitaker Report. However, the recommendations of the Henchy Committee were revisited in the Department of Health's (DOH) "Green Paper on Mental Health" in 1992.[117] The Green Paper acknowledged the trend in removing mentally ill persons from the prison as a "major policy goal" of the "last century" but that it remained incomplete and the role of psychiatric services in relation to offenders with MHPs was undefined in Ireland. The Green Paper envisaged that "new legislation should address the outstanding issues".[118] It reiterated the limited options identified in the Henchy Report available to members of the judiciary in responding to defendants and offenders with MHPs. The Green Paper also acknowledged that a judge could suspend a sentence if a person voluntarily agreed to seek treatment.[119] The Green Paper considered the lack of specialist forensic services as being advantageous (in comparison to European Countries) on the basis of savings public monies. Its reasoning was that the service in the CMH and the services offered locally in prison avoided placing demands on general psychiatric services.

However, the Green Paper did acknowledge the powers that were generally available in other jurisdictions to courts to refer persons with MHPs to psychiatric hospitals were absent in Ireland.[120] The Green Paper listed a range of remand powers, including probation orders that could require psychiatric treatment. However, the DOH also listed the difficulties that giving these powers to the courts caused for "psychiatric services".[121] The main concerns related to increased number of "detained patients"; "tension in psychiatric hospitals at a time when the emphasis on security was being reduced"; the stigma associated with voluntary admission and detention for non-forensic patients in the

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[117] "Green Paper on Mental Health" (Dublin: Department of Health, Pl 8918, 1992) at chapter 23. The Green Paper excluded from its terms of reference the other issues examined by the Henchy Committee such as the insanity defence, diminished responsibility review of person detained on foot of the insanity defence as they were to be dealt with by the Minister for Justice.

[118] *Ibid*, at page 98.

[119] *Ibid*.

[120] *Ibid*.

[121] *Ibid*, at page 100.

psychiatric hospital may be increased and the potential need for additional security in psychiatric hospitals.[122]

Nonetheless the DOH was convinced that the conferral of powers of diversion could be overcome. In support of its position it used NI as a comparator. Its examination of the difficulties that the exercise of these powers in NI, where mentally ill offenders could be admitted to all psychiatric hospitals, showed that the difficulties were not "insurmountable".[123] Despite their reservations the DOH acknowledged that extending powers of diversion to the courts would bring Ireland "closer to the European norm" and would be the more humane option as articulated by the Henchy Committee.[124] In the Green Paper it was noted that Government was inclined to the "balance of advantage … in providing the courts with a wider range of options in dealing with mentally ill offenders, including the referral of mentally ill defendants and offenders to psychiatric hospitals".[125] However, it was indicated that this power of referral was to be subject to a gatekeeper by way of an independent report on the mental state of the person the courts wished to be referred for assessment or treatment in a psychiatric hospital. It was also envisaged that the Health Boards (as they were then) would have an opportunity to comment on the appropriateness of the proposed referral.[126] The Green Paper acknowledged that there would be a need to ensure that persons detained for "long periods" would need to have their detention reviewed by a body empowered to discharge patients (or at least make recommendations to the court as to whether continued detention or discharge was justified).[127]
The Green Paper outlined the problems in transferring to the CMH persons believed to have committed an indictable offence under

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[122] *Ibid*.

[123] *Ibid*. The Green Paper analysis of the situation in NI was confusing. Despite asserting that the difficulties posed were "insurmountable" it acknowledged that the numbers referred by the courts were low. In addition psychiatric hospitals in NI do not have to accept all patients are the "most difficult and dangerous" patients are sent to specialist forensic services in "Britain" as analogous services do not exist in NI.

[124] *Ibid*, at page 101.

[125] *Ibid*.

[126] *Ibid*.

[127] *Ibid*.

section 207 of the *Mental Treatment Act 1945*.[128] The Green Paper rowed away from the progressive recommendations of the Henchy Committee, which sought to address the stigma of the CMH by extending the range of places, that offender with MHPs could be sent (EG a greater number of "designated centres"). Instead the Green Paper envisaged that the CMH would "continue to be the hospital to which the most difficult and dangerous persons would be referred from the courts and the prisons".[129]

The Green Paper called for submissions on the wisdom of conferring powers to the court of referral of persons with MHPs to psychiatric hospitals for assessment or treatment and the scope and nature of these powers of referral. If consultees were not in support of conferring these powers to the courts the Green Paper invited submissions on other ways of responding to the needs of persons with MHPs coming before the courts. Submissions were also invited in relation to the procedures governing transfer of patients to CMH.

The Green Paper suggested that the courts would have meaningful powers in transferring offenders with MHPs out of the prison system and connecting them with psychiatric services. However, this was called into question when the plans for the development of forensic psychiatry services outlined in the Green Paper are considered.[130] The Eastern Health Board's "operation plan for the future operation of a national forensic service" at the CMH at the time envisaged reducing the number of places at the hospital from 84 to 70.[131] A 31 place secure unit on the site of the CMH and 40 additional places were to be provided in a new extension. The Green Paper articulated a different approach to that of the Henchy Committee Report with scant reference to community care and a role for a range of public and private centres to act as "designated centres". Bearing in mind that the Green Paper envisaged that if the courts were to have referral powers they would be limited to cases necessitating services being delivered in the CMH. The

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[128] *Ibid*, at page 102.

[129] *Ibid*. However, the Green Paper suggested that a change in the status of the CMH to a "special psychiatric centre" and the development of forensic mental health services would enhance the "therapeutic role" of the hospital.

[130] *Ibid*, at pages 31-32.

[131] *Ibid*.

approach of the Green Paper meant that the capacity of the courts in diverting defendants for treatment ran into the obvious problem of limited beds in the CMH. There was a reference to the CMH providing an advisory role to all Health Boards in respect of "treatment and management of disturbed patients".[132] However, this was not intended to be a response to provide expertise to psychiatric services dealing with defendants/offenders referred by the courts. Rather this development was presumably designed to ward off requests to transfer patients from services to the CMH.

7. White Paper: A New Mental Health Act

The White Paper followed the Green Paper in 1995 and marked an altered approach to "mentally disordered offenders" in comparison to the approach suggested in the Green Paper.[133] The White Paper again acknowledged that the lack of power conferred on the courts to arrange medical assessment or treatment of a defendant or convicted person suffering from a mental disorder was a "major gap in provision".[134] The responses that the DOH received on the extension of powers to the courts to refer and accused or convicted person to an "approved centre" was described in the White Paper as generating a "clear division on opinion amongst the respondents to the Green Paper".[135] The White Paper reported that the main opposition to the proposed extension of power to the court, was not that the courts would have the powers and that would be undesirable. Rather the exercise of the courts power was dependent on the involvement of the Health Boards (as they were then) and it was considered that they were "not competent to provide a penal service".[136] The objection to the involvement of the health boards is problematical for a number of reasons. The purpose of transfer as envisaged in the Green Paper and more so in the Report of the Henchy Committee was to problem solve and take a "humane" approach to responding to the needs of mentally ill persons appearing before the courts. Opposition to diversion on the

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[132] *Ibid*, at page 32.

[133] "White Paper: A New Mental Health Act" (Dublin: Department of Health, Pl 1824, 1995) chapter 7.

[134] *Ibid*, at page 67.

[135] *Ibid*, at page 68.

[136] *Ibid*.

basis that general mental health services could not cope with patients with a penal profile is spurious. It also demonstrates a failure to comprehend or disregard the rationale behind the proposal and represents a negative and discriminatory attitude towards prisoners requiring mental health services that would deny the right to health care (equivalence and equality for prisoners).[137]

Another rationale articulated in the White Paper opposing the provision of transfer powers for judges related to "reservations about the implications for security in accepting such referrals" and "fears" that the therapeutic or recovery ethos in hospitals would be undermined and the impact of the presence of accused or convicted mentally ill persons on other service uses.[138] The other rationale articulated in the White Paper opposing the extension of powers of referral to the courts included "disquiet" about returning to the "locked ward" approach to psychiatric treatment "associated with custodial care" of the past.[139] This rationale tied in with another objection to court powers of referral to psychiatric services, namely that such referral would result in indefinite detention "on protective grounds" as opposed to shorter periods of detention for fixed sentences in the prison setting.[140] The majority of respondents to the Green Paper opposed the provision of powers to the courts to refer offenders or defendants with MHPs to psychiatric services for assessment or treatment.[141]

Surprisingly despite this strong professional opposition to diversion, the Government remained strongly committed (or so it seemed) in the White Paper to addressing the issue of defendants and offenders and with MHPs appearing before the courts. There was a clear commitment that the new mental health legislation (what was to become the *Mental Health Act 2001*) would have provisions facilitating the assessment and treatment of persons with MHPs.[142] There was a reference to ensuring

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[137] See Chapter 2: Literature Review, Part 1 and Part 2 on the barriers facing defendant and offenders with MHPs accessing services in the community.

[138] "White Paper: A New Mental Health Act" (Dublin: Department of Health, Pl 1824, 1995) at page 68 .

[139] *Ibid*, at page 69.

[140] *Ibid*.

[141] *Ibid*.

[142] *Ibid*, at pages 70-73.

that if accused or convicted persons were receiving treatment and assessment that they would "not be subjected to a stricter mental health code than the rest of the population, unless such extra powers are specifically justified".[143] In acknowledgement of the strong professional opposition to diversion, the White Paper sought to comfort mental health professionals (in respect of powers being conferred to the courts), by asserting that "clinical autonomy of medical staff involved in the care of mentally disordered persons" would be respected.[144]

What the Government envisaged in the White Paper was that new powers for members of the judiciary would facilitate "minimum formality".[145] However, the system proposed in facilitating assessment and treatment required a judge to request the Probation Service to prepare a report to advise the judge as to whether a medical report was necessary.[146] If the report from the Probation Service recommended a medical report it was envisaged that the new legislation would allow the court to hold the prisoner on remand, the defendant on bail or in custody in order to facilitate the completion of the medical report.[147] The medical reports were to be carried out by a consultant psychiatrist in the service where the accused or convicted person ordinarily resided.[148] In circumstances where a person voluntarily engaged with treatment they would enter into a recognisance with the court for the period of the treatment.[149] The White Paper envisaged that once the treatment was completed that the person, depending on what stage they had reached in the criminal process, would return for sentencing or resume the criminal proceedings.[150] There was no discussion in the White Paper as to

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[143] *Ibid*, at pages 70.

[144] *Ibid*.

[145] *Ibid*, at pages 79.

[146] *Ibid*.

[147] *Ibid*. This was a very bureaucratic proposal; a legal representative for the defendant person ought be in a position to advocate for assessment, particularly if facilitated or encouraged by the judge.

[148] *Ibid*.

[149] *Ibid*.

[150] *Ibid*.

offsetting time spent receiving treatment against the imposition of a custodial sentence.

The White Paper sought to connect the court process following the provision of the medical report to the proposed mental health legislation. It was envisaged that where a medical report indicated that the person met the criteria of involuntary detention in an "approved centre" and was unwilling to accept treatment they would be involuntarily detained. [151] Again the criminal justice process (sentencing or trial) would resume once the forced treatment was completed. The safeguards around the deprivation of liberty applying to persons being compelled to receive treatment coming from the courts was to be the same for others persons entering under the civil system under the new mental health legislation that would repeal and replace the 1945 Act.[152]

There is no doubt that there were many problems, shortcomings and logistical issues with the proposals contained in the White Paper. However, there was an acceptance that Irish law in not providing for assessment and treatment of persons with MHPs coming before the criminal courts meant, "Ireland was unusual among European Countries".[153] One of the very obvious differences in approach of the Henchy Committee Report in 1978 and the White Paper in 1995 was that there was an obvious absence of facilitating community outpatient treatment in the 1995 White Paper. The approach also contrasted with the enlightened approach in the Whitaker Report. The White Paper also envisaged that even where medical reports identified a need for treatment for defendants and offenders, they would be remanded in custody "not permitted bail" and would be treated in the prison setting or on transfer to the "special psychiatric centre". There was discussion

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[151] *Ibid*.

[152] *Ibid*. It was anticipated in the White Paper that if it was indicated in a medial report that a person required detention and treatment in a "secure environment" there would be transfer provisions to the "special psychiatric centre" if the clinical director of the centre concurred with the view in the medical report and it was envisaged that the new tribunal system would have to approve the transfer. It is of note that the White Paper envisaged a role for the proposed tribunal system to review the detention of persons detained in the "special psychiatric centre" but not on an equal basis with persons detained in "approved centres" as review only kicked in after a year and was to operate on "yearly intervals thereafter" see pages 79-80.

[153] *Ibid*, at pages 69.

in the White Paper of the MI Principles and the COE Recommendation that require equivalence of treatment for prisoners to that available in the community.[154] In the White Paper the Government seemed motivated to address Ireland's status as unusual in light of the CPT's criticism of the lack of power for the courts to direct persons for assessment and treatment. In fact the 1993 CPT Report on Ireland endorsed the recommendations of the Henchy Committee and the proposals in the Green Paper and asked the Government to keep the Committee informed of progress in enacting the proposals.[155]

A number of internal reviews in the Department of Justice (DOJ) were on-going when the White Paper was published. These reviews examined issues such as the insanity defence and diminished responsibility. Despite the recommendations of the Henchy Report 1978, and the proposals in the Green and White Papers proposals relating to the assessment and treatment of persons with MHPs were omitted from the *Mental Health Act 2001*. There were 100 consultees listed in the White Paper the vast majority of which were mental health professionals, in particular, psychiatrists.[156]

The failure to introduce powers of diversion for judges on foot of the recommendation of the White Paper has been criticised.[157] Ryan and Whelan have described the "current system for dealing with offenders with mental disorders" as inadequate and identified that the problem is partially explained "in the lack of legal powers for Irish judges to sentence a convicted person to a mental health treatment centre".[158] The rationale for omitting an entire chapter in the White Paper was not fully explained. There was little discussion of the relevance of the new mental health legislation to defendants and offenders with MHPs, as it

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[154] *Ibid*.

[155] See "Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 26 to 5 October 1993" (Strasbourg: Council of Europe, 1993).

[156] There appeared to be no lawyers apart from a submission from the President of the District Court and a submission from Mary Keys.

[157] Ryan and Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (*Web Journal of Current Issues*: 1, 2012).

[158] *Ibid*.

moved through the different stages of the legislative process.[159] However, a number of amendments to the Mental Health Bill were proposed to provide for "a scheme of court diversion whereby persons before the court can be diverted to suitable mental health facilities".[160] It was in the context of these proposals that the rationale in the omission of the proposals outlined in the White Paper was articulated. The explanation for the omission was that there was a need to move with "urgent necessity to progress legislation on involuntary detention to ensure this country's compliance with the European Convention on Human Rights".[161] This is a reference to the friendly settlement in the ECtHR case of *Croke v Ireland*, which is discussed in greater detail below. As discussed above, the Henchy Report contained a very comprehensive Bill that detailed how powers of diversion would be linked to mental health legislation. Given this considerable groundwork it is not clear why these provisions were not provided for in the Bill. The extensive work by the Henchy Committee included the drafting of statutory provisions on diversion. This foundation would have made inclusion of diversion provisions feasible. Nevertheless it was indicated that the Minister intended "to return to the issue after the Bill has been enacted". This did not happen and the absence of provisions, processes and initiatives on diversion for defendants and offenders with MHPs prevails.[162]

8. Forensic Mental Health Services in Ireland

It is clear from the above discussion above that there had been plans to develop forensic mental health services from the 1960s and renewed commitments in the 1990s. However, these plans have not developed to any great extent and forensic mental health services are still concentrated at the CMH. However "A Vision for Change" has given an impetus for greater consideration of forensic mental health services and there has been expansion in the reach of forensic services,

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[159] Although some amendments at the Committee stage were suggested See Henry "Mental Health Bill, 1999: Committee Stage" (Seanad Éireann: 167, 13 June 2001).

[160] *Ibid*.

[161] *Ibid*. Senator Dr. Henry acknowledged that it was regrettable that the provisions on diversion were not included as, given "how long it takes to have measures enacted" but conceded that the need to enact the legislation to comply with the ECHR.

[162] *Ibid*.

particularly through the work of the Prison In-reach and Court Liaison Service (PIRCLS) in Cloverhill (a remand prison in Dublin) and the development of a High Support Unit for prisoners with MHPs in Mountjoy. The MHC has sought to develop policy on forensic services, through the establishment of the Forensic Mental Health Services Committee in 2004.[163] The MHC then published a Discussion Paper in 2006, which was made available online and disseminated widely.[164] Subsequently in 2011 the MHC published a Position Paper on forensic mental health services for adults.[165]

In terms of the design of forensic mental health services in Ireland the MHC made very practical suggestions. The Commission was of the view that given the size of the population high and medium secure care should be make available centrally in one location in the Dublin area.[166] It envisaged that all other forensic mental health services together with low secure units should to be delivered regionally. The rationale for this approach was that the needs of service users are not effectively met through the availability of forensic mental health services from one central compound. The provision of forensic mental health services regionally would be an important development that has the potential to divert persons with MHPs from the criminal justice system. The delivery of forensic mental services in this way opens up the potential for diversion from the criminal justice system earlier in the process and more options will be open to judges making decision on whether to remand persons when sentencing. It appears that there has been a decision to build a comprehensive forensic facility to replace the CMH

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[163] The terms of reference of the Committee were to review models of best practice in forensic mental health services; to review and clarify definitions within the area of forensic mental health; to review current provision of secure care and forensic mental health services in Ireland for adults and children /adolescents; to review mental health services within prisons and to prepare a discussion paper including recommendations on forensic mental health services for the Commission with a view to wider circulation as a discussion paper issued by the Commission. See "Forensic Mental Health Services for Adults in Ireland" (Dublin: Mental Health Commission, Discussion Paper, 2006) at page 4.

[164] *Ibid*.

[165] "Mental Health Commission Position Paper: Forensic Mental Health Services For Adults in Ireland" (Dublin: Mental Health Commission, Position Paper, February 2011). The Position Paper took into consideration the recommendations in "A Vision for Change" (published subsequently to the MHC's initial Discussion Paper) that related to forensic mental health services.

[166] *Ibid*, at page 15.

in its current location in Dun Drum.[167] It is envisaged that this facility will contain services for adult forensic mental health services, children's forensic mental health services and forensic services for people with ID.[168] The provision of regional services has been described as consisting of "intensive care rehabilitation units".[169]

The MHC recommended mental health professionals, Gardaí, lawyers and the courts in all regions "… should have a comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings".[170] This was also supplemented with the recommendation that "Appropriate Person, Police and Court Diversion Schemes" should be delivered as a priority.[171] The Commission in its Position Paper also recommended the development of clear protocols to be put in place between forensic and general mental health teams in order to make possible a "… seamless referral and treatment pathways … in ensuring optimal care for service users."[172] As part of that the Commission encouraged collaboration to ensure continuity of care that envisaged service users accessing multidisciplinary teams that would include; consultant psychiatrists; mental health nurses; clinical psychologists; mental health social workers; occupational therapists and addiction counsellors; and where necessary professionals to provide vocational training, speech and language therapy, education.

Other relevant recommendations made in the Position Paper include the suggestion that mental health services to each prison population should be provided by the forensic mental health service for the region

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[167] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012) at page 49.

[168] *Ibid*.

[169] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012) at page 49.

[170] *Ibid*, at page 20. The MHC referred to the policy direction outlined in "A Vision for Change" of diversion towards treatment and recovery options and the policy position of the National Crime Council to introduce Community Courts in Ireland.

[171] *Ibid*, at page 22.

[172] *Ibid*, at page 18.

in which the prison is situated as a secondary in-reach service.[173] This is an important feature of a forensic mental health service as it has potential to ensure the continuity of mental health services to prisoners when they leave prison. The MHC also envisaged that the regional forensic mental health services would work closely with other services such as the medical services in the prison, psychology, social work, probation officers, addition counsellors and vocational services. From a rights perspective the Commission recommended that mental health services provided in prisons should be led by the Recommendations on European Prison Rules (COE, Committee of Ministers to member states on the European Prison Rules).[174]

The MHC stated that it was "… important that in any new legislation in the mental health sphere, Ireland should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients between England, Wales, Scotland, NI and the Republic of Ireland".[175] This recommendation was designed to reduce frustration and confusion for mental health professionals and families involved "in inter-country transfers and make best use of referral to specialist services".[176] This statement suggests that the MHC envisage the continued use of use of specialised forensic mental health services outside the state. That is at odds with the position of the Irish College of Psychiatrists who regard the creation of forensic mental health services in Ireland as ending the needs to outsource service provision abroad. Indeed the Irish College of Psychiatrists regard the resource implications of creating forensic mental health services being offset by ending outsourcing.[177] It has been noted that in Ireland persons with

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[173] "Mental Health Commission Position Paper: Forensic Mental Health Services For Adults in Ireland" (Dublin: Mental Health Commission, Position Paper, February 2011) at page 21.

[174] The MHC was mindful that human rights considerations should be core to the principles and ethical guidelines in the delivery of forensic mental health services. In that regard there was a reference to the CRPD with a particular emphasis placed on Articles 14 and 25. See pages 9-11 and appendix 1.

[175] "Mental Health Commission Position Paper: Forensic Mental Health Services For Adults in Ireland" (Dublin: Mental Health Commission, Position Paper, February 2011).

[176] *Ibid*.

[177] The College considered that a "substantial number of patients are currently receiving such a specialist service outside of Ireland (mainly in UK). The Working Group considers that the funding required for such placement would provide the necessary finance to establish this specialist service within Ireland". Although it should be noted that the Irish College of Psychiatrists did acknowledge that the cost saving would be progressively made over time in

MHPs have limited "support structures" and as a result can become homeless, or their conduct in the community can bring them into contact with the criminal justice system, with many people being "misdirected towards prison rather than appropriate mental healthcare or support services".[178]

In 2007 the Irish Mental Health Coalition (now called Mental Health Reform) challenged the proposed relocation of the CMH to the grounds of Thornton Hall in North County Dublin.[179] The Coalition challenged the proposed colocation on human right grounds arguing that a therapeutic facility for persons with MHPs on the grounds of a prison was "stigmatising and discriminatory".[180] The Coalition cited the widespread position to the proposal by the families and carers of patients in the CMH, NGOs, the MHC, the Clinical Director of the CMH and the Irish Human Rights Commission (IHRC). The Coalition also asserted that the proposal was at odds with values and principles set out in "A Vision for Change".[181] The discourse that emerged from the Government's proposals to locate the CMH on the grounds of the proposed new super prison was interesting on committed to the notion that persons in receipt of psychiatric treatment are patients not prisoners.[182] The campaign was successful as it is to be separately located on the grounds of an old psychiatric hospital near Dublin.

There have been significant problems in implementing "A Vision for Change" with the Independent Monitoring Group describing progress as "slow and inconsistent".[183] The Independent Monitoring Group

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line with the development of mental health services. See "People with a Learning Disability who Offend: Forgiven but Forgotten?" (Dublin: The Irish College of Psychiatrists, 2007, Occasional Paper 63) at page 6.

[178] "From Neglect to Respect A 10-point Agenda for Action by the new Irish Government on Mental Health" (Dublin: Irish Mental Health Coalition, June 2007) at page 3.

[179] *Ibid*, at point 9 on the agenda.

[180] *Ibid*.

[181] *Ibid*.

[182] See for example "Prisoners Not Patients: Report on the Central Mental Hospital Round Table Meeting" (Dublin: The Central Mental Hospital Group, January 2008) a report prepared by the families of persons detained in the CMH.

[183] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012). See also the first, second, third, fourth and fifth reports of the Independent Monitoring Group on the implementation of A Vision for Change.

explaining the failure to deliver "A Vision for Change" has identified a number of reasons. The reasons include the absence of a National Mental Health Service Directorate with the authority and control over resources for mental health services and the absence of a comprehensive time lined and costed implementation plan and a lack of "coherency" in the planning and development of services based in the community.[184] The Independent Monitoring Group has been critical of the failure to develop diversion programmes inline with what was envisaged in "A Vision for Change". In its most recent report it recommended that the Forensic Mental Health Services (FMHS) should be "expanded and reconfigured so as to provide court diversion services and legislation should be devised to allow this to take place".[185]

9. Mental Health and Criminal Justice Policy in Ireland

A significant amount of policy work from the 1960s, 1970s, 1990s and 2000s recommended law reform and modernisation of mental health services. These policy initiatives while accepted by successive Irish governments have remained unimplemented. The responses to defendants and offenders with MHPs and ID remain wholly inadequate. This section examines the extent to which recent developments in criminal justice policy have considered defendants and offenders with MHPs and ID. There is a clear demarcation between the DOH, which has responsibility for "A Vision for Change", and the DOJ, which has responsibility for criminal justice and penal policy. As will be seen from the discussion below, mental health as an issue is conspicuously absent from the policy initiatives on crime and criminal justice. This suggests that commitment to developing diversion within Irish criminal justice policy is uncertain.

9.1. The Current Programme for Government

There is no specific reference in the current programme for government to the development of forensic mental services or

[184] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012) at page 3.

[185] *Ibid*, at page 65.

diversion of defendants and offenders with MHPs or ID from the criminal justice system. However, it was stated that the "policy on mental health incorporates the recommendations of A Vision for Change". [186] The implication being that the recommendations contained in "A Vision for Change" in relation to forensic mental health services and diversion have the backing of the government. However, it is of note that the DOJ has never explicitly adopted a policy of diversion and little action has been taken to achieve diversion through different provisions, processes or initiatives.

In the Programme for Government in the area of sentencing and penal reform there was a commitment to ensuring "that violent offenders and other serious offenders serve appropriate prison sentences while at the same time switching away from prison sentences and towards less costly non-custodial options for non-violent and less serious offenders."[187] It was stated that such an approach would reduce the prison population and alleviate overcrowding in Irish prisons.[188] There was also a commitment to implementation of the *Fines Act 2010* and an extension in the use of Community Service Orders.[189] Under this law judges, in considering the imposition of a prison sentence of one year or less, would be required to consider the appropriateness of Community Service Orders as an alternative to the custodial sentence.[190]

Amongst the tougher measures included was a commitment to introduce "a series of post-imprisonment restraint orders for violent and sexual offenders to include electronic tagging and other restrictions, which may be imposed at the time of sentencing."[191] Interestingly, there was an expression of interest in rehabilitation. It proposed that violent and sexual offenders will only "… earn remission based on good behaviour, participation in education and training, and completion of addiction treatment programmes and, where appropriate, sex offender

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[186] "Government for National Recovery 2011-2016" (Dublin: 2011) at page 7.

[187] *Ibid*, at page 48.

[188] *Ibid*.

[189] *Ibid*.

[190] *Ibid*.

[191] *Ibid*.

programmes".[192] There was also a promise to review the *Prison Act 2007* with a view to incentivising engagement with rehabilitative services in prison.[193] The Programme for Government also includes an undertaking to address the disconnection between the Prison Service and the Probation Service through the creation of "… an integrated offender management programme."[194]

9.2. Juvenile Offenders and the Criminal Justice System in Ireland

While there had been a failure to develop diversion provisions, processes and initiatives, for adults with MHPs and ID, a system of diversion has been developed for juvenile defendants and offenders. As Hanly states "[t]he modern law recognises that children are not adults and cannot be treated as adults. In recognition of the vulnerability of children, special provisions have been developed for their punishment, reflecting their unique status".[195] If a minor commits a criminal offence it is open to the Gardaí to caution the minor and keep them under supervision rather than pursuing prosecution. This is a long established and successful form of diversion dating back to 1963. The Garda Juvenile Diversion Programme now exists across the country and is included as part of the *Children Act 2001*. A child suspected of having committed an offence is referred to the Garda Juvenile Diversion Programme.[196]

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[192] *Ibid*.

[193] *Ibid*.

[194] *Ibid*, at page 49. Under the heading of Anti-Social Behaviour in the Programme for Government there was an expression of commitment to "… give special emphasis to alternative programmes for juvenile offenders" to be achieved through extensions of the Juvenile Liaison Officer Scheme and the Garda Juvenile Diversion Programme. There was also a commitment to "… the extended use of Restorative Justice where appropriate" and an examination of "outcomes-based contracts" with community organisations aimed at reducing reoffending by young people.

[195] Hanly "Child Offenders: The Changing Response Of Irish Law" (*Dublin University Law Journal*: 4(1), 1997, 113).

[196] This form of diversion is widely used, for example, in 2005 there were 17,567 children referred to the programme and 75% were issued a caution. See the Office of the Minister for Children website at: http://www.dcya.gov.ie/viewtxt.asp?fn=/documents/YouthJustice/gardadiversion.htm. <Last accessed 10 November 2013> In order to avail of the programme a minor must admit to the alleged offence and take responsibility for it. A minor may agree as part of a caution to apologise to a victim, a curfew, compensation or commit to a sporting and recreational activity.

A minor might also be referred to a Garda Youth Diversion Projects through the Garda Juvenile Diversion Programme. The Garda Youth Diversion Projects operate separately to the Garda Juvenile Diversion but works in concert. These projects are "community based, multi-agency crime prevention initiatives" under the DOJ and administered through Garda Community Relations Section.[197] They are another example of a problem solving approach to crime and operate at the local community level and involve activities with children. There are currently 100 of these projects in operation.[198] The projects seek to assist minors to end behaviour that is likely to lead them and their peers into contact with the criminal justice system or into further contact. Garda Youth Diversion Projects are believed to have the potential to foster in participants a sense of community and develop social skills through the different activities. The different activities include education, sport, music, art and training for employment.

In circumstances where a minor is not able to avail of diversion through the Garda Juvenile Diversion Programme the probation service provide specific supports for juvenile offenders through Young Persons' Probation (YPP). YPP is a specialised division within the Probation Service, which is resourced to work specifically with children, aged 12 – 18 who have come into contact with the criminal courts.[199] YPP was established primarily to implement the sections of the *Children Act 2001* that relate to YPP.[200] YPP takes a therapeutic jurisprudence approach in its promotion of community based sanctions, a problem solving approach and restorative justice in tackling the underlying causes of crime and reduce re-offending.[201]

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[197] "Designing Effective Local Responses to Youth Crime: A Baseline Analysis of the Garda Youth Diversion Projects" (Dublin: Irish Youth Justice Service, 2009).

[198] A full list of projects is available at: http://www.iyjs.ie/en/IYJS/Pages/WP08000078. <Last accessed 10 November 2013> See "National Youth Justice Strategy 2008 – 2010" (Dublin: Irish Youth Justice Service, 2008), Appendix 2 at page 43.

[199] There are currently 13 community-based projects run as private limited companies, which operate independently by boards of management. A list of YPP projects is available at: http://www.iyjs.ie/en/IYJS/Pages/WP08000102. <Last accessed 10 November 2013>

[200] The Irish Youth Justice Service (IYJS) funds and works closely with Young Persons' Probation with regard to the implementation of the relevant sections of the Children Act 2001.

[201] YPP engages with approximately 600 young offenders throughout the country on an annual basis. The work of the YPP involves the preparation of pre-sanction assessments for the courts, the supervision of offenders in the community as referred by the court and the supervision of offenders under conditional release from custody. YPP also provides a counselling service to

YPP operates on a national basis with locations in Dublin, Cork, Waterford, Limerick, Sligo and Drogheda. At these locations teams of officer work and are managed by Senior Probation Officers in the community. YPP provides services to all Children Courts' sittings as there are dedicated Court Liaison Officers in the Dublin, Cork and Limerick Courts. YPP is also based in St. Patrick's Institution and provides "inreach services" to the Children Detention Schools. This therapeutic jurisprudence approach is visible in the multi-agency approach of YPP, which seeks to address the needs of young offenders. It works in partnership with FÁS and the local Vocational Educational Committees in offering training and education opportunities.[202]

The development of diversion in respect of defendants and offenders who are minors in no way suggests that juvenile defendants and offenders with MHPs have in all instances been diverted from the criminal justice system. In fact successive Governments have a poor record in addressing the needs of minors in contact with the criminal justice system including those with MHPs and ID. St Patrick's Institution has been criticised for its poor standards and lack of safety for minors detained there.[203] The reports of the Inspector of Prisons have been highly critical of systematic problems in the institution and document the mistreatment of minors and human rights abuses. The most recently published Report from the Inspector documented the appalling treatment of a vulnerable minor with MHPs detained in St Patrick's Institution.[204] The conditions of detention could amount to a

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young offenders and their families.

[202] Interestingly residential projects operated by YPP is now being phased out with the intention of engaging external service providers, through a tender process, to offer services in a new ways.

[203] St Patrick's Institution is a closed, medium security prison that detains minor; both persons remanded and persons sentenced.

[204] The Report documented that a court in Dublin committed a prisoner to St Patrick's Institution. The prisoner was detained in a holding cell in the Court complex from approximately 12 noon to 6 pm. The Inspector reported that the prisoner was shaking from the cold, the window of his cell was jammed in an open position, and he was not permitted to telephone his family. The conditions of his cell were described as "filthy". the bed and frame were "filthy", the flushing mechanism for the toilet was broken and the toilet was full of excrement. The prisoner informed the Inspector that he was on medication for a "psychiatric illness since", which he was without. He previously was a patient in a psychiatric hospital. The juvenile explained that if he did not take his medication soon his head would "be all over the place". The Inspector reported that he considered him to be "a vulnerable person… [h]e was afraid and crying when I was leaving him". See "Office of The Inspector of Prisons Annual Report 2012" (Nenagh: Office of the Inspector of Prisons, July 2013) pages 19-20.

prima facie violation of Article 3 of the ECHR. This Report by the Inspector of Prisons prompted the Minister for Justice to announce that the institution will be closed in 2013.[205]

9.3. Drug Treatment Court Programme

Despite the failure to develop diversion provisions, processes and initiatives for defendants with MHPs and ID, a drug treatment court has been developed in recent years. This is a problem solving court based on therapeutic jurisprudence principles (see Chapter 2: Literature Review, Part 1). The Programme was established in 2001 with the purpose of addressing the rising levels of drug use and drug-related crime in Dublin in the 1990's. The Programme adopts a problem solving approach to offenders with drug addition when they come before the District Court on minor criminal charges that are linked to their drug addiction.[206] Applicants are required to undergo an assessment for eligibility to participate. Participants are chosen on the basis of their seriousness about tackling "their drug habit and undergo treatment".[207] Unlike the juvenile diversion programmes this Programme does not operate nationally and participants are required to "live in Dublin (ideally at an address with the postcodes of Dublin 1, 3 or 7)".[208]

However, despite early positive reviews of its work there has been criticism of the low number of referrals to the court.[209] The Programme was made permanent in 2006. However, the Minister for Justice at the time decided not be expand the Programme until an up-to-date review

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[205] See "Minister Shatter publishes Inspector of Prisons Annual Report for 2012; An Assessment of the Irish Prison System by the Inspector of Prisons and announces plans for the future use of St Patrick's Institution" (Dublin: Department of Justice, 3 July 2013).

[206] In order to participate in the Drug Treatment Court Programme an offender must be over the age of 18 and is required to plead guilty or have been convicted of the offence or offences that are charged with and be dependant on prohibited drugs. Prospective participants or their legal representatives apply to the sentencing judge to participate in the Programme when their case comes before the District Court. Applicants are required to be willing to co-operate fully with the Court and end criminal behaviour.

[207] See the Court Service website at: http://www.courts.ie/offices.nsf/fd1b5d60ef39f31380256e43003d0107/cfaf3511b9b9639e80256e45005861cf?OpenDocument. <Last accessed 10 November 2013>

[208] *Ibid*.

[209] "Drug Treatment Court to be Expanded" (Irish Penal Reform Trust, 24 May 2010).

of its efficiency had been carried out. Unlike diversion provisions, processes and initiatives for juvenile offenders the support for this problem solving court has not been as universal. Press reports emerged in 2009 suggesting that the Programme would be "wound up" following deliberations of the Public Accounts Committee.[210] However, much work has been done to support its operation and to address criticisms of its effectiveness. One of the main criticisms was that the "standards sought from participants were so high as to put people off even considering participating."[211] This was particularly the case as the assessment of the success of participants was predicated on a "pass" or "fail" system that "… masked the huge progress that individuals were making".[212] According to the Court Service approximately "… 85% of graduates from the programme were found not to have been convicted of an offence since graduation and significant progress was also made among those who did not manage to complete the programme."[213]

Under the reformulated operation of the Programme participants continue to be drug tested as part of their treatment and progress is measured over the period of their participation. A "greater weighting is ascribed to positive behaviours, such as not coming to unfavourable notice of the Gardaí" and participants receive credits for attending the in-house support group.[214] The criticisms of the "pass" or "fail" system have been addressed with achievements of participants now being recognised as those who achieve a "silver standard" but not reaching the "gold standard" may result in a report from the Drug Treatment Court Judge to their Sentencing Judge proposing a suspended as opposed to a custodial sentence. The multidisciplinary approach of the Programme is further evidenced by the reformulated Support and Advisory Committee that includes senior management from the Health Service Executive (HSE), the Probation Service, An Garda Síochána, City of Dublin VEC, the Health Research Board and the Courts Service.

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[210] Ward "New look Drug Treatment Court Offers Hope for the Future" (*Court Service News*: 13(1), 2011) at page 5.

[211] *Ibid*.

[212] *Ibid*.

[213] *Ibid*.

[214] *Ibid*. The in-house support group is based on the '12 steps' approach to managing addictions.

In addressing the criticisms of the narrow geographical criteria for participating in the Programme the Court Service recently stated that it "…hopes to be able to accept participants with addresses outside Dublin North Inner City in the near future."[215] The Review published in May 2010 stated that the "… limited evidence available suggests that the Drug Treatment Court has had a positive effect on offenders participating in the programme, in terms of lower rates of recidivism, and in terms of improved quality of life for the participants, their families and the wider community."[216] This Review carried out renewed political support for the Programme and recommended it should be extended in suitable cases to the Circuit Court rather than limiting the scheme to the District Court. In addition the Review recommended the phased removal of geographical restrictions for potential participants and the lowering of the minimum age of participants. Interestingly the review found that even though there had been low referral rates to the Court the programme had very promising results with respect to changing the behaviour of offenders. Ryan and Whelan have suggested that the inadequate resources have "hindered the success of the Irish Drug Treatment Court" and the quantities of successful graduates are low in comparison to similar courts in other jurisdictions.[217] The failure to develop residential services in particular has been identified as a major impediment for the Irish Drug Treatment Court.[218] The model used in the Irish Drug Court of staying criminal charges and dropping charges when a participant graduates was considered desirable.[219]

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[215] Ward "New look Drug Treatment Court Offers Hope for the Future" (*Court Service News*: 13(1), 2011) at page 5.

[216] "Review of the Drug Treatment Court" (Dublin: Department of Justice, Equality and Law Reform, May 2010) at page 27.

[217] Ryan and Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (*Web Journal of Current Issues*: 1, 2012).

[218] "Review of the Drug Treatment Court" (Dublin: Department of Justice, Equality and Law Reform, 2010).

[219] Ryan and Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (*Web Journal of Current Issues*: 1, 2012). Voluntary participation and competence to decide to enter the programme were suggested as essential elements that ought to inform the design of a mental health court and continuity of care and services beyond graduation.

9.4. White Paper on Crime

The DOJ under the previous government commenced the process of developing a White Paper on Crime.[220] It was envisaged that the White Paper would set out the overall policy framework for strategies to combat and prevent crime. It was due to be published in 2012 but has not been published before the submission of this thesis. The development of the White Paper has involved a system-wide examination of the approaches to intervention, prevention and enforcement. The rationale underlying this examination is to reduce offending and promote public protection. There was a noticeable absence of any discussion of crime prevention as it relates to defendants and offenders with MHPs or ID.[221]

The DOJ's second consultation document on developing its White Paper examined the issue of criminal sanctions.[222] The feedback from the consultations on the Second Consultation Document on criminal sanctions did contain a small section on mental health issues.[223] It was reported that some of the submissions received concerned the treatment of offenders with MHPs. It was "argued that this is a longstanding issue and serious consideration needs to be given to these offenders with additional resources being made available."[224] There was also a suggestion that PIRCLS was an example of best practice that could be expanded.

The development of the White Paper on crime is significant process as

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[220] See the Department of Justice and Equality website at: http://www.justice.ie/en/JELR/Pages/White_Paper_on_Crime. <Last accessed 10 November 2013>

[221] "White Paper on Crime: Crime Prevention and Community Safety" (Dublin: Department of Justice and Equality, Discussion Document No. 1, July 2009). None of the questions contained in the consultation document specifically referred to defendants and offenders with MHPs or offenders with ID. However, the IPA's Report on the regional consultations carried out on the Consultation Document did contain some references to mental health issues as part of crime prevention.

[222] "White Paper on Crime: Criminal Sanctions" "(Dublin: Department of Justice and Equality, Discussion Document No. 2, August 2010).

[223] See "White Paper on Crime Consultation Process: Criminal Sanctions Overview of Written Submissions Received"(Dublin: Department of Justice and Equality, Discussion Document No. 2, August 2010).

[224] *Ibid*, at page 26.

it is envisaged that the White Paper will set out the overall policy framework for strategies to combat and prevent crime. It is regrettable then that the consultation process managed by the DOJ has failed to facilitate a discourse around defendants and offenders with MHPs and ID. The development of diversion provisions, processes and initiatives are key in responding to defendants and offenders with MHPs and ID.[225] Criticisms of the White Paper include commentators describing it "… as an attempt to focus the crime prevention debate narrowly on the crimes of the poor and the marginalised, the prioritising of surveillance and control over social regeneration, and the reinforcement of existing structures and policies." [226] The DOJ has carried out further consultations on organised and white-collar crime, older citizens and the issue of crime and the community and the criminal justice system.[227] Hopefully the narrow approach adopted in the development of the White Paper can be abandoned and a broader approach embraced and future consultations will engage specifically with the issues relating to defendants and offenders with MHPs and ID.

It is unclear from the Programme for Government whether the new Government will continue with the development on the White Paper on Crime.[228] Should progress with the White Paper proceed it would be essential that diversion be included as a central part of the Programme. This would mean that there is for the first time a clear and unambiguous Government commitment to diversion, a commitment that is currently not in evidence in policy or practice.

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[225] See Chapter 2: Literature Review, Part 1.

[226] Walsh and Mulqueen "Framing the Crime Prevention Discourse in Ireland: Borrowing the Appearance while Avoiding the Substance of the UN Guidelines" (*Irish Jurist*: 45, 2010, pages 152-181).

[227] See the Department of Justice and Equality's website at: http://www.justice.ie/en/JELR/Pages/White_Paper_on_Crime. <Last accessed 10 November 2013>

[228] However, there is a commitment to enact legislation to strengthen the rights of victims of crime and their families and to address white-collar crime, strengthen the powers of the Criminal Assets Bureau and establish a DNA Database amongst other reforms.

9.5. Community Courts

The Crime Council of Ireland recommended that Community Courts be established in Ireland.[229] The recommendation envisaged that Community Courts be established as stand alone courts in areas of high population and could form part of the ordinary District Courts in rural areas.[230] Key to the operation of the Community Courts is a "… proper assessment of each defendant".[231] The Crime Council of Ireland recommended pre-court assessment of all participants in the Community Courts on the basis of international best practice.[232] The Crime Council envisaged that assessment after arrest and before a court appearance should be done in order to determine whether a defendant has an addiction problem, housing, social welfare entitlements, or a MHP.[233] A real shortcoming of the Crime Council's Report is that it failed to engage in any discussion around the use of the Drug Treatment Court that operates in Dublin. It was also disappointing that there was not a broader consideration of specialised problem solving courts such as the potential development of a mental health court in the Dublin area. However, the problem solving approach embodied in Community Courts is a positive policy development and has great potential in working effectively with defendants and offenders with MHPs and ID and providing community based alternatives to imprisonment. While there has been little progress in developing Community Courts in Ireland the idea of establishing such courts was recently endorsed by the Chairperson of the Oireachtas Justice Committee.[234]

10. Involuntary Admission through the Mental Health Act 2001

The *Mental Health Act 2001* does not include formal procedures for

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[229] "Problem Solving Justice: The Case for Community Courts in Ireland" (Dublin: National Crime Council, April 2007) at page 6.

[230] *Ibid*.

[231] *Ibid*.

[232] *Ibid*, at page 41.

[233] *Ibid*.

[234] See "Stanton Proposes New York-style Community Court for Ireland" (Dublin: July 2013). Available at: http://stanton.ie/2013/07/22/stanton-proposes-new-york-style-community-court-for-ireland/. <Last accessed 10 November 2013>

diversion of persons with MHPs, from the criminal justice system (see above). However, Gardaí play a central role in involuntary admissions under the *Mental Health Act 2001*.[235] They act as applicants for admission and assist in the removal and return of the person to "approved centres".[236] According to the latest report from the MHC spouses/partners/relatives are involved in 57% of applications for admission followed by the Gardaí at 22%.[237] Gardaí are empowered under section 12 of the *Mental Health Act 2001* to detain a person and take them into custody. The power in section 12 confers a power to forcibly enter a home, where the Garda have reasonable grounds to believe that there is likelihood that the person will cause immediate harm to themselves or to others.

Amnesty International Ireland reporting on the views of service users suggested the involvement of the Gardaí in involuntary admission, was "stigmatising and should be kept to a minimum".[238] Amnesty also criticised Article 12 of the Act and recommended that "Gardaí should bring the person to an approved centre for assessment" and that only in exceptional circumstances should it be permissible to detain somebody in a Garda station and the detention should be for the "minimum period practicable within which an assessment by a medical practitioner must take place".[239] The available statistics on the involvement of Gardaí in the admission process under the *Mental Health Act 2001* do not provide a breakdown of how the Gardaí become involved in the admission. It may be the case that in the majority of cases the Gardaí were assisting members of staff working in an "approved centre" with an involuntary admission (in line with their powers under sections 13 and 27 of the Act), or it may be the case that the Gardaí were using their powers in some cases to connect a person to services in an informal way. Further information on the nature and

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[235] See "Report of Joint Working Group on Mental Health Services and the Police 2009" (Dublin: Mental Health Commission and An Garda Síochana, 2009).

[236] The Health (Miscellaneous Provisions) Act 2009 amended sections 13 and 27 Mental Health Act 2001 to provide that independent contractors to assist in involuntary admissions of persons.

[237] See "Mental Health Commission Annual Report 2012 Including Report of the Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2013) at page 35.

[238] Page 94.

[239] "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011) at page 95.

circumstances of Garda involvement in involuntary admissions would be of use in assessing the way in which Gardaí become involved in involuntary admissions.

11. Prison In-reach and Court Liaison Service (PIRCLS)

Kennedy has suggested that the over-representation of persons with MHPs in the criminal justice system:

> "[P]robably reflects the rejection by community mental health services of those who do not fit the pattern for care in the community. Care in the community is good for the majority of mentally ill people when it is properly staffed and funded, but its attraction for Government lies in the possibility of cutting the staff numbers and costs of traditional mental hospital care. The result is a service that by default discriminates against young men with severe mental illnesses".[240]

In addressing the deficiencies in the provision of mental health services in the community the PIRCLS has emerged as the only dedicated diversion initiative aimed at identifying and linking defendants and offenders to mental health services in Ireland. Diversion at this point of the criminal justice process involves defendants who have been arrested, charged and are facing court proceedings.[241] PIRCLS is integrated within Cloverhill Remand Court. PIRCLS has a standarised system for identifying persons with "major mental illness" on remand and to then facilitate diversion to appropriate "health care settings".[242] It offers a large geographical "footprint" dealing with approximately 57% of prisoners remanded from Irish courts.[243]

The aim of PIRCLS is to assist patients, the criminal justice system and

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[240] "The Whitaker Report 20 Years On: Lessons Learned or Lessons Forgotten" (Dublin: Irish Penal Reform Trust, 2007) at pages 83-84.

[241] See Chapter 2: Literature Review, Part 1.

[242] McInerney, Davoren, Flynn, Mullins, Fitzpatrick, Caddow, Caddow, Quigle, Black, Kennedy and O'Neill "Implementing a court diversion and liaison scheme in a remand prison by systematic screening of new receptions: a 6 year participatory action research study of 20,084 consecutive male remands" (*International Journal of Mental Health Systems*: 7(18), 2013) at page 5. Not final version.

[243] *Ibid*, at page 6.

local psychiatric services by identifying mentally ill persons when remanded to prison as rapidly as possible, and to put in place practical solutions for accessing appropriate mental healthcare. PIRCLS consists of a mental health team of one consultant forensic psychiatrist, two psychiatric trainees and three experienced nurses, which operates a full-time service Monday to Friday.[244] Mentally ill prisoners are identified and put in place as quickly as possible solutions for accessing appropriate treatment for their MHPs. It operates a liaison model that seeks to link "patients" to their local psychiatric service when this is assessed as being "feasible and safe". One of the many positive aspects of this initiative is that it identifies persons who have a primary diagnosis of psychotic illness including "co-morbid substance misuse problems".[245]

The systematic screening of newly received remand prisoners in Cloverhill identified that 2.8% (561/20,084) had a current psychosis.[246] This compares with the finding of Curtin et al. in the same prison in 2004 that 3.8% had a current psychosis.[247] The Cloverhill programme diverted 572 persons from prison to mental health services over the 6-year period of its work.[248] People were diverted to different places following risk assessment; 89 to a secure forensic hospital, 164 to community mental health hospitals, 319 to other community mental health services.[249]

Staff of the National Forensic Mental Health Service (who run PIRCLS at Cloverhill) are less enthusiastic about diversion provisions, processes and initiatives that operate earlier in the criminal justice system. In support of this position they cite studies that show such diversion programmes have "inequalities between local areas, and the need for standardisation of approach to enable equal access over larger geographical areas and population aggregates".[250] They indicated that

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[244] *Ibid*, at page 9.

[245] *Ibid*.

[246] *Ibid*, at page 17.

[247] *Ibid*.

[248] *Ibid*.

[249] *Ibid*.

[250] *Ibid*, at page 18.

their model was dependent on sufficient staffing and experience to be available 5 days a week in the remand centre. It also stated that it was dependent upon "sufficient volume of remand committal … to make this service both clinically effective in terms of numbers diverted, and cost effective".[251] In that regard offering a similar service in the smaller prisons that remand prisoners on bail and prisoners serving sentences "would probably not be viable to provide a team-based service such as this for such relatively small numbers".[252] Presumably other diversion programmes that were connecting persons to services earlier in the process would undermine the clinical effectiveness and cost effectiveness of the Cloverhill programme.

There has traditionally been a powerful professional lobby from psychiatrists against the extension of power of diversion to the courts. This is perhaps most accurately illustrated by the responses to the Government's Green Paper on Mental Health discussed above. It is suggested here that the development of diversion programmes earlier in the process is at odds with the interests or preferred modus operandi of the National Forensic Mental Health Service. While this service has identified the benefit of earlier diversion services it has concluded that its "centralized model … provides for a standardized and equitable approach for large population aggregates, as well as economies of scale through integration with prison inreach services for remand prisoners".[253] This is of concern as the development of community mental health services and the creation of forensic mental health services envisaged in "A Vision for Change". This view of the National Forensic Mental Health Service as to the infeasibility of diversion provisions, processes and initiatives earlier in the criminal justice system (See Chapter 2: Literature Review, Part 1) is likely to stall the development of diversion in Ireland.

The Independent Monitoring Group, while describing PIRCLS for prisoners on remand as a "proactive development", reaffirmed the

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[251] *Ibid*.

[252] *Ibid*.

[253] *Ibid*.

need for expansion to cover "all prison locations".[254] The Independent Monitoring Group also identified that diversion services for prisoners detained on remand ought to be developed on a national basis.[255] The limited reach of the Cloverhill initiative has been noted by Byrne and Irwin who acknowledge that despite its good work and outcomes "it is significantly under resourced" and "has yet to be extended nationally, with many people falling between the cracks in existing services".[256] It has also been noted that the failure to develop community mental health teams and address serious shortages in specialist services has added to a system that allows many people to fall between the cracks.[257] It is of concern the extent to which the Cloverhill scheme caters for and responds to the needs of female prisoners. The majority of female prisoners are imprisoned in the purpose built "Dóchas Centre" in Dublin and the remainder are located in a separate part of Limerick Prison.[258] There are questions as to the extent to which diversion services will develop to respond to the needs of female offenders.

While the National Forensic Mental Health Service see the Cloverhill project as being sufficient to respond to the needs of defendants and offenders with MHPs Ryan and Whelan have suggested the need for a mental health court to supplement its work.[259] Ryan and Whelan recommended that a mental health court, operating on a statutory basis in conjunction with the prison in-reach programmes would work more effectively.[260] They also identified that scarcity of resources for mental health care and the need to develop community mental heath

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[254] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012) at page 49.

[255] *Ibid*, at page 104.

[256] Byrne and Irwin "The Added Value of A Human Rights Based Approach to Mental Health in Irish Prisons" (*Medico-Legal Journal of Ireland*: 16(1), 2010, pages 34-38).

[257] *Ibid*.

[258] See the Irish Prison Service website at: http://www.irishprisons.ie/index.php/about-us/overview-of-the-irish-prison-service. <Last accessed 10 November 2013>

[259] See Ryan and Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (*Web Journal of Current Issues*: 1, 2012). They recommended the "close cooperation between the judiciary, the Courts Service, the Department of Justice and Equality, the Prison Service, the HSE and the Probation Service, amongst other agencies" in creating a mental health court.

[260] *Ibid*.

services are a barrier to the development of diversion programmes supported by a mental health court. Indeed Kennedy considers court diversion schemes are only a "partial solution" noting this already happens informally through a "*de facto* court diversion scheme … currently operated through the psychiatric in-reach clinics provided by clinicians from the CMH to remand prisons".[261] He also suggests that section 4(6) of the *Criminal Law (Insanity) Act 2006* on fitness to stand trial "if used creatively" could facilitate diversion.[262] However, a system of diversion based on attributing incapacity to a person with a MHP in order to secure diversion is at odds with the CRPD.[263] Indeed it would be undesirable to seek to achieve diversion through provisions on unfitness to plead; as such use would be at odds with the rationale for the provisions.

12. Mental Health Services in Irish Prisons

This section considers the effects of not providing for diversion provisions, processes and initiatives in Ireland. The most significant effect is the over-representation of persons with MHPs in the Irish prison population. The experience of persons with MHPs in the criminal justice system has been negative, with a failure to provide appropriate mental health services well documented. The Human Rights Committee's concluding observations on Ireland's compliance with the ICCPR expressed concern at the continued increased use of incarceration and the "persistence of adverse conditions in a number of prisons".[264] In addition to the issues such as inadequate hygiene facilities, the non-segregation of remand prisoners, the high prevalence of inter-prisoner violence the Committee also expressed concern with the deficiencies in the provision of mental health care for prisoners.[265]

The Inspectorate of Mental Health Services, an independent arm of the

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[261] "The Whitaker Report 20 Years On: Lessons Learned or Lessons Forgotten" (Dublin: Irish Penal Reform Trust, 2007) at page 84.

[262] *Ibid*, at pages 83-84.

[263] See Chapter 2: Literature Review, Part 2.

[264] "Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant: Concluding observations of the Human Rights Committee, Ireland" (United Nations: Human Rights Committee, CCPR/C/IRL/CO/3, 2008) at page 4.

[265] *Ibid*, at pages 4-5.

MHC published a Report following an inspection carried out in Mountjoy prison in 2010.[266] While nurse led mental health clinics have been introduced in Mountjoy and the creation of a HSU for vulnerable prisoners the services available to offenders with MHPs were identified as being insufficient. Mental Health services were "… limited to sessional input from Non Consultant Hospital Doctors (NCHD) and a consultant psychiatrist."[267] The Inspectorate also noted that the service was not a multidisciplinary clinical team and did not have participation from clinical psychologists, occupational therapists or social workers. Therefore, full treatment planning was not happening.[268] The Inspectorate expressed concern that there were periods where the only resource available to safeguard vulnerable prisoner was the use of observation cells and that these were used on occasion for a period of weeks. Concern was also expressed in relation to decisions "… to place prisoners in the safety observation cells for the purpose of alleviating mental illness was taken by nursing staff without the necessity for medical review after four hours (as is the case for residents of approved centres, Rules Governing the Use of Seclusion, Section 69(2), *Mental Health Act 2001*). The procedure for reviewing prisoners in the safety observation cells, included review after five days."[269]

A reduction in the Irish prison population is necessary as there is an over-representation of certain groups

> "[B]y virtue of their social vulnerability: the homeless, those addicted to drugs, the mentally ill. Certainly putting people in prison who have either mental illness or a personality disorder is no good to anyone. It doesn't cure them. It will almost certainly make them worse. It puts an impossible burden on Governors and prison staff and indeed on fellow prisoners".[270]

There is a clear evidence-base on the prevalence of psychiatric

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[266] "Mental Health Services 2010: Inspection of Mental Health Services in Prisons" (Dublin: Mental Health Commission, 2010).

[267] *Ibid*, at page 6.

[268] *Ibid*.

[269] *Ibid*.

[270] "The Whitaker Report 20 Years On: Lessons Learned or Lessons Forgotten" (Dublin: Irish Penal Reform Trust, 2007) at page 55.

morbidity in Irish prisons.[271] The recommendations contained in a "Vision for Change" in relation to forensic mental health services in many ways acknowledge "the longstanding "criminalisation" of the mentally ill with disproportionally higher rates of mental illness in prison (particularly remands settings) than in the community."[272] O'Neill et al's research indicates that the rates of psychosis of prisoners serving custodial sentences are comparable to other jurisdictions. However, Duffy et al. also found a significantly higher prevalence of psychosis in life-sentenced prisoners (6.1%) compared to fixed sentenced prisoners (1.8%).[273] The research also showed that drugs and alcohol problems were very prevalent in this population.[274] However, there is evidence that in Ireland there are higher rates of psychosis in the remand prisoner population when compared to other countries.[275] The research found that the six-month prevalence of psychosis was 7.6%, which was almost twice the rate in an international meta-analysis.[276] The research suggested that a major depressive disorder was present in 10.1%.[277] While substance abuse problems were common the research suggested that there was no significant difference between rates of substance abuse in psychotic and "non-psychotic prisoners". A total of 31.2% of remand prisoners had a lifetime history of mental illness.[278] This research provides a very clear evidence-base that there are significantly high levels of "psychiatric morbidity" in Irish prisons.

The failure to respond to the needs of persons with MHPs in the prison

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[271] Duffy et al "Psychiatric Morbidity in the Male Sentenced Irish Prison Population" (*Irish Journal of Psychological Medicine*: (2006), 23(2), 54).
In addition a study by Hannon, Kelleher and Friel suggested 48% of male prison population and 75% of female prisoners required psychiatric treatment. See Hannon, Kelleher and Friel "General Healthcare Study of the Irish Prisoner Population" (Dublin: Government Publications, 2000).

[272] O'Neill, McInerney and Fitzpatrick "Prison Inreach and Court Liaison Services in Ireland" (Dublin: National Disability Authority, 2007).

[273] Duffy et al "Psychiatric Morbidity in the Male Sentenced Irish Prison Population" (*Irish Journal of Psychological Medicine*: (2006), 23(2), 54).

[274] *Ibid*.

[275] Linehan et al "Psychiatric morbidity in a cross-sectional sample of male remanded prisoners" (*Irish Journal of Psychological Medicine*: 22(4), 2005, 128).

[276] *Ibid*.

[277] *Ibid*.

[278] *Ibid*. This statistic excludes substance misuse, adjustment disorder and personality disorder.

system remains a significant problem as evidenced by recent report from the prison inspection authorities. In its annual report the Cork Prison Visiting Committee expressed its concern with the housing of mentally ill prisoners.[279] The Committee noted that there were prisoners with psychological and psychiatric problems; however, the facilities for housing prisoners with MHPs were described as being "totally inadequate".[280] The Committee conceded that this situation was at odds with the Irish Prison Service's core value and commitment to "human dignity and care".[281]

The tragic death of a 21-year-old prisoner Gary Douch in Mountjoy in 2006 further evidences the inadequacy of accommodation for prisoners with MHPs.[282] When Gary Douch was attacked he was detained in a holding cell in Mountjoy Prison with six other prisoners. The holding cell was originally constructed to hold prisoners for the prison registration process. However, due to overcrowding the holding cell was being used for overnight accommodation. One of Gary Douch's cellmates was a man called Stephen Egan who was diagnosed as having a "schizo-affective disorder" and who had been transferred recently from the CMH to Mountjoy Prison. In what was believed to be an unprovoked attack Stephen Egan strangled Gary Douch to death.[283] Stephen Egan was later convicted for the homicide and successfully raised the defence of diminished responsibility.[284]

This case illustrates the inadequacy of the current provision in Irish law and policy for responding to defendants and offenders with MHPs in the criminal justice system. Given the controversy that this case generated and the opening of a Commission of Investigation it the death of Gary Douch it was hoped that much needed reform may follow. However, while the Commission of Inquiry was scheduled to report at the end of 2007 the Report has yet to be published. The delay

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[279] "Cork Prison Visiting Committee Annual Report 2012" (Dublin: Department of Justice 2012) at page 3.

[280] *Ibid*.

[281] *Ibid*.

[282] See "Roundup: Reactions to further delays in report regarding the killing of Gary Douch" (Dublin: Irish Penal Reform Trust, 13 June 2013).

[283] *Ibid*.

[284] *Ibid*.

is as a result of obtaining "documents and information" and the surfacing of new evidence has required the opening of the investigation.[285] IPRT has criticised the failure to publish the review and is of the view that the delays in delivering a "deliver a prompt and effective report" is in breach of the European Convention on Human Rights.[286]

The failure to produce the Report into Gary Douch's death is hardly surprising given the poor track record of the Government in responding effectively to the needs of persons with MHPs contact with the criminal justice system. The failure to respond to the needs of Stephen Egan and provide him with effective treatment and suitable accommodation no doubt contributed to the death of Gary Douch. This tragic case has also served to further stigmatise defendants and offenders with MHPs and promulgate the conflation of mental illness and dangerousness. IPRT is of the view that the delay in publishing the Report "for 7 years with little to no public outcry suggests a deep public and political apathy towards vulnerable young men in the prison system".[287]

Solitary confinement as discussed in Chapter 2: Literature Review, Part 1 can have hugely negative effects on both physical and mental health.[288] It has been noted that in many jurisdictions solitary confinement is "used as a substitute for proper medical or psychiatric care for mentally disordered individuals".[289] It is unsurprising then that given the lack of developed law and policy responding to defendants and offenders with MHPs there appears to be a heavy use of solitary confinement in Irish Prisons. In March 2013 it was reported 193 prisoners were on "23-hour lock up". Of this 193 87 were imprisoned in Wheatfield Prison and 44 in St Patrick's Institution, which

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[285] *Ibid*.

[286] *Ibid*.

[287] *Ibid*.

[288] See in particular Shalev "A sourcebook on Solitary Confinement" (London: Manheim Centre for Criminology, London School of Economics, 2008).

[289] "The Istanbul statement on the use and effects of solitary confinement" (Istanbul: Adopted 9th December 2007, International Psychological Trauma Symposium) at page 1.

included 2 seventeen-year-old boys.[290] These prisoners described as "protection prisoners" are considered to be "at risk" in the general prison population and can achieve this status by requesting protection or can be imposed by "prison management".[291] IPRT has been very critical of the use of "lock up" commenting that the practice is "not sustainable or acceptable that the main response to a threat of violence is to lock up threatened prisoners for 23 hours a day, with little or no access to work, education or training, exacerbating mental and physical health issues".[292]

The HSU (referred to above) was created following a critical Report form the Inspector of Prisons in August 2009.[293] The failure to provide a proper system of identification and transfer of persons with MHPs to services in the community necessitated this triage system of mental health service provision. The High Support Unit is designed to deal primarily with persons with MHPs but also with persons requiring "detoxification" and "additional monitoring".[294] Therefore, the terminology of "vulnerable" prisoners is used to reflect the use for other categories of prisoners other than prisoners with MHPs.[295]

"Special observation cells" have traditionally been used in Mountjoy to contain and restrain mentally ill prisoners.[296] The indication from the research on the use of the High Support Unit suggests that it has resulted in a "significant reduction" in the use of special observation cells in the prison with an average daily or monthly fall of 59% since the Unit became operational.[297] The other benefits identified in the

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[290] See Dáil Questions (Dublin: Written Answers Nos. 195-204, 19 March 2013). Available at: http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2013032100065?opendocument#WRT01150. <Last accessed 10 November 2013>

[291] *Ibid*.

[292] "New Sourcebook on Solitary Confinement released" (Dublin: Irish Penal Reform Trust, 28 May 2013).

[293] See Williamson "A Collaborative Approach to Working with Vulnerable Prisoners: The Establishment and Operation of the High Support Unit at Mountjoy Prison" (*Irish Probation Journal*: 9, 2012, pages 177-191).

[294] *Ibid*, at page 183.

[295] *Ibid*.

[296] *Ibid*.

[297] See Giblin, Kelly, Kelly, Kennedy and Mohan "Reducing the Use of Seclusion for Mental Disorder in Prison: Implementing a High Support Unit in Prison Using Participant Action

literature on the High Support Unit in Mountjoy was that it "streamlined communication" with the National Forensic Service at the CMH.[298] The HSU improved the continuity of care with 70% of prisoners being transferred back from the CMH being placed in the High Support Unit.[299] The engagement of prisoners with MHPs with the High Support Unit has had the benefit of identifying the physical health needs of prisoners and facilitated the Probation Service in drafting intervention and supervision plans for the "vulnerable" prisoners.[300]

Section 99 of the *Criminal Justice Act 2006* confers the court with the power to make an order sentencing a person to a period of imprisonment and to suspend part of all of the sentence, if the convicted persons enters a recognisance with conditions that can include Probation supervision for a fixed period following release from custody. The Probation Service has acknowledged that a number of persons subject to a mandatory Probation Supervision Order require treatment for MHPs. The Probation Service's engagement with the HSU has increased its awareness of its own challenges in the "assessment and supervision of offenders with MHPs".[301] The Probation Service has asserted that this development in sentencing has required the Probation Service to "manage offenders on a through care basis" by "linking custody and community in a new way" that its connection to the HSU was described as enhancing practice.[302] Since its establishment in 2010 the HSU has successful in not only in reducing the use of special observation cells in the prison but also in increasing "the communication and cooperation between the mental health services, general healthcare and the Probation Service in the prison"[303]. There are proposals that the HSU model will be "rolled out across the prison estate".[304] Given the premium placed on the effectiveness of the HSU,

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Research" (*International Journal of Mental Health Systems*: 6(2), 2012, pages 1-8).

[298] Williamson "A Collaborative Approach to Working with Vulnerable Prisoners: The Establishment and Operation of the High Support Unit at Mountjoy Prison" (*Irish Probation Journal*: 9, 2012, 177-191) at pages 184-185.

[299] *Ibid*, at page 185.

[300] *Ibid*.

[301] *Ibid*, at pages 185-186.

[302] *Ibid*, at page 186.

[303] *Ibid*, at page 189.

[304] *Ibid*.

there is a concern that prison based programmes will be developed and expanded, to the detriment of identifying and diverting persons earlier in the criminal justice system.

The HSU has received much praise including the World Health Organisation's Health in Prison – Best Practice Award. However, it is important to remember that the HSU fits into an international trend where psychiatric hospitals are effectively created in the prison complex. This poses difficulties in light of the CRPD where there is a right to habilitation and rehabilitation and a right to live and be included in the community. It is contended that diversion for habilitation and rehabilitation should be given greater consideration in Irish penal policy and the impact of imprisonment on PWDs should be given greater consideration also.

13. Irish Case Law

Given the failure to develop diversion provisions, processes and initiatives for defendants and offenders with MHPs and ID, the courts have been called upon by prisoners with MHPs seeking to vindicate their rights. However, the Irish Constitution on the whole has proved to be a weak tool in advancing the rights of PWDs.[305] In considering challenges to the lawfulness of the detention of persons with MHPs the courts have taken a paternalistic approach in interpreting the rights of applicants subject to the civil commitment legislation.[306] In the case of *Re Philip Clarke*, the provisions of the *Mental Treatment Act 1945* (as they were then), which permitted the Gardaí to detain persons with MHPs were challenged.[307] The Supreme Court held that allowing a person suffering from mental illness to remain at large, putting him and others in danger could not assure the common good and freedom and

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[305] See Whyte "Constitutional Litigation on Disability Rights" (*Irish Jurist*: 2, 2012, pages 303-322).

[306] While the approach of the Irish Courts has been very restrictive, the notable exception was in *RT v Director of the Central Mental Hospital* [1995] 2 IR 65. This case related to the provision of procedural safeguards surrounding the detention of persons determined not fit to stand trial, which were considered insufficient. It should be noted that the decision in this case, aimed to safeguard the rights of the applicant who was considered vulnerable.

[307] [1950] IR 235. The applicant argued that the 1945 Act breached his fundamental rights under the constitution mainly on the grounds that there was no judicial oversight of the deprivation of liberty.

dignity of the individual. O'Byrne J stated "[t]he impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well-being of the public generally. The existence of mental infirmity is too widespread to be overlooked".[308] The Supreme Court, five decades later, took a similar approach in *Croke v Smith (No 2)*.[309] This paternalistic approach in interpreting the 1945 Act, has now become embedded in the body of case law that has emerged under its successor the 2001 Act.[310] In addition there is a growing body of case law, exploring narrow procedural aspects of the 2006 Act.[311]

There are only a small number of cases where prisoners with MHPs have sought to assert their constitutional rights and rights under the ECHR. As Herrick notes when prisoners have sought to assert their rights "the approach of the courts to interpreting these rights can be generally characterised as non-interventionist" with the courts taking the view that the rights of prisoners' are unavoidably "diminished by

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[308] *Ibid*.

[309] [1998] 1 IR 101.

[310] See for example *JH v Lawlor, Clinical Director of Jonathan Swift Clinic, St James Hospital* [2007] IEHC 225; *MR v Byrne and Flynn* [2007] IEHC 73; *EH v Clinical Director of St Vincent's Hospital* [2009] 3 IR 774; *HSE v MX* [2011] IEHC 326 and *PL v Clinical Director of St Patricks University Hospital* [2012] IEHC 15. In *MR v Byrne and Flynn*, O'Neill J held that section 4 of the 2001 act "in my opinion gives statutory expression to the kind of paternalistic approach mandated in the case of Philip Clarke and approved in the case of *Croke v Smith*". For a discussion on the paternalistic approach of the Mental Health Act see "Interim Report of the Steering Group on the Review of the Mental Health Act 2001" (Dublin: Department of Health, 2012) at pages 9-11.

[311] The cases on the 2006 Act have not dealt with any substantive issue of diversion and as such are outside the scope of this thesis. However, there are a number of judgments that indicate that the CMH have had difficulties in complying with its statutory obligations under the Mental Health Act 2001. A recent example is the case of *AM v Harry Kennedy (In his role as Clinical Director of the Central Mental Hospital) v The Mental Health Commission v The Health Service Executive* [2013] IEHC 55. This case involved an application under section 73 to institute civil proceedings of the *Mental Health Act 2001*. The applicant alleged that she was detained unlawfully outside the scope of legislation and in order to take a civil case she was required to get leave from the High Court, which was granted by Judge Iseult O'Malley. The judgment in this case is an important one in obliging the MHC in taking a more active role in ensuring that psychiatrists responsible for the involuntary detention of persons comply with the procedural requirements of the legislation. Interestingly the judge in this case in commenting on the failures of the Clinical Director of the CMH 's compliance with his obligations under the 2001 Act stated that she had "no reason at all not to accept that this was done in good faith, but it is not clear to me why he thought he had the authority to amend her decision" at paragraph 26.

virtue of their imprisonment".[312]

This perspective is evidenced in the early case of the *State (C) v Frawley*.[313] The applicant in this case challenged the constitutionality of his detention.[314] He was suffering from what was described as "a severe sociopathic disorder", which led him to commit violent acts that primarily were harmful to him. This risk of self-harm led the prison authorities to subject him to a vigorous regime of restraint, which they considered to be in his best interests. One of the central issues was that he was not receiving the type of services that he wanted and the specialised services that expert witnesses said he required. The court rejected that the State had a "duty to build, equip and staff the very specialised unit". [315] The decision was informed by a strict understanding of the separation of powers, an approach to the separation of powers doctrine that has since been rigidly adhered to.[316] In *State (McDonagh) v Frawley* a different applicant, also a prisoner complained of a backache, for which he claimed he was not receiving proper treatment.[317] The prisoner sought habeas corpus on the basis of the breach of his constitutional right to bodily integrity.[318] The Chief Justice speaking for the court, took a very restrictive view as to the rights of the prisoner stating:

> "While so held as a prisoner pursuant to a lawful warrant, many of the applicant's normal constitutional rights are abrogated or suspended. He must accept prison discipline and accommodate

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[312] Herrick "Prisoners' Rights" in Kilkelly (ed) *ECHR and Irish Law* (Bristol: Jordan Publishing, 2nd ed, 2009) at page 328.

[313] [1976] IR 365.

[314] The habeas corpus procedure is provided for in Article 40.4 of the Irish Constitution. For a comprehensive discussion of the habeas corpus procedure and mental health see Keys "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (*Dublin University Law Journal*: 24, 2002, 26).

[315] *Ibid*, at 372.

[316] See *Sinnott v Minister for Education* [2001] 2 IR 545 and *TD v The Minister for Education* 4 IR [2001] 259. See Quinlivan and Keys "Official Indifference and Persistent Procrastination: An Analysis of Sinnott" (*Judicial Studies Institute Journal*: 2(2), 2002, pages 163-189).

[317] [1978] IR 131.

[318] The High Court and the Supreme Court did not query whether the lack of treatment could amount to a breach of the right to bodily integrity. Rather the court found in this case that the complaint had not been substantiated.

himself to the reasonable organisation of prison life laid down in the prison regulations".[319]

A less restrictive approach was taken in *State (Richardson) v The Governor of Mountjoy Prison* a number of years later. In this case Barrington J recognised that there was a right not to have ones health endangered in prison.[320] However, no other cases have emerged in the intervening period where the courts have availed of opportunities to protect the right to health of prisoners either in respect of their physical or mental health.[321] This is despite a lack of services; poor physical conditions and a host of other deficiencies in the Irish prison system being well document by the CPT and the reports of Inspector of Prisons. The Irish Penal Reform Trust in *IPRT v The Governor of Mountjoy Prison* sought to vindicate the rights of two prisoners with MHPs.[322] The IPRT challenged "systematic deficiencies" in the treatment of prisoners with "psychiatric problems" in the State's largest prison Mountjoy. One of the prisoners was detained in a padded cell in Mountjoy prison for a period of two weeks.[323] This was considered necessary, as there were no available beds in the CMH.[324] The second man was detained in a cell for a number of days; during this period he was naked and covered in his own excrement.[325] Both of the applicants claimed that they did not receive adequate supervision by mental health professionals in the prison. More importantly they argued that the conditions they were subjected were both unconstitutional and contrary to Article 3 of the ECHR. The judgment of Gilligan J in 2006 granting the IPRT *locus standi* (a hurdle that needs to be overcome in order to progress with constitutional litigation) was appealed to the

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[319] *Ibid*, at 135.

[320] [1980] ILRM 82. This case related to a female prisoner who provided evidence to the court of repulsive sanitary conditions in Mountjoy and that these conditions threatened her health.

[321] For example see *Mulligan v Governor of Portlaoise Prison* [2010] IEHC 269 where the High Court refused to find that slopping out violated the rights of the applicant under Articles 3 and 8 of the ECHR. For an overview of the vexed and ongoing controversy on the practice od "slopping out" see "IPRT Briefing on Sanitation and Slopping Out in Irish Prisons" (Dublin: Irish Penal Reform Trust, 2011).

[322] See *IPRT v The Governor of Mountjoy Prison* [2005] IEHC 305.

[323] Herrick "Prisoners' Rights" in Kilkelly (ed) *ECHR and Irish Law* (Bristol: Jordan Publishing, 2nd ed, 2009) at page 346-347.

[324] *Ibid*.

[325] *Ibid*.

Supreme Court. In 2008, the Supreme Court held that the issue of locus standi ought to be considered together with the substantive issues in the case and returned the matter to the High Court. The case has not yet come on for hearing.[326] This case illustrates the ineffectiveness of public interest litigation in vindicating the rights of prisoners with MHPs and ID.

While Irish constitutional law has proven a weak tool in vindicating the rights of persons with MHPs the ECHR has provided the impetus for reform. While the Croke case was unsuccessful before the Irish courts it was deemed admissible before the ECtHR.[327] The case was ultimately resolved by friendly settlement and provided the momentum for the repeal and replacement of the *Mental Treatment Act 1945* with the *Mental Health Act 2001*.[328] Whyte has concluded that constitutional litigation is not effective in "promoting the interests of PWDs" as such "one is forced to the conclusion that, on balance, the tactic of relying on the courts has not delivered as much as might have been hoped for and, for PWDs, as for other marginalised groups, the political route to reform cannot be avoided".[329]

It is argued that the failure to develop procedures, processes and initiatives aimed at diverting persons with MHPs from the criminal justice system, has resulted in human rights abuses for prisoners with MHPs. It is clear from these cases that in the absence of formal diversion provisions, procedures and initiatives, the Irish courts have been called upon to intercede on behalf of prisoners, when the state has failed to provide adequate services for both mental and physical health. The discussion of the case law reveals that beyond protecting narrow procedural and due process matters that courts have not taken

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[326] IPRT seem unwilling to progress with the case, fearful that the costs being awarded against should they not be successful at trial.

[327] *Croke v Ireland* (Application No 3326/96).

[328] Croke challenged to the lawfulness of his detention arguing that section 172 of the Mental Treatment Act 1945 was deficient in providing the safeguards required by Article 5(4) of the ECHR as interpreted by the ECtHR. *O'Reilly v Ireland* (Application No 24196/94) was also a case that was admitted for hearing in the ECtHR con consideration of arbitrary detention under Article 5(1)(e) also reached a friendly settlement. For a discussion on these cases see Keys *Mental Health Act 2001* (Dublin: Roundhall, 2002) at page 8.

[329] See Whyte "Constitutional Litigation on Disability Rights" (*Irish Jurist*: 2, 2012, pages 303-322) at page 321.

opportunities to vindicate rights of prisoners with MHPs. As was seen in the *State (C) v Frawley* the court refused to require the Executive to provide specialised treatment for the applicant. In these judgments there was no consideration of ordering the prisoners release as an alternative to making orders requiring services. The *State (C) v Frawley* and the *IPRT v The Governor of Mountjoy Prison* cases highlight the difficulties and barriers facing persons with MHPs in Irish prisons. Diversion at different points of the system is clearly a better approach, and underscores the need to develop a range of effective diversion provisions, processes and initiatives. The promotion of the rights of persons with MHPs and ID in prison is unlikely to be achieved through litigation on constitutional and ECHR rights. As Whyte suggests the "political route to reform cannot be avoided".[330] The CRPD can play an important role in informing the different types of diversion and ensure that a premium is placed on community living and facilitating access to services that realise the rights to recovery, health, habilitation and rehabilitation.[331]

14. The Criminal Law (Insanity) Act 2006

While its recommendations on diversion remain unimplemented, some of the other recommendations of the Henchy Committee Report were eventually given statutory expression by way of the *Criminal Law (Insanity) Act 2006*. Until the introduction of the 2006 Act a person was found guilty but insane under the provisions of the *Trial of Lunatics Act 1883*. When this occurred the court was obliged to commit the defendant to the CMH. The 2006 Act provides for a Mental Health (Criminal Law) Review Board (MHRB) to review the cases of persons committed to "designated centres" following findings of unfitness to be tried or verdicts of not guilty by reason of insanity. These new procedures mark a vast improvement on the old review system, which was based on decision-making by the executive through the Minister for Justice. Under the Act these reviews are undertaken every 6 months or following an application by the detained person or on the basis of the MHRB's own initiative.

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[330] *Ibid*.

[331] See Chapter 2: Literature Review, Part 2.

District court judges normally deal with the issue of the fitness of an accused for trial in criminal proceedings. In Ireland, there are a limited number of options available to the courts in this regard. Judges "… must attempt to choose between the alternative courses of action available, bearing in mind such principles as the right to liberty, the right to a fair trial and the duty to protect the accused person and/or the public in appropriate cases."[332] The 2006 Act sets out in section 4(2) that an accused person will not be deemed unfit to be tried if he or she is unable by reason of mental disorder to understand the nature or course of the proceedings so as the plead to the charge, instruct a legal representative, make a proper defence.[333]

Until the introduction of the 2006 Act a person was found guilty but insane under the provisions of the *Trial of Lunatics Act 1883* the court was obliged to commit the defendant to the CMH. In *Application of Gallagher (No 1)* [334] the applicant argued that the release of a person in such circumstances was part of the administration of justice and as such could only be carried out by a court. The Supreme Court rejected this argument. In 1991 an ad hoc Advisory Committee was established to consider whether a person still suffering from a mental disorder might be a danger to themselves or others. This Committee made recommendations to the Minister for Justice, however, its findings were not binding on the Minister. This procedure was replaced by the 2006 Act, which provides for the MHRB to review the cases of persons committed to "designated centres" following findings of unfitness to be tried or verdicts of not guilty by reason of insanity. Under the Act these reviews are undertaken every 6 months or following an application by the detained person or on the basis of the MHRB's own initiative.

The MHRB is empowered to make orders as it thinks proper in relation to the patient. They can order further detention, care or treatment, or for the discharge of the patient unconditionally or subject to conditions for outpatient treatment or supervision or orders for both. The MHRB consists of a number of persons and is chaired by a practicing barrister

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[332] Whelan "Fitness for Trial in the District Court: The Legal Perspective" (*Judicial Studies Institute Journal*: 2, 2007, page 124).

[333] Under section 1 of the Act ''mental disorder'' includes mental illness, mental disability, dementia or any disease of the mind, but excludes intoxication.

[334] [1991] 1 IR 31.

or solicitor of not less than 10 years experience or a serving or former judge of the Supreme Court, High Court or Circuit Court. The MHRB also has at least one consultant psychiatrist as an ordinary member. The 2006 Act allows the MHRB to settle to a large extent on its own procedure, and is obliged to assign a legal representative and to establish a legal aid scheme for the purpose of providing legal representation. Under the 2006 Act the MHRB is entitled to summon witnesses and take evidence on oath and sitting are held in private. Interestingly, under 12(6)(e) of the 2006 Act the Minister for Justice, Equality and Law Reform, the Director of Public Prosecutions (DPP) and the Minister for Defence can be heard or represented at the sittings of the MHRB. This presumably is to ensure that the interests of public safety receive additional safeguards. The CPT in its most recent report on Ireland stated that a comparative reading of both the *Mental Health Act 2001* and *Criminal Law (Insanity) Act 2006* indicates that patients placed under the 2006 Act potentially benefit from considerably fewer safeguards than those placed under the *Mental Health Act 2001*.[335] It noted that 2006 Act lacks provisions on the use of physical restraint, seclusion and inspection. Similarly, the mandate of the MHRB is limited when compared with that of the Mental Health Tribunal under the civil mental health system.

The IHRC in October 2009 was granted leave to appear before the Supreme Court as amicus curiae in the case *JB v Mental Health (Review Board) & Others*, which raised important issues about the extent to which aspects of 2006 Act respects human rights principles.[336] That case concerned the continuing detention of the appellant who had been found not guilty of murder by reason of insanity in the CMH.[337] The MHRB reviewed the applicant's detention, but determined that the person should be released subject to a number of conditions, although the conditions could not be legally enforced.[338] The IHRC's submission

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[335] "Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 13 October 2006" (Strasbourg: Council of Europe, 2007) at paragraph 106.

[336] [2008] IEHC 303. See the Irish Human Rights Commission website at: http://www.ihrc.ie/home/wnarticle.asp?NID=238&T=N. <Last accessed 10 November 2013>

[337] This was a tragic case where the applicant killed his 5-year-old daughter.

[338] The proceedings are entitled *JB v The Mental Health (Criminal Law) Review Board, the Minister for Justice, Equality and Law Reform, Ireland and The Attorney General*.

addressed circumstances where a person originally convicted of murder but now deemed to be "not guilty by virtue of insanity" can continue to be detained by the State. This case highlights the focus on managing dangerousness and risk. The applicant JB argued that he no longer fulfilled the criteria authorising his detention and had "responded in a very real way to the care and treatment afforded him".[339] He was on temporary release, working in a warehouse living with his family four nights each week but was required to spend three nights a week in a hostel on the grounds of the CMH. In this case the MHRB and the medical team from the CMH were happy to discharge him but wanted to attach conditions to his release.

Following this case the *Criminal Law (Insanity) Act 2010* was introduced to address the shortcoming of the 2006 Act and resulted in this case been struck out of the Supreme Court in February 2011.[340] Under the 2006 Act the MHRB is empowered to grant patients conditional discharge where it considers the patient suitable for discharge. The 2010 Act amended the 2006 Act to make provision for a patient to be returned to the "approved centre" in circumstances where they are in material breach of the conditional discharge order.

Some of the tensions that arise following the "successful" invocation of the insanity defence presented themselves in the case of *People (DPP) v B*.[341] The High Court (Central Criminal Court) in 2011, Sheehan J ordered that the defendant B be detained in the CMH after a jury found him not guilty by reason of insanity on a charge of aggravated sexual assault.[342] When the trial judge made that order he expressed "… grave concerns about the adequacy of the treatment the defendant had received during the two and a half year period that he had already been in the CMH" when he was considered unfit for trial.[343] The judge

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[339] *Ibid*.

[340] It is unfortunate that this case was settled in that the Supreme Court were required to consider the important issues around the MHRB obligations in assuming the State's functions in taking decisions on the detention of citizens, is bound by provisions of the Irish Constitution and European Convention on Human Rights.

[341] [2011] IECCC1.

[342] The defendant was tried in the Central Criminal Court on a charge of aggravated sexual assault contrary to section 3 of the *Criminal Law (Rape)(Amendment) Act 1990*. The trial took place over two days and the jury returned a verdict of not guilty by reason of insanity.

[343] *Ibid*, at paragraph 1.

was critical of B's psychiatrist whom he felt "does not see it as part of her function … to attempt to enter into a meaningful therapeutic relationship with the defendant".

The judge acknowledged that there was a "huge discrepancy in the protection afforded to patients detained pursuant to the *Criminal Law (Insanity) Act 2006* and those admitted to the CMH pursuant to the *Mental Health Act 2001*".[344] The judge expressed frustration that the 2006 Act restricted where he could commit the defendant. Sheehan J noted that the 2006 Act "removes any possibility for this Court to consider whether the CMH is appropriate, adequate or suitable for this particular defendant once it is decided that he is in need of further in-patient care or treatment".

Sheehan J accepted acknowledged that the goal of the detention of a person who raised the not guilty by reason of insanity verdict was not to punish the person. Rather the goal was to assist the person who was considered not morally blameworthy to recover.

> "All the above matters give rise to a concern as to whether the CMH is the appropriate environment in which the defendant can achieve rehabilitation, let alone the kind of environment that will allow him to flourish as a human being. The emphasis on anti-psychotic medication, with the obvious detrimental effects to his physical health, and the failure by his psychiatrist to enter into a meaningful therapeutic relationship with him, as well as the apparent lack of real interest in the sources of the defendant's illness, are all causes for concern. Furthermore, the manner in which his initial refusal of Clozapine was dealt with is also a cause for concern. Rather than using the defendant's refusal as a platform on which to build a real relationship with the defendant, every effort was made to overcome this refusal by enlisting the support of others including family members."

In Chapter 2: Literature Review, Part 2 the notions of recovery, the right to health and habilitation and rehabilitation were discussed. It was suggested that these concepts had the potential to address the human rights concerns with diversion including human rights based critiques

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[344] *Ibid*.

of the insanity defence. However, the discrepancies in the protections afforded to patients detained under the 2006 and 2001 Acts are an issue for concern and need to be addressed. The criticisms of Sheehan J call into question the extent to which a non-punitive approach to the indefinite detention of persons remitted to the CMH is provided for under the 2006 Act.

In the *People (DPP) v Redmond*[345] the issues surrounding the capacity of offenders to be held responsible was the central issue.[346] The accused pleaded guilty to the offence of assault causing harm contrary to section 4 of the *Non-Fatal Offences Against the Person Act 1997*.[347] It emerged during the course of sentencing that the offender "… had a considerable psychiatric history and had been attending hospital for psychiatric treatment on the date of the offence". The victim of the assault was a patient in the hospital where the accused had been a patient. There was no apparent motivation for the assault and the accused informed his psychiatrist after the attack that it was "… in response to voices telling him to "get them"".[348] In addition reports were submitted to the Court from a number of different consultant psychiatrists outlining the accused's mental health and his psychiatric history. A report from one psychiatrist "… drew a distinction between a core psychiatric illness activated by drugs or alcohol, and a psychiatric illness induced by drug or alcohol use".[349] The psychiatrist also suggested that the accused was suffering from a psychiatric illness that was drug or alcohol induced "… that the accused could be held responsible in law for the disorganisation that drugs and alcohol cause."[350]

The trial judge queried whether under Irish law "… persons mentally

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[345] [2006] 2 ILRM 182.

[346] The MHC in its Position Paper on forensic mental health services in Ireland emphasised the need to enact the proposed legislation on mental capacity law as a vital priority as it is core in safeguarding "… the human rights of people availing of forensic mental health services." "Mental Health Commission Position Paper: Forensic Mental Health Services For Adults in Ireland" (Dublin: Mental Health Commission, Position Paper, February 2011) at page 20.

[347] There was no disagreement as to the fitness of the accused in this case to plead.

[348] *Ibid*.

[349] *Ibid*.

[350] *Ibid*.

incapacitated for reasons outside their control fell to be treated differently from persons who were mentally incapacitated by substance abuse voluntarily undertaken". Counsel for the accused informed the trial judge that the defendant's guilty plea was motivated by his preference for a definite term of imprisonment as opposed to "… a period of indefinite detention in the CMH which would result if he were found to be insane at the time of the offence". This case illustrates the difficulties associated with the determination of criminal responsibility and the differing consequences arising from defences open to offenders with MHPs (see Chapter 2: Literature Review, Part 2). The trial judge was concerned that accepting the plea of guilty would be wrong "… on the basis that persons who were not guilty by reason of insanity were deserving of treatment rather than punishment, whereas persons who were guilty of an offence were deserving of punishment".[351]

The case was referred as a consultative case to the Supreme Court, asking whether he had the power to overrule the defendant's decision not to enter the insanity defence.[352] The Supreme Court reached a majority decision and considered that while it was possible that a verdict of insanity might be legally appropriate in the case, the trial judge was not entitled to refuse his guilty plea and force a defendant to alter his plea.[353] The rationale for the decision was based on the capacity of the accused. The Supreme Court recognised that it "… was not suggested that he was not fit to plead" and the accused was entitled to "… have tactical reasons" for his plea and that "reason that he pleaded was a perfectly good one and it could not be said to be an abuse of the process of the court."[354]

Geoghegan J recognised that at the sentencing stage it was open to a judge to take into account any physical or mental factors that could

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[351] *Ibid*.

[352] The exact formulation of the question referred to the Supreme Court is as follows: "Have I the power/duty or should I decline to act on a plea of guilty if, on the evidence before me, I am satisfied that I have substantial grounds for believing that the accused was insane at the time he committed the acts alleged to constitute the offence. Should I in those circumstances decline to accept a plea of guilty, enter a plea of "not guilty" on behalf of the accused and seek to ensure that the issue of his insanity is fully investigated in the course of his trial?"

[353] Geoghegan J, Fennelly J, Kearns J and Macken J. concurring and Denham J dissenting.

[354] *Ibid*.

"reasonably … either mitigate or aggravate a sentence".[355] Fennelly J made the point that insanity was a matter of defence and there is an assumption that a person is sane and responsible for their actions. As a consequence Fennelly J stated that a person asserting insanity must prove it, therefore a judge cannot "substitute a plea of not guilty in a case such as the present".[356] Fennelly J further stated that a person "… sane at the time he makes the plea, is entitled to choose whether to raise the defence that he was not sane at the time he committed the criminal acts with which he is charged. If he appears not to be fit to plead, the prosecution has the right to raise the issue".[357] Kearns J stated that intervention by a judge in setting aside the plea of the accused has significant consequences. He set out a test to be applied in determining whether a plea could be set aside namely that a "… judge would require to be satisfied that very exceptional circumstances are demonstrated and a very high threshold met before he actively intervenes to 'second guess' the accused and his legal or medical advisers who opt to plead or conduct a defence in a particular way." In this particular case Kearns J considered those exceptional circumstances did not exist.

In her dissenting judgment Denham J adopted a similar approach to Kearns J in that intervention could only happen in "exceptional circumstances". [358] However, she stated that the threshold of "exceptional circumstances" was met in this particular case. She considered the fact that the accused was pleading guilty with a view to avoiding detention in a psychiatric hospital (for an indefinite length of time), opting instead to obtain a definite sentence through a guilty plea was an exceptional circumstance. However, Denham J considered the fact that "… the judge had been informed of this situation and consequently would be proceeding to sentence for something which he had substantial grounds for believing was not a crime" was an even

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[355] *Ibid*.

[356] *Ibid*.

[357] *Ibid*.

[358] *Ibid*. Denham J. interestingly in her judgment held that there was an obligation on both the defence and the prosecution to raise the issue of insanity. She went further in stating "… depending on the circumstances, as well as there being a duty on the prosecution to raise the issue of insanity, there is a duty on the trial judge to raise the issue."

greater exceptional circumstance. The right to enter a plea was not an "absolute right" as the "court at all times retains an inherent jurisdiction, and indeed a duty, to protect the fairness of the proceedings, to protect a fair trial process and to protect the integrity of the court process". Another important component of Denham's dissenting judgment was that the trial judge had considerable reason for considering that the accused was "incapable of having the necessary mental element to constitute the crime". As such she considered that the "… judge was being asked to collude in a situation where he has substantial grounds for believing that there was no crime. The judge was being asked to support a sham".

Although only raised in a small number of cases the insanity defence is an important component of Irish criminal law. While the insanity defence and its rationale remains controversial and contested it is likely to be retained as a key part of the criminal law throughout the world. The principal objection to the defence from the perspective of the CRPD is that it infringes the recognition of legal capacity in Article 12. The judgment of the Supreme Court in *People (DPP) v Redmond* challenges this assertion insofar as the defence cannot be imposed on a defendant. In short the position is that a defendant preferring treatment in a psychiatric hospital can invoke the defence, while a defendant preferring a determinate sentence by not invoking the defence is entitled to plead guilty to the offence(s). This approach guards against substitute decision-making albeit that some of the judgments acknowledged that in "exceptional circumstances" the defence could be imposed on an unwilling defendant.

15. Sentencing of Offenders with MHPs and ID

The administration of the criminal justice system in Ireland has been significantly influenced "… by a dynamic judicial interpretation of the Constitution during the past 50 years".[359] The Supreme Court in *People (Attorney General) v O'Callaghan* held that an accused person could not be denied bail on the basis of predicted future offending.[360] It has been suggested that the leading decisions of the Supreme Court "… were motivated by a concern for the rights of suspects and accused

[359] O'Malley *The Criminal Process* (Dublin: Thomson Reuters 2009) at page 1.

[360] [1966] IR 501.

persons who found themselves facing the coercive power of the state."[361]

It is a well-established principle of Irish constitutional law that the sentence imposed by the court must be proportionate to the offence and the personal circumstances of the offender.[362] A trial judge calculates a proportionate sentence through locating the offence within the appropriate "scale of gravity" and then applying credit for any mitigating factors to the "otherwise proportionate sentence".[363] The mitigation is applied to the proportionate sentence not the maximum sentence, except where the offence is so serious that the proportionate sentence is the maximum sentence.[364] When sentencing an offender a judge is required to give credit to any factors such as a guilty plea or no previous convictions.[365] In sentencing all offenders including offenders with MHPs or ID a judge is never obliged to impose a custodial sentence unless the offence(s) carry a mandatory sentence.[366]

It is important to note that proportionality "… may remain the dominant distributive principle of sentencing in Irish law but it has never ousted rehabilitation as a legitimate consideration in determining the nature or severity of sanction in a specific case."[367] The sentencing judge can decide to adopt a rehabilitative approach to sentencing, for example, by not imposing an immediate custodial sentence. However, where an offence is a serious one a judge may be unwilling to do this with offenders with a MHP or ID. In addition the lack of forensic mental health services and a lack of non-custodial sentencing options results in Irish judges having little space to adopt a rehabilitative approach to sentencing. Clearly an offender who is linked in with a forensic mental health service such as PIRCLS is more likely to convince a judge to

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[361] O'Malley *The Criminal Process* (Dublin: Thomson Reuters 2009) at page 1.

[362] See *People (DPP) v O'Driscoll* (1972) 1 Frewen 351; *People (DPP) v C(W)* [1994] 1 IRLM 321; *People (DPP) v M* [1994] 3 IR 306; *People (DPP) v Kelly* [2005] 1 IRLM 19; *People (DPP) v K(G)* [2008] IECCA 110. See generally O'Malley *The Criminal Process* (Dublin: Thomson Reuters, 2009) at page 872.

[363] O'Malley *The Criminal Process* (Dublin: Thomson Reuters, 2009) at page 872.

[364] *Ibid*.

[365] *Ibid*.

[366] *Ibid*. Very few offences carry a mandatory sentence

[367] O'Malley *The Criminal Process* (Dublin: Thomson Reuters, 2009) at page 892.

impose a non-custodial sentence. Evidence that offenders with MHPs perform better in community-based alternatives to prison bolsters the case for diversion from prison, as crime reduction is a legitimate goal in sentencing. The Court of Criminal Appeal has acknowledged that it might be counter-productive to impose a custodial sentence when more positive outcomes can be achieved through keeping an offender in the community, under supervision.[368]

The presence of a mental illness or ID falling short of the insanity defence or diminished responsibility is still relevant in sentencing in Ireland. O'Malley suggests that under Irish law where a "… a casual link can be established between the illness or disability and the behaviour constituting the offence, it clearly reduces the moral culpability of the accused. His mental condition is therefore a relevant personal circumstance in the computation of a proportionate sentence" especially because it seems that proportionate sentencing is a constitutional requirement.[369] This causal link is essential as "[m]ere evidence of a mental condition or abnormality at the time of the offence is seldom sufficient to justify mitigation".[370] O'Malley suggests that the court must have regard to the impact that imprisonment will have on a person with a disability.[371] He suggests that the principle of "equivalence of impact" provides another reason to treat a mental illness or disability as a mitigating factor.[372] There is precedent that suggests that Irish courts will mitigate a sentence on the basis of an offender having an ID. The Court of Criminal Appeal in *People (DPP) v O'R (M)* referred to the "intellectual shortcomings" of the accused person in refusing an application by the DPP to review the sentence.[373]

O'Malley has noted that there is little by way of special sentencing options available to the courts "such as hospital orders, for mentally ill offenders" and "there is no easy solution … as the political branches of

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[368] *People (DPP) v Mullarney* ex tempore, Court of Criminal Appeal, July 11, 2008 cited in O'Malley *The Criminal Process* (Dublin: Roundhall, 2009) at page 893.

[369] O'Malley *The Criminal Process* (Dublin: Roundhall, 2009) at pages 880-881.

[370] See O'Malley *Sexual Offences: Law, Policy and Punishment* (Dublin: Roundhall, 2nd ed, forthcoming 2014) see "Chapter 23: General Principles of Sentencing".

[371] O'Malley *The Criminal Process* (Dublin: Roundhall, 2009), at page 881.

[372] *Ibid*

[373] [2008] 10 JIC 2004.

government have been remiss in the obligation to provide appropriate facilities for mentally ill offenders."[374] O'Malley also points out that a strictly proportionate approach as required by the Irish constitution necessitates leniency while a public protection approach involves extended incarceration.[375] While the safety of the public remains a legitimate consideration the principle of proportionate sentencing should apply.[376] However, evidence that an offender posed an immediate risk of reoffending "may well justify an immediate custodial sentence rather than … a suspended sentence or a community service order which a court might otherwise have considered".[377] This situation inevitably calls into question the basis on which the court makes a decision not to give a suspended sentence or a community service order. The lack of services and supports in the community in Ireland means that perceptions of dangerousness inevitably led to custodial sentences (see Chapter 2: Literature Review). The lack of diversion provisions, processes and initiatives in Ireland, results in the imposition of custodial sentences in circumstances where non-custodial sentence would have been sufficient. However, there still remains an obligation on the judge to determine the length of the sentence "in accordance with the proportionality principle."[378] Once a sentence is served and the offender released it is for the civil authorities to "… decide if further steps are necessary to protect the offender himself or others from harm."[379] This is a wholly unsatisfactory situation as an offender with a MHP will be punished through detention and when released may be subject to further deprivation of liberty under the *Mental Health Act 2001*.

There has been a sharp increase in the prison population since the 1990s. The factors that explain this increase have been identified as including the increased numbers of persons remanded in custody, as it is feared they will commit further offences if granted bail, the growth in the number of longer sentences and the use of temporary release as a

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[374] *Ibid*.

[375] *Ibid*.

[376] *People (DPP) v C(M)* unreported High Court, June 16 1995.

[377] O'Malley *The Criminal Process* (Dublin: Roundhall, 2009) at page 881.

[378] *Ibid*.

[379] *Ibid*.

response to overcrowding in Irish prisons.[380] Kilcommins et al suggest that it remains to be seen whether Ireland has entered into what Garland describes as the "criminal complex" as the punitive shift requires commitment and planning at the political level, which they consider has not yet happened in Ireland.[381]

16. Failure to Divert Defendants and Offenders with MHPs and ID

The Inspector of Irish Prisons has documented serious and on-going issues in Irish prisons for persons with MHPs. However, this has not disrupted decades of inaction on the issues.[382] It is not clear as to why diversion of defendants and offenders with MHPs has not developed in Ireland. One possible explanation is the development of a "culture of control".[383] However, in Ireland the demise of rehabilitation and the rise of punitiveness experience have not happened in the same way as other jurisdictions. This is unlikely to be a factor as there was little "systematic headway" in rehabilitation in Ireland and while there are "pockets" of rehabilitative practice in the criminal justice system there has been "little sustained institutional interest in rehabilitation".[384] There was little support for the idea of rehabilitation in the four decades following Irish independence, as crime rates were low, most offending was of a minor level.[385] The ownership of rehabilitative efforts in the 1970s was in the hands of religious organisations and the lack of expertise or professional activity in rehabilitative processes in

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[380] Kilcommins, O'Donnell, O'Sullivan and Vaughan *Crime, Punishment and the Search for Order in Ireland* (Dublin: Institute of Public Administration, 2004) at page 290.

[381] *Ibid*, at page 291.

[382] See the reports that are available online 2008-2012: "Office of The Inspector of Prisons Annual Report 2012" (Nenagh: Office of the Inspector of Prisons, July 2013); "Office of The Inspector of Prisons Annual Report 2011" (Nenagh: Office of the Inspector of Prisons, May 2012); "Office of The Inspector of Prisons Annual Report 2010" (Nenagh: Office of the Inspector of Prisons, May 2011); "Office of The Inspector of Prisons Annual Report 2009" (Nenagh: Office of the Inspector of Prisons, September 2010) and "Office of The Inspector of Prisons Annual Report 2008" (Nenagh: Office of the Inspector of Prisons, May 2009).

[383] See Garland *The Culture of Control: Crime and Social Order in Contemporary Society* (Oxford: Oxford University Press, 2001).

[384] Kilcommins, O'Donnell, O'Sullivan and Vaughan *Crime, Punishment and the Search for Order in Ireland* (Dublin: Institute of Public Administration, 2004) at page 288.

[385] *Ibid*.

Ireland resulted in rehabilitation not having any prominent, never mind any dominant role in Ireland.[386] The suggestion that rehabilitation has only ever operated at the "rhetorical" level in Ireland may be an important theoretical perspective, in explaining the failure of successive Governments in implementing the proposals in the Henchy Report, which would have introduced referral powers for courts and permitting them to refer persons to be assessed and access mental health services.

It has been argued that penal policy has not been politicised to the same extent as has occurred in other jurisdictions. There has certainly been an increase in the use of political rhetoric since the 1980s in Ireland regarding penal policy (EG the use of terms such as "zero tolerance"). However, this has not permeated the political discourse on crime, as crime is not a major election issue in Ireland unlike other jurisdictions.[387] The failure to respond to the needs of defendants and offenders with MHPs and ID in the criminal justice system is not a product of political antagonism towards the issues.[388] In other jurisdictions high profile cases of persons with MHPs committing homicides have impacted public policy. This has not been the case in Ireland with the discourse around the dangerousness and risk posed by defendants and offenders with MHPs not featuring prominently.

Application of Gallagher (No 1)[389] *and (No 2)*[390] is perhaps the only analogous case and it is suggested that the fall out from this case has resulted in concern in releasing persons from the CMH, but has perhaps has had little impact beyond that. However, Whelan suggests "[t]he Gallagher saga has had major implications for mental health law in Ireland over the years".[391] Gallagher shot and murdered his girlfriend and her mother on the grounds of Sligo General Hospital. His girlfriend had wanted to terminate their relationship in the week prior

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[386] *Ibid*.

[387] *Ibid*.

[388] *Ibid*.

[389] [1991] 1 IR 31.

[390] [1996] 3 IR 10.

[391] Whelan "John Gallagher and mental health law" (Irish Law Updates, 23 May 2012). Available at: http://irishlawblog.blogspot.ie/2012/05/john-gallagher-and-mental-health-law.html. <Last accessed 10 November 2013>

to her homicide; however, Gallagher did not accept this and persisted in contacting her. The week prior to the homicides Gallagher attacked a man with a knife as the man had danced with his girlfriend. Three days before her homicide the victim made a report to the Gardaí that Gallagher had raped her. When he was questioned about the rape he admitted himself to the local psychiatric hospital. However, the following day he discharged himself as his girlfriend decided not to pursue the charge, as she was apprehensive of the publicity that would be associated with the trial. He went to his home got a gun and shot both women, after which he "drove wildly around Donegal", handcuffed himself to the wheel of his car and drove into the sea. Gardaí who were in pursuit rescued him from his car.[392]

At his trial Gallagher admitted shooting the two women and raised the insanity defence. There was conflicting psychiatric evidence provided to the court. One psychiatrist was of the view that the handcuffing incident demonstrated that his judgment and emotional control was impaired at the time of the offence.[393] Another psychiatrist gave evidence that Gallagher was taking slimming tablets that may have caused a "paranoid schizophrenic attack".[394] Another psychiatrist gave evidence that Gallagher was not suffering from a mental illness at the time of the commission of the offence and that his actions could be explained as the "ordinary human emotions of jealousy and revenge".[395] The jury in the case decided in a majority verdict of 10-2 that Gallagher was guilty but insane and he was sent to the CMH. He made a number of applications including one within 6 months to the High Court to be released on the basis that he was no longer insane, supported by medical evidence.[396] The High Court rejected his initial application as it considered that it was a matter for the executive to decide upon his release, a decision that the Supreme Court upheld.

This case is telling for a number of reasons. As McAuley suggests the statements from the Minister for Justice at the time on the Gallagher

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[392] For a good description and discussion of the case see McAuley *Insanity, Psychiatry and Criminal Responsibility* (Dublin: Roundhall Press, 1993) at pages 122-125.

[393] *Ibid*, at page 123.

[394] *Ibid.*

[395] *Ibid.*

[396] *Application of Gallagher (No 1)* [1991] 1 IR 31.

case indicated a suspicion that he ought not to have succeeded with the insanity defence but rather the partial defence of diminished responsibility.[397] However, that was a defence that would not be on the statute books until the 2006 Act. The Government could not be seen to facilitate Gallagher's release, as the perception would be that he was literally getting away with murder. A number of applications by Gallagher seeking his release followed and in *Application of Gallagher (No 2)* in 1996 the High Court found that Gallagher did not have a mental disorder rather that he had a personality disorder.[398] However, the High Court upheld the legality of his continued detention on the basis of the existence of the personality disorder. The High Court judgment could be criticised for failure to consider the significant delays by the Minister for Justice in implementing the independent review system (now provided for by the *Criminal Law (Insanity) Act 2006)*. Importantly the court established that Gallagher could not be involuntarily detained solely on the basis that he was perceived to pose a risk as that would amount to preventative detention. In 2000 following another failed legal challenge to secure his release from the CMH, Gallagher absconded and was living in NI. The case caused much controversy and haunted the development of law and policy in the area for many years, particularly around the powers to recall person on release from the CMH.[399] In May 2012 Gallagher presented himself to the CMH and was subsequently released a short time later following a review by the MHRB as he detention would be unlawful under the 2006 Act presumably on the basis he did not have a mental disorder or pose a risk to the public.[400]

Given the foregoing discussion the discourse around dangerousness and risk cannot be identified as the factor that has limited the development of diversion provisions, processes and initiatives in Ireland. In fact diversion can be used negatively to manage and control

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[397] McAuley *Insanity, Psychiatry and Criminal Responsibility* (Dublin: Roundhall Press, 1993) at pages 123.

[398] *Application of Gallagher (No 2)* [1996] 3 IR 10.

[399] The controversy surrounding recall powers is evidenced by the inclusion of the issue within the terms of reference of the current Department of Justice Review of the Criminal Law (Insanity) Act 2006.

[400] Harkin "Notorious killer John Gallagher surrenders after 12 years on the run" (Irish Independent, 23 May 2012).

defendants and offenders with MHPs and restrict their human rights.[401] A possible explanation of the failure to develop diversion is the resistance of mental health professionals to formal diversion, as evidenced by the submissions on the Green Paper, discussed above. Dhanda notes that mental health professionals "have been found to appear in two ways in the legal context: as pressure groups before legislatures and as expert witnesses before courts".[402] She also notes "as pressure groups before legislatures, they have at different times lobbied for greater professional empowerment" and the "deregulation of the care and treatment" of persons with MHPs.[403] The failure to develop formal diversion then ensures that mental health professionals retain greater control over the entry of defendants and offenders with MHPs into general psychiatry services.

The dominance or at least historical dominance of psychiatry in policy formation in Irish mental health is illustrated by the discourse around the review of the *Mental Health Act 2001*. The *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* advocated a human rights based approach and a move away from the paternalistic approach adopted in the current legislation.[404] Reflecting on this approach Professor Harry Kennedy a prominent forensic psychiatrist referred to a "real risk of groupthink in the process of reviewing and revising such laws. Excluded from the current process are any of those clinicians or carers who provide for the most rapidly growing group of people with severe mental illness – not in the community, not in hospitals, but in prisons".[405] Professor Kennedy was critical of the lack of involvement of forensic psychiatrists in this review process, in terms of membership of the group, perhaps reasonably so in view of the population that he works with. However, Professor Kennedy's comments indicate a view that reform or consideration of reform requires the central involvement of clinicians.

"Groupthink allocates mental health legislation to the DOH and

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[401] See Chapter 2: Literature Review, Part 2.

[402] Dhanda *Legal Order and Mental Disorder* (New Dehli: Sage Publications, 2000) at page 319.

[403] *Ibid*.

[404] See "Interim Report of the Steering Group on the Review of the Mental Health Act 2001" (Dublin: Department of Health, 2012).

[405] Kennedy "Libertarian groupthink not helping mentally ill" (Irish Times, 12 September 2012).

> criminal insanity law to the Department of Justice, and surprisingly allocates mental capacity law and disability law to the Department of Justice also – a unique combination of groupthink and lack of joined-up thinking. There should instead be a shared functionality between this congeries of statutes that can best be compared to a Russian doll, starting with all-encompassing disability legislation, within which sits mental capacity legislation, then mental health legislation and (the smallest and most difficult to find) criminal legislation regarding the mentally disordered.
>
> Legal groupthink holds that rights form a hierarchy and the right to freedom takes priority over all other rights. In the US, this doctrine is used to justify leaving untreated mentally ill people to wander the streets, homeless, hungry, helpless, tormented and deprived of dignity."

While Professor Kennedy's comments reflect a view that mental health professionals ought to inform (and perhaps also set) the law reform agenda. They also point up the disconnection of the on-going law reform processes on mental capacity law and mental health law. The DOJ in 2011 commenced a review of the *Criminal Law (Insanity) Act 2006*. The DOJ through a limited consultation process, are examining whether the *Criminal Law (Insanity) Act 2006* can be amended to facilitate schemes for the diversion of persons with mental disorders who have committed minor offences from the criminal justice system. It is of note that the terms of reference for the Review also include the reform of the defence of insanity and procedures for the recall of persons released from the CMH. There is no mention of persons with ID coming into contact with the criminal justice system, within the terms of reference for this review.

A number of things are striking when one considers this review process. First, the scale of the review process is very limited. To date there has been no wide public consultation process; rather the DOJ have taken a targeted approach in identifying professionals with an interest in the area and seeking their views on the terms of reference. The second aspect that is relevant for the purpose of this thesis, is that it is taking place at the same time as the on-going review of the *Mental Health Act 2001* and publication of the *Assisted Decision-Making (Capacity) Bill 2013*, which will repeal and replace the *Regulation Lunacy (Ireland) Act*

1871. These law reform processes are happening in isolation with no coherent or consistent work on the issues of defendants and offenders with MHPs and ID coming into contact with the criminal justice system. The on-going review of the *Mental Health Act 2001* is essentially a substantive review of the legislation as required by section 75 of the Act. The Interim Report was published in 2012 with the final report due for publication shortly.[406] The continued disconnection between the civil mental health law (the 2001 Act) and the criminal mental health law (the 2006 Act) is disappointing and undermines any synergy for the development of diversion provisions, processes and initiatives for persons with MHPs coming into contact with the criminal justice system.

The disconnection is all the more disappointing as the approach of the Steering Group in the Interim Report is generally very positive in aligning itself closer to the guiding principles of the CRPD. For example, there is a recognition that the guiding principles of the 2001 Act should not be based on the "best interests" approach and should instead be based on a "rights based approach" and an assertion that "paternalism is incompatible" with this approach.[407] It was also provisionally recommended that autonomy and self-determination should replace "best interests" as the guiding principles for the legislation.[408] The other hierarchy of rights recommended include bodily integrity, recovery and least restriction.[409] The proposals are perhaps not as radical as they initially sounded, as the rebuttable presumption of capacity is retained (see Chapter 2: Literature). While some of the concepts are at odds with the evolving provisions in the CRPD, for example Article 12, the approach is aligned more closer with the CRPD than previously. The approach taken to the review of the 2001 Act, if implemented could facilitate formal diversion.

The Thornton Hall Review Group in its Report recommended that the DOJ examine the issue of persons with mental illness coming into

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[406] "Interim Report of the Steering Group on the Review of the Mental Health Act 2001" (Dublin: Department of Health, 2012).

[407] *Ibid*, at page 11.

[408] *Ibid.*

[409] *Ibid.*

contact with the criminal justice system.[410] The Minister for Justice acting on the recommendation created an Interdepartmental Group to look at the issue and report back. The membership of the Interdepartmental Group includes representatives from the DOJ and the DOH, as well as relevant services including the HSE, the National Forensic Mental Health Service, the Garda Síochána and the Irish Prison Service. This latest instalment in the review process is disconnected from the other reviews and it is unlikely that its recommendations will have any impact. The membership of the Interdepartmental Group is limited with no attempt (it seems) for independent membership or expertise. Interestingly, members of the legal profession and the judiciary are not represented on this Group. There has been little civil society advocacy on the issue of diversion. While Amnesty International and Mental Health Reform have made submissions and have referenced the experience of persons with MHPs coming into contact with the criminal justice system as part of their work no substantial engagement with the issues has happened to date.[411]

The Interdepartmental Group was convened at a time when there was a unique opportunity to examine the treatment of persons with MHPs (and persons with ID if they expanded their terms of reference) who come into contact with the criminal system, against a broader law reform agenda the 2001 Act and the 2006 Act and the development of legal capacity legislation. This review process is also happening against a backdrop of Ireland's preparations to become a State Party to the CRPD. However, given the lack of external expertise or perspectives and the dominance of mental health professionals in

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[410] "Report of the Thornton Hall Project Review Group" (Dublin: Department of Justice, July 2011). The Review process is jointly chaired by both the Department of Health and the Department of Justice.

[411] Amnesty International produced a Report in 2003 that set out criticisms of the treatment in Ireland of persons with MHPs in light of international human rights law. See "The Neglected Quarter" (Dublin: Amnesty International Ireland, 2003). A significant amount of the Report considered the discrimination faced by persons with MHPs who came into contact with the criminal justice system. Amnesty International also made a submission to the Interdepartmental Group as did Mental Health Reform. See "Submission to the Interdepartmental Group to examine the issue of people with mental illness coming into contact with the criminal justice system" (Dublin: Amnesty International Ireland, May 2012) and "Submission to the Interdepartmental Group to examine the issue of people with mental illness [sic] coming into contact with the criminal justice system" (Dublin: Mental Health Reform, 2012). However, engagement has been piecemeal and have not compromised a central part of their research or campaign strategies.

dominating the discourse around offenders with MHPs, and their centrality in this group, it is suggested that this review is unlikely to yield any novel recommendations.

The assertion by the IPRT that there is a lack of interest in the rights of prisoners with MHPs is further evidenced by examination by reference to the NGO and service user landscape in Ireland. A very powerful NGO lobby has campaigned effectively, for respect for the human rights of persons subject to the *Mental Health Act 2001*. Amnesty International campaigned specifically on mental health and human rights in Ireland from 2003 until 2013 and produced a comprehensive Review of the *Mental Health Act 2001*, prepared for use by NGOs and stakeholders to use the language of human rights in campaigning for reform of the legislation.[412] Mental Health Reform (formerly the Irish Mental Health Coalition) has been very influential in campaigning in the area of mental health law and policy. It is disappointing then that neither organisation campaigned for diversion as part of the on-going reviews of the 2001 and 2006 Acts.[413] It is argued that without the political power of the civil society lobby, that has proved to be essential for progressing reform of mental health law and policy in the civil context, it will be even more challenging to develop law and policy in respect of defendants and offenders with MHPs and ID coming into contact with the criminal justice system.

Article 31 of the CRPD requires the collection of statistics. Article 31 reflects that rational policy is dependant on the availability of an accurate picture of the status of PWDs; as such it makes sense that the CRPD requires the collection of such data in order to give effect to the Convention. In that regard the lack of research and data on defendants and offenders with MHPs and ID can be identified as a major deficit that has contributed to the failure to develop formal diversion programmes. There is no research office within the DOJ and there is little official data published by the Government on the operation of the different parts of

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[412] "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011).

[413] However, both organisations did produce submissions to the interdepartmental group, see "Submission to the 'Interdepartmental Group to examine the issue of people with mental illness coming into contact with the criminal justice system'" (Dublin: Amnesty International Ireland, May 2012) and "Submission to the Interdepartmental Group to examine the issue of people with mental illness [sic] coming into contact with the criminal justice system" (Dublin: Mental Health Reform, 2012).

the criminal justice system.[414] There has been little information on sentencing patterns, with initial steps towards addressing this information gap through the Irish Sentencing Information System.[415] However, the cumulative effect of the large deficits in data "is that the criminal justice terrain remains poorly mapped".[416] These massive data deficits make the study of the Irish criminal justice system and policy development difficult and it has been observed that "even the most straight forward question [is] frustratingly difficult to answer and has created an environment where important decisions are taken by policymakers starved of reliable, consistent and current information".[417] It has also been observed that we know more about approaches to policing and imprisonment in the 19th century than we know about these issues in the late 20th century as the statistics collected by Victorian civil servants on sentencing and punishment are in many ways superior to the statistics we now have.[418]

Professor Frances Ruane the Director of the Economic and Social Research Institute had commented on some of the "less-positive feature[s]" of policymaking such as the "extensive use of 'expert groups' operating over relatively short periods, often required to develop major strategy positions".[419] She commented that other countries use such groups occasionally Ireland "seems to use them more frequently".[420] Ruane calls into question the utility of policymaking through the expert group model, highlighting the uncertainty of their role and asking whether they are intended to "generate new ideas" or to "challenge conventional thinking" or to build greater policy coherence or to develop a broader consensus.[421] She also questions the independence of the expert groups and "how … they make sense of existing research

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[414] Kilcommins, O'Donnell, O'Sullivan and Vaughan *Crime, Punishment and the Search for Order in Ireland* (Dublin: Institute of Public Administration, 2004) at page vii.

[415] See http://www.irishsentencing.ie. <Last accessed 10 November 2013>

[416] Kilcommins, O'Donnell, O'Sullivan and Vaughan *Crime, Punishment and the Search for Order in Ireland* (Dublin: Institute of Public Administration, 2004) at page vii.

[417] *Ibid*.

[418] *Ibid*.

[419] Ruane "Research evidence and policymaking in Ireland" (*Administration*: 60(2), 2012, pages 119-138) at page 127.

[420] *Ibid*, at page 128.

[421] *Ibid*.

evidence" and the quality of the reports produced. She also questions whether it would be more desirable and transparent to "develop expertise within the relevant departments and agencies" and then circulate the reports for broader circulation.[422]

In the area of policy implementation Molloy has identified "severe implementation deficit disorder" as a significant barrier to addressing a variety of problems in Ireland.[423] Molloy noted that enquiries and investigations have made very sensible recommendations on a range of different areas including mental health services and that even when resources are available there has been a failure to implement recommendations made.[424] He suggested that the "carriers of implementation deficit disorder" are organised groups with strong bargaining power such as barristers, the trade unions, medical consultants, property developers, senior public servants, executives and board members who have reached the top.[425] He also noted that executives and board members reached the top "because, in most cases, they were competent but, more importantly, because they were a good cultural fit … unlikely ever to have questioned the prevailing culture".[426]

Molloy suggests a number of recommendations to address the "implementation deficit disorder", which are relevant here to addressing the failure to progress law and policy reform in relation to defendants and offenders with MHPs and ID in contact with the criminal justice system. One of Molloy's recommendations relates to the need for external help, which is essential as reform is difficult to achieve from the inside and reform within a closed system is impossible to achieve.[427] It is also suggested that it is necessary to address institutional cultures, which are identified as the "root cause of failure and the biggest obstacle to reform".[428] Molloy suggests that even if the

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[422] *Ibid*.

[423] Molloy "Ireland's Sixth Crisis Severe: Implementation Deficit Disorder" (Glenties: 30th MacGill Summer School, "Reforming the Republic", 19 July 2010) at page 1.

[424] *Ibid*.

[425] *Ibid*, at page 2.

[426] *Ibid*.

[427] *Ibid*, at page 3.

[428] *Ibid*, at page 7.

"interdepartmental Group to examine the issue of people with mental illness coming into contact with the criminal justice system"" it is unlikely that novel or interesting recommendations are likely to be forthcoming. Even if innovative, workable recommendations on formal diversion such as those recommended by the Henchy Committee in 1978, it is unlikely that they will be implemented.

While the implementation deficit disorder may explain policy stagnation, Judge Dermot Kinlen the former Inspector of Prisons, suggested a more pessimistic view of stagnation in penal policy:

> "I have unfortunately discovered as Inspector of Prisons, Ministerial and Departmental obsession with power, control and secrecy has changed little in the intervening twenty years, nor has the disdain for independent criticism or oversight of the workings of the DOJ and the Prison Service. For this reason, far too many of the problems identified … have not been addressed, and continue to thrive today".[429]

17. Community Treatment Orders

Ireland has not developed legislative provisions for compulsory treatment in the community in the same manner as other jurisdictions. However, there has been an interest in developing powers to compel treatment in the community in Ireland in order to ensure patients comply with their treatment upon release.[430] Section 26 of the *Mental Health Act 2001* provides that a consultant can grant leave to a person involuntarily detained to be temporarily discharged. The consultant can attach conditions to the release and permission can be withdrawn at any time. While the MHC is of the view that the purpose section 26 is to "to accommodate the gradual reintegration of a person into the community on a controlled basis in advance of complete discharge" there has been concern that the provision is being used as a form of

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[429] "The Whitaker Report 20 Years On: Lessons Learned or Lessons Forgotten" (Dublin: Irish Penal Reform Trust, 2007) at page 54.

[430] See "Community Treatment Orders and Readmissions" (Dublin: Health Research Board). This research examined the need for community treatment orders given the high rates of readmission, which was described as a "revolving door" process.

community treatment order.[431] Amnesty International has been critical of the use of section 26, describing its use as imposing "*de facto* community treatment" without proper safeguards and guidance on the use of the power.[432]

Powers compelling treatment in the community are used to mitigate the risks posed by diverting persons with MHPs from the criminal justice system into the community.[433] The failure to develop provisions mandating community treatment may have restricted the development of diversion provisions. The absence of control over persons with MHPs diverted into the community, would be essential given the Gallagher controversy, which resulted in much concern amongst politicians, psychiatrists and officials in the DOJ with the limitations of power to recall persons released from care into the community.

18. Defendants and Offenders with ID

The increased visibility of persons with ID in the community means that anti-social or criminal conduct is also more visible in the community, and is increasingly being dealt with in the criminal justice system.[434] However, there has been little research on the prevalence of defendants and offenders with ID in contact with criminal justice system in Ireland. This section examines the available literature and the relevant law and policy relating to defendants and offenders with ID.

18.1. Commission of Inquiry on Mental Handicap 1965

In understanding how the criminal justice system responds to defendants and offenders with ID it is first necessary to consider the Report of the Commission of Inquiry on Mental Handicap. The Report published in 1965 facilitated the move away from institutional care to the provision of community care for persons with ID.[435] The approach

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[431] "Mental Health Commission Report Annual Report 2009" (Dublin: Mental Health Commission, 2009) at page 84.

[432] "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011) at page 133.

[433] See Chapter 2: Literature Review, Part 1.

[434] *Ibid*.

[435] "Report of the Commission of Inquiry on Mental Handicap" (Dublin: Stationary Office, 1965) at page xxvi. The terms of reference for the Commission were narrow asking the Commission

of the Report was very much of its time, rooted in a medical model of disability the saw "mental handicap" as "one of our gravest problems in the fields of health and education".[436] The Commission asserted that "mental handicap" results "in great loss to the nation through lack of productivity, through under productivity of the mentally handicapped and through the dependency of the mentally handicapped on others" and that in "probably every country, the amount of money and effort heretofore expended on prevention, care and treatment has been out of proportion to the impact of mental handicap on the individual, the family and the community". [437]

However, despite the Commission's dated approach it did note that experience had demonstrated that "the potential ability of the mentally handicapped is far greater than was previously believed … given suitable care and treatment, particularly when they are young, a large number will be able to lead an independent existence". [438] The Commission also noted that many persons had the capacity to make "a contribution towards their maintenance and the dependency of the vast majority will be greatly reduced".[439] In addition the Commission gave the nod to independent living and acknowledged the increasing provision of special services for persons with "mental handicap" from the 1950s. The Commission emphasised the need for what we might now describe as "awareness raising" and recommended the "dissemination of information" about "mental handicap" with a view to informing public opinion. The Commission considered this "as one of the most important duties of workers in the field of mental handicap".[440]

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to report on facilities, services and training and education for persons with "mental handicap" and how these could be improved or augmented. The Commission was also asked to report on the need to improve and augment the training for persons providing care, treatment or training to persons with "mental handicap". The Commission were also mandated to report on the arrangements for employment placement or after-care of "mentally handicapped persons who have been trained in institutions" and how these could be improved and augmented.

[436] *Ibid*, at page xiii.

[437] *Ibid*.

[438] *Ibid*.

[439] *Ibid*.

[440] *Ibid*, at pages 169-170. They also recommended that the National Association for the Mentally Handicapped in Ireland should, receive public monies in order to disseminate information about "mental handicap" through "suitable literature, films and publicity material to interested persons and groups".

The Commission made a number of important recommendations in respect of the "mentally handicapped" and the criminal justice system, (even though outside the narrow scope of its terms of reference), which are relevant today.[441] The Commission recommended the creation of a special centre for "mentally handicapped delinquents", to respond to circumstances where a person "suspected of being mentally handicapped appears before a court".[442] It was envisaged that this centre would facilitate the court with disposal through "diagnostic and assessment services" and the provision of reports to assist the court.[443] The Commission also recommended diversion powers for the court to remand "mentally handicapped" persons to a centre willing to accept him, or to the special centre for "mentally handicapped delinquents".[444] The recommendations were vey much based on the notion of diversion as the Commission envisaged powers for the court "to permit the Courts to remand mentally handicapped persons to homes for the mentally handicapped instead of to prisons".[445]

The 1965 Report came at a time when there was a growing awareness of persons with ID. There was consideration of compulsory treatment for persons with "mental handicap" and how to respond to circumstances where parents or guardians opposed the provision of services.[446] The Commission envisaged that persons with ID would generally be admitted to services informally but that there would be a small number of adults that necessitated the creation of "powers of compulsory admission and detention".[447] These admissions were to be made either in the person's own interests, or the interests of others.[448] In that regard the Commission recommended that provisions similar to those in the mental health legislation be enacted to regulate

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[441] *Ibid*, at page 161.

[442] *Ibid*.

[443] *Ibid*.

[444] *Ibid*.

[445] *Ibid*, at page 163.4

[446] *Ibid*, at page 162.

[447] *Ibid*.

[448] *Ibid*.

compulsory admission and detention.[449] The Commission envisaged that any power of detention ought to be limited initially to one year and should be renewable for periods not exceeding five years and recommend a number of other procedural safeguards around the deprivation of liberty.[450]

The recommendations of the Commission discussed above remained unimplemented. Persons with ID are dealt with in the same way informally in terms of admission to services with some subject to informal compulsion. However, from the 1960s onwards services for PWDs expanded in Ireland and persons with ID have become more visible in the community. There has been recent focus on the need to move away from congregated settings for persons with ID to community living in line with Article 19 of the CRPD.[451] There has been a systemic failure to inspect ID services, with voluntary standards issued by the National Disability Authority (NDA) and the Health Information and Quality Authority (HIQA). The "bournewood gap" identified by the ECtHR judgment in *HL v United Kingdom* exists in Ireland and it remains to be seen whether the new capacity legislation or interim review of the mental health legislation will adequately address this.[452]

18.2. The Literature on Defendants and Offenders with ID in Ireland

There is little Irish literature on defendants and offenders with ID.[453] It

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[449] *Ibid*.

[450] *Ibid*.

[451] See "Time to Move on from Congregated Settings: A Strategy for Community Inclusion" (Dublin: Health Service Executive, Report of the Working Group on Congregated Settings, June 2011). Representative bodies of persons with ID (EG Inclusion Ireland) have lobbied the forthcoming legislation, which will repeal and replace the wardship system. The wardship system has stripped persons with ID of their legal capacity and subjected wards to a harsh regime of substitute decision -making.

[452] *HL v The United Kingdom* (Application No 45508/99, Judgment 5 October 2004). For a discussion of deficiencies of the current Irish law see Murray "Safeguarding the Right to Liberty of Incapable Compliant Patients with a Mental Disorder in Ireland" (*Dublin University Law Journal*: 29, 2007, pages 279-311).

[453] For example, it was noted that there has been no research examining the level of criminal behaviour amongst service users of Irish mental health services who have an ID. See "A National Survey of Offending Behaviour amongst Intellectually Disabled Users of Mental Health

has been suggested that criminal offending by persons with ID "is often under-reported" in Ireland.[454] There was little discussion of defendants and offenders with ID in the Whitaker Report in 1985.[455] The Committee considered that the appropriate response was to develop specialised programmes that placed an "emphasis on remedial education" and suitable placement upon release from prison. This seems to reflect the trend in the UK where it is suggested that a significant number of persons with ID in the UK are being formally or informally managed in the community since deinstitutionalisation. The literature internationally suggests that there has been a reluctance to prosecute defendants with ID.[456]

It was suggested in "A Vision for Change" that issues pertaining to competence and *mens rea* complicate holding a person with ID accountable for criminal conduct.[457] Another suggested reason for the under-reporting of criminal behaviour of persons with ID might be that blurring between criminal conduct and behaviour that is considered to be "challenging".[458] The Irish College of Psychiatrists in their Report also noted that the under-reporting creates difficulties of offending behaviour was in part due to this overlap and suggested that under-reporting creates difficulties in defining and measuring offenders with ID.[459] In other jurisdictions it has suggested that the failure to develop dedicated services for offenders with ID was stifled as offenders with MHPs fell between different services and the lack of dedicated funding.[460]

Services in Ireland" (Dublin: National Disability Authority, 2008).

[454] "A Vision for Change" (Dublin: Stationery Office, 2006) at page 132.

[455] "Report of the Committee of Inquiry into the Penal System" (Dublin: Stationary Office, 1985) at page 87. Five and a half lines of text was dedicated to the issue with the Committee recommending that greater efforts should be made to identify prisoners with "mental handicap" and "slow learners".

[456] See Chapter 2: Literature Review, Part 1.

[457] "A Vision for Change" (Dublin: Stationery Office, 2006).

[458] Emerson *Challenging Behaviour: Analysis and Intervention in people with Learning Disabilities* (Cambridge: Cambridge University Press, 1995).

[459] "People with a Learning Disability who Offend: Forgiven but Forgotten? (Dublin: The Irish College of Psychiatrists, 2007, Occasional Paper 63) at page 5.

[460] Myers "On the Borderline? People with Learning Disabilities and/ or Autism Spectrum Disorders in Secure, Forensic and other Specialist settings" (Edinburgh: Scottish Development Centre for Mental Health, 2004). See Chapter 2: Literature Review, Part 1.

In the key informant interviews that were undertaken to inform this research the invisibility of persons with ID within the criminal justice system was highlighted.[461] It was suggested that defendants with an ID might not want their legal representative to inform the court that they had an ID as the proceedings are in open court.[462] It was suggested that "codes" are used to convey to the judge that a person is "vulnerable" in circumstances where disclosure in open court is not possible.[463] A solicitor may also refer subtly to services that a person is in receipt of and inform the judge that a representative of a service is present in court.[464] It was suggested that persons with ID are over-represented in Irish prisons.[465] If someone is found fit they are rushed through the system with little support, particularly persons considered to have mild ID.[466]

Another interview with a key informant suggested that a number of service users with an ID are sometimes identified as expressing "paedophiliac inclinations", which require restrictions to protect children.[467] Restrictions imposed by the service include supervision when out in public or limiting the persons' movements within the service.[468] It was suggested that if no allegation of a crime had been made then Gardaí are not involved.[469] In cases where there were allegations Gardaí were contacted but prosecutions did not follow investigation.[470] The service had little guidance on the legality of the imposition of these restrictions and sought to balance decisions

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[461] See Chapter 1: Introduction for background to the key informant interviews and for a discussion of the methodology.

[462] "Key Informant Interview Number 9: Practicing Solicitor" (Transcript of interview on file author).

[463] *Ibid*.

[464] *Ibid*.

[465] "Key Informant Interview Number 4: Forensic Psychologist" (Transcript of interview on file with author).

[466] *Ibid*.

[467] "Key Informant Interview Number 11: Manager Residential Service for Persons with Intellectual Disability" (Transcript of interview on file with author).

[468] *Ibid*.

[469] *Ibid*.

[470] *Ibid*.

through the human rights committee for the service.[471] The absence of human rights compliant law in Ireland means that these restrictions are taking place informally with no safeguards against restrictions on liberty and with no oversight. One key informant suggested that rights committees were used as a means of reviewing restrictions.[472] However, this informal review process would not satisfy the requirements of the ECHR in requiring an independent overview of deprivation of liberty.

The invisibility of persons with ID dealt with informally in services has been compounded by the lack of independent inspection standards for such services. Until November 2013 there was no independent inspection of residential services for persons with ID. The lack of independent review led to an invisibility issue and increased risk of exploitation and abuse of PWDs.[473] The lack of inspection has meant that the approach of service providers in Ireland to service users considered to have committed a crime or likely to do so has not been open to independent review and scrutiny. The Health Information and Quality Authority (HIQA) new standards (2013) for the first time provide for the independent inspection of public, private or voluntary bodies or organisations providing residential services and or residential respite services.[474] The new standards are very paternalistic in nature as evidenced by the principles underlying the standards (EG "Safeguard and protect each person").[475] However, there is also a commitment to provide "care and support to promote autonomy".[476] The standards are not robust with regard to protecting the right to liberty but there is recognition of promoting "integration within the community and the development of social networks".[477] HIQA can play a pivotal role in

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[471] *Ibid*.

[472] *Ibid*.

[473] See "Final Report of the Commission of Inquiry into Child Abuse" (Dublin: Commission of Inquiry into Child Abuse, 2009) and "Enquiry Report on the Human Rights Issues Arising from the Operation of a Residential and Day Care Centre for Persons with a Severe to Profound Intellectual Disability" (Dublin: Irish Human Rights Commission, 2010).

[474] See "National Standards for Residential Services for Children and Adults with Disabilities" (Dublin: Health Information and Quality Authority, 2013).

[475] *Ibid*, at page 6.

[476] *Ibid*, at page 5.

[477] *Ibid*, at page 6.

bringing visibility to the response of services to service users who are considered to pose risk to others. There is provision in their 2013 standards for examining this issue. Under the standard on the "rights and diversity of each person" persons should be "given appropriate assistance to engage in legal proceedings, and are encouraged to access legal advice and representation in any forum where their rights are being determined, in litigation, or when any criminal charge is made against them".[478]

"A Vision for Change" has recommended the development of forensic mental health services and forensic services for persons with ID. Under "A Vision for Change" forensic mental health services are to be provided in the form of; four additional multidisciplinary, community-based forensic mental health teams to be provided nationally (on the basis of one per HSE region); 10-bed dedicated residential facility with a fully resourced child and adolescent mental health team provided with a national remit and an additional community-based, child and adolescent forensic mental health team should also be provided; 10 bed residential unit with a fully resourced multidisciplinary mental health team for care of intellectually disabled persons who become severely disturbed in the context of the criminal justice system.[479] It remains to be seen what services will actually be provided in the proposed facility to replace the CMH (see above).

Following the publication of "A Vision for Change" the Forensic Learning Disability Working Group was established by the Irish College of Psychiatrists with the goal of assessing the level of need for a Forensic Learning Disability Service in Ireland and develop a position paper.[480] In that regard a national survey was carried out in order to feed into its position paper "People with a Learning Disability who Offend: Forgiven but Forgotten".[481] The Irish College of Psychiatrists welcomed the commitment to a forensic ID service in Ireland as

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[478] *Ibid*, at page 64.

[479] "A Vision for Change" (Dublin: Stationery Office, 2006) at pages 136-141.

[480] There was much anecdotal evidence of significant unmet need in this area, which formed the main impetus for this work.

[481] "People with a Learning Disability who Offend: Forgiven but Forgotten? (Dublin: The Irish College of Psychiatrists, 2007, Occasional Paper 63).

envisaged in "A Vision for Change".[482] However, the College was very critical of the level of service to be provided (10 bed residential unit) as they considered "… it inadequate when compared with the service provision recommended in the research literature."[483] As part of this research they conducted a survey of service providers in Ireland. This involved a consultation with stakeholders using focus groups. The main findings of the Working Group survey were that 431 persons with a learning disability and offending behaviour were identified nationally and the majority of this population consisted of "males with learning disability in the moderate or severe range."[484] The survey also reported that the majority of service providers strongly supported the urgent development of a forensic service for persons with ID. The survey revealed, "105 patients reported to require urgent forensic service assessment, care and treatment."[485]

The College while welcoming the development of court diversion schemes pointed out the need to include in the development of diversion schemes provision for persons with an ID who offend.[486] The Report was critical of the procedures for the admission of persons with ID to mental health centres under the *Mental Health Act 2001* and the *Criminal Law (Insanity) Act 2006*. It was considered that the existing facilities largely provided general adult psychiatric services that do not cater to the specialist facilities required for "… assessment, care and treatment".[487]

In the survey carried out by the College the range of learning disability reflected the population catered for by ID service providers. Therefore, offenders with "mild" ID were not captured in the data. However, there is other available evidence that suggests that a significant proportion of the prison population have a mild "learning disability". Research commissioned by the DOJ examined the incidence of "learning

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[482] *Ibid*, at page 5.

[483] *Ibid*.

[484] *Ibid*.

[485] *Ibid*, at page 6.

[486] *Ibid*.

[487] *Ibid*. There was also criticism of the placement of persons with ID deemed unfit to stand trial in the CMH as opposed to a specialised service.

disability" in the Irish prison population from a randomly selected sample of 264 prisoners.[488] The study revealed 28.8% of the sample scored below 70 on the Kaufman Brief Intelligence Test, which represents one of the necessary indicators of "learning disability".[489] The data collected also indicated that the average school leaving age was 14.67 and 80% had never seen a school counsellor or psychologist while at school.[490] Interestingly 65.5% of the sample population had been suspended from school at some stage and 40.2% of the sample population had been expelled from school.[491] It was suggested in this study that the "… nature of their disability presents additional challenges to services for the prevention and management of criminal behaviour".[492] It was further suggested that addressing the problems of offenders with "learning disability" required specialised support services within the criminal justice and education systems that respond to specific needs.[493] Other recommendations in the Report related to early identification and the provision of support to children with learning disabilities "… who are at high-risk for later delinquency".[494]

There was also a recommendation to develop diversion services for defendant and offenders with "learning disability", which would include an "early-warning" screening system that identifies individuals with "learning disability" when they first come into contact with the criminal justice system.[495] It recommended that Gardaí should operate a brief screening assessment and a "systematic referral for full psychological assessment of all individuals who are identified through the screening process".[496] Other recommendations included the development of specialised probation services that could work to integrate offenders

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[488] Murphy et al "A Survey of the Level of Learning Disability Among the Prison Population in Ireland" (Dublin: Department of Justice, Equality and Law Reform, 2000). Approximately 10% of the prisoners in each prison under the jurisdiction of the Department of Justice, Equality and Law Reform completed psychometric tests and a questionnaire.

[489] *Ibid*, at page 14.

[490] *Ibid*, at pages 14-15.

[491] *Ibid*, at page 15.

[492] Ibid, at page 18.

[493] *Ibid*.

[494] *Ibid*, at page 19.

[495] *Ibid*.

[496] *Ibid*.

with "learning disability" within their local community. Training programmes were recommended for the relevant stakeholders (Gardaí, probation officers, members of the judiciary and members of the legal professions).[497] There were a number of other recommendations in relation to the creation of specialised prison programmes and recommendations in relation to post-release support services.[498]

It is clear from the available evidence that there is a significant unmet need for the provision of forensic services for persons with ID. There is a significant gap between the scale of the service envisaged in "A Vision for Change" and the scale of the service needed as suggested by the Irish College of Psychiatry research. The comprehensive needs assessment of forensic services for persons with ID is essential in bridging the gap between what is envisaged in "A Vision for Change" and the unmet needs. However, there has been sufficient understanding and knowledge about the problems and the problem of implementation once again is manifest.

18.3. Reasonable Accommodations for Suspects with ID

Persons with MHPs and ID face many barriers in the criminal justice system. Indeed many jurisdictions have sought to address the disadvantages and barriers faced by suspects of crimes who have ID.[499] Ireland unlike other jurisdictions has not developed adequate procedural safeguards for suspects with an ID.[500]

However, there are some special measures tailored to respond to the needs of defendants with MHPs and ID in Ireland. In particular, regulations 13 and 22 of the Criminal Justice Act 1984 (Treatment of Persons in Custody in Garda Síochána Stations) Regulations 1987 provide that when a Garda in charge of custody is aware that a suspect is "mentally handicapped", the suspect should not be questioned without the presence of a responsible adult (except in limited

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[497] *Ibid*, at page 20.

[498] *Ibid*.

[499] See Chapter 2: Literature Review.

[500] As will be discussed in chapters 4, 5, 6 and 7 a number of special measures have been introduced to safeguard persons with an ID at different points of the criminal justice system, in particular, at the questioning stage.

circumstances).[501] The narrow scope of the 1987 regulations focuses on the creation of and maintenance of a custody record. This record documents interviews, and includes requests made, visits from Gardaí, family members, and legal representatives. Essentially the 1987 regulations provide that a parent, guardian, spouse, relative or other responsible person be contacted when a person with "mental handicap" is arrested. There is no provision for corresponding support for persons with MHPs, which is a deficit with the current regulations.

There is a lack of detail about the role of the support person provided for in the 1987 regulations. There are no details about the qualifications needed to undertake this role. O'Neill suggests that if this role is a meaningful one then "the process the powers and duties of the support person should … be outlined in a statutory instrument".[502] A further weakness with the current regulations is that there is no sanction for breaches of the regulations. It has been suggested that where the regulations have been breached a judge should be provided with "express legislative discretion" to exclude the evidence obtained.[503] O'Neill is critical of the lack of training that has historically been provided to Gardaí in Ireland, as they provide "the interface between people with mental illness and ID and the criminal justice system".[504]

The lack of law and policy in this area means that persons with ID are particularly vulnerability within the Irish criminal justice system as aptly illustrated by the case of Dean Lyons.[505] Dean Lyons was questioned in relation to a murder in Grangegorman in 1997 and confessed to the murder. In a subsequent inquiry report into the case by George Birmingham SC, Dean Lyons was described as being "border line mentally handicapped" at the time of his questioning.[506] He was

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[501] See Criminal Justice Act, 1984 (Treatment of Persons in Custody in Garda Síochána Stations) Regulations, 1987 (S.I. No. 119/1987). For a discussion on these regulations as they relate to persons with MHPs and ID see O'Neill *Irish Mental Health Law* (Dublin: First Law, 2005) at pages 423-428.

[502] *Ibid*, at page 427.

[503] *Ibid.*

[504] *Ibid*, at pages 427-428.

[505] See Birmingham "Report of the Commission of Investigation: Dean Lyons Case" (Dublin: Department of Justice, 2006).

[506] *Ibid*, at page 6.

described as being "exceptionally suggestible and … had an abnormal tendency to give into leading questions".[507] In the Report it was revealed that Dean Lyons received information on the details of the murder from the Gardaí questioning him, which facilitated the credibility of his confession.

After Dean Lyons confession to the murders in July 1997 a second suspect admitted to the murders in August 1997. In October 1997 a detailed Garda report on the case was submitted to the Chief State Solicitor's Office recommending prosecution of Dean Lyons. An assistant Garda Commissioner subsequently investigated the different "admissions" and issued a Report in January 1998, which concluded that Dean Lyons had no involvement in the murders. This Report in conjunction with expert evidence obtained by both the prosecution and defence that the confessions were unreliable resulted in the DPP withdrawing criminal charges against Dean Lyons. He subsequently died in 2000.

The deficits with the current regulations governing the police interview of suspects with ID were illustrated here. Given the vulnerability of Dean Lyons one would have expected that he would have been provided with a support person at interview. However, this did not happen, in the review there was reference to the special measures provided for in the *Criminal Justice Act, 1984 (Treatment of Persons in Custody in Garda Síochána Stations) Regulations 1987*. The Sergeant responsible for complying with the regulations, in giving evidence to the review described Dean Lyons as "not very articulate", "not very bright" and "very timid".[508] These descriptions would indicate that special measures and accommodations ought to have been put in place in respect of the interviewing of Dean Lyons in accordance with the regulations. However, it was found that it would be "wholly unreal" with the benefit of hindsight to identify that Dean Lyons should have benefited from these special measures when interviewed.[509] This case supports the suggestion that the current regulations are ineffectual and discussion of them is scant in the academic literature and in case law.

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[507] *Ibid*.

[508] *Ibid*, at page 83.

[509] *Ibid*, at pages 83-84.

The terms of reference for a subsequent inquiry set up by the Government were quite narrow limiting the investigation to fact-finding and unfortunately did not contain any recommendations as to how to address the deficits of Garda questioning of vulnerable suspects. This case aptly illustrates the difficulties facing persons with ID coming into contact with the criminal justice system and the need for special measures available in other jurisdictions. It is also contended that these special measures are required as part of Ireland's obligations once it ratifies the CRPD under Article 13. Flowing from these obligations under Article 13 it is essential that training is provided for members of the Gardaí so that they can identify and respond to the needs of persons with ID and provide accommodations where required.

19. Accessibility of the Irish Criminal Justice System to PWDs

It is essential that the criminal justice system is accessible to PWDs and that extends to defendants, witnesses and victims.[510] While there is little research on the accessibility of the criminal justice system for defendants and offenders with disabilities in Ireland there has been some recent research on barriers to access to justice for PWDs from the perspective of victims.[511] While the issues of access to justice for defendant and offenders with disabilities are different to the issues and experiences of victims of crime who have a disability, some of the findings of this research are relevant to the discussions in this chapter.

The recent research of Edwards et al identified a number of barriers for victims of crime at the different stages of the criminal justice system.[512] These barriers included structural barriers in terms of communication between institutions, and lack of clarity within an agency relating to responsibility for dealing with victims of crime who may have impairments.[513] Procedural barriers were identified in terms complex procedures and processes with the criminal justice system.[514] In that

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[510] See Chapter 2: Literature Review, Part 2.

[511] See Edwards, Harold and Kilcommins "Access to Justice for People with Disabilities as Victims of Crime in Ireland" (Cork: School of Applied Social Studies and Centre for Criminal Justice and Human Rights, Faculty of Law, University College Cork, February 2012).

[512] *Ibid*.

[513] *Ibid*, at page 123.

[514] *Ibid*, at page 124.

regard it was identified that PWDs are provided with little information about procedures. In addition procedures can seem intimidating and confusing and a lack of accommodation in making procedures accessible.[515] The research identified the "adversarial process in which the principle of orality is key … itself can disadvantage PWDs who are not able to communicate in a clear and persuasive manner".[516] Another difficulty identified in the research was attitudinal barriers within the criminal justice system where different professional groupings (Gardaí, barristers, and the judiciary) make assumptions about PWDs and are "unaware of the capabilities and capacities of PWDs".[517] The other set of barriers identified in the research included physical barriers in the built environment and the failure to provide information in accessible formats.[518]

This research also included findings from qualitative interviews with key informants. While the study related to victims with disabilities, the findings are relevant from the perspective of defendants and offenders with MHPs and ID in Ireland. The study revealed that there was "a lack of strategic identification of PWDs as a specific group within the broader victim constituency".[519] This lack of strategic identification echoes the lack of strategic identification of persons with ID and MHPs at the different stages of the criminal justice system in Ireland, with the exception of the project operating out of Cloverhill Remand Centre. The research suggested that this lack of "strategic identification" operated at the "central government policy level and in the practice of organisations" and was reflected in a lack of data collected in respect of PWDs as victims of crime, and an absence of consistent data collection amongst different agencies in the criminal justice system.[520]

The findings from the qualitative interviews with key informants revealed positive measures in respect of vulnerable witnesses. However, there was "uncertainty about the extent to which they are

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[515] *Ibid*.

[516] *Ibid*, at page 2.

[517] *Ibid*, at page 127.

[518] *Ibid*, at page 128-129.

[519] *Ibid*, at page 5.

[520] *Ibid*.

being used in the context of PWDs".[521] The lack of training for the different professional groups working within the criminal justice system was identified as a problem.[522] The groups in need of additional training were the Gardaí, Office of the DPP and the Courts Service.[523]

The need for adequate training cannot be understated as being integral in ensuring an accessible criminal justice system. Article 13 of the CRPD obliges State Parties to promote appropriate training for persons working in the field of administration of justice, including police and prison staff. The Independent Monitoring Group for "A Vision for Change" also identified the need to provide additional training on mental health to persons working in the criminal justice system in Ireland.[524] In particular, there is an opportunity for the guiding principles enshrined in Article 3 of the CRPD to be embedded into this training.

One of the immediate opportunities is in respect of training of Gardaí as there is a radical overhaul of the current training system involving a move from the current Student / Probationer programme to the new Bachelor of Arts in Applied Policing.[525] One of the modules in the new Bachelor of Arts in Applied Policing is entitled "Policing with Communities". This module is designed to provide student Gardaí with both the personal and professional skill set to proactively police in a modem way that is responsive to vulnerable members of society. Part of the module is entitled "Mental Illness Awareness", which proposes to deal with different categories of mental illness, the power of Gardaí, procedures and processes for transportation of persons with MHPs.[526] In addition to this element of training on mental health a two day training course ASIST (suicide prevention course), will be delivered in

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[521] *Ibid*, at page 6.

[522] *Ibid*, at page 10.

[523] *Ibid*.

[524] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012) at page 65.

[525] The new Bachelor of Arts in Applied Policing programme was recommended by the review undertaken by the Garda Siochana Training and Development Review Group. It is seen as best practice in police education resulting.

[526] Unit 5 of the Module on "Policing with Communities".

partnership between the HSE and An Garda Síochana. As these courses are being introduced it is essential that the rights based perspective discussed in Chapter 2: Literature Review, Part 2 is incorporated. The Independent Monitoring Group for "A Vision for Change" also asserted "any gaps in mental health awareness training are identified" ought to be examined and addressed through the development of further training.[527]

A Memorandum of Understanding between the HSE and Garda Síochána was signed in September 2010.[528] Echoing the painfully drawn out experience of delivering reform of law, policy and practice in the area of mental health there have been delays in putting the memorandum into action. The Independent Monitoring Group for "A Vision for Change" noted in its most recent report that an Inspector had been nominated in each division to act as liaison person to the approved centre for the catchment area(s) that extends to their division in line with the memorandum. In addition a training programme has been developed and delivered by the Garda College for these liaison Inspectors. This development is an important one that provides an opportunity for a coherent approach in identifying and responding to the needs of persons with MHPs coming into contact with the criminal justice system. The creation of a national network of senior Gardaí in each division has the potential to develop further informal diversion of persons with MHPs from the criminal justice system. This national network has also the potential to facilitate diversion programme beyond the narrow remit currently provided.

20. Conclusions

Diversion has emerged in different guises, at different points of the criminal justice system, in different jurisdictions. Diversion is an increasingly important tool in seeking to address the over-

[527] See "A Vision for Change – the Report of the Expert Group on Mental Health Policy: Sixth Annual Report on implementation 2011" (Dublin: Independent Monitoring Group, June 2012) at page 66.

[528] "Memorandum of Understanding Between An Garda Siochana and the HSE on the Removal to or Return of a Person to an Approved Centre in Accordance with Section 13 and Section 27, and the Removal of a Person to an Approved Centre in Accordance with Section 12, of the Mental Health Act 2001". (Dublin: 16 September 2010).

representation of persons with MHPs in the criminal justice system. While there is a clear evidence-base of this over-representation, diversion has not been developed as a response to this problem. The literature review in Chapter 2: Literature Review Part 1 identified 5 categories of diversion; diversion in the community; diversion following arrest; diversion before the trial; diversion at the court and diversion following conviction. There are few diversion provisions, processes and initiatives at these points in the criminal justice system in Ireland. However, the most significant recent development has been the creation of PIRCLS in Cloverhill, albeit that this is a limited initiative.

The prison system cannot be considered in isolation from a "parallel history" of other "total institutions" which were created such as asylums "enforced a similar economy of time and the same order of surveillance and control".[529] This is particularly the case in Ireland, where historical evaluation of institutionalisation paints a bleak and shameful history. Asylums were developed in Ireland to respond to the over-representation of persons with MHPs and ID in prisons and houses of industry. Inquiries from the 1960s have recognised that the deinstitutionalisation process required law and policy reform to meet the needs of persons with MHPs and ID coming into contact with the criminal justice system. Accordingly recommendations were made that prisons and detention centres ought to make arrangements with local health authorities to provide the necessary psychiatric services to prisoners; these recommendations were never implemented.

The Report of the Henchy Committee in 1978 was a key moment in identifying that Ireland was out of step in comparison with other jurisdictions, in not providing powers to the courts to connect persons with MHPs to mental health services. The recommendations in the Report could have been implemented (if there had been political will) as the Bill expertly connected the proposed powers of diversion to the *Mental Treatment Act 1945*. While the Report contained regressive recommendations on the use of preventative detention, on the whole it contained very positive provisions such as powers that would allow criminal courts for all matters summary and indictable to connect

[529] Ignatieff "State, Civil society and Total Institutions: A Critique of Recent Social Histories of Punishment" in Cohen and Scull (eds) *Social Control and the State: Historical and Contemporary Essays* (Oxford: Martin Robinson, 1983) at page 83. See also Chapter 2: Literature Review, Part 1.

accused and convicted person to local mental health services. The Report of the Henchy Committee asserted that the inability or restricted ability of the Irish criminal law to facilitate "appropriate psychiatric treatment" was a "grave defect" with the law. To address these "grave defects" the Henchy Report proposed amendments to the substantive criminal law and recommended "wide powers" that permitted the courts both before and following conviction to refer or commit an accused person to a "designated centre". The Henchy Report recommended that the courts making orders under its proposed Bill, would be empowered to make orders for "outpatient treatment" in the community. Despite the Committee's recommendations, which were progressive for their time, they remain unimplemented and defects continue to persist to this day.

There is a long history and clear commitment to innovative and problem solving approaches to juvenile crime. This is evidenced by the development of diversion programmes dating back to the 1960's and the enshrinement of the state commitment to diversion in this area through the *Children Act 2001*. However, there has not been a similar commitment to innovative and problem solving approaches in responding to adult crime. In addition problem-solving approaches have been devised to respond to the needs of adults with addictions, through the Drug Treatment Court. However, this diversion initiative based on principles of therapeutic jurisprudence has slipped into ineffectiveness. Recent policy initiatives on crime, criminal justice and penal policy, have not recommended the development of diversion provisions, processes and initiatives to respond to defendants and offenders with MHPs and ID. It is unclear from the Programme for Government whether the Government will continue with the development on the White Paper on Crime. Should progress with the White Paper proceed it would be essential that diversion be included as a central part of the Programme. This would mean that there would be for the first time a clear and unambiguous Government commitment to diversion, a commitment that is currently not in evidence in policy or practice.

Barriers to accessing services in the community were identified as a significant factor in explaining the over-representation of persons with

MHPs in the prison population.[530] Diversion in the community has great potential to connect persons with services and avoid contact with the criminal justice system in the first place. There is little evidence of community-based diversion in Ireland, although informal diversion may happen in the community in the absence of formal diversion. However, Enright notes, "Irish prisons have become a dumping ground for the mentally ill and those struggling to cope with the effects of homelessness, addiction or personal vulnerability. We have actively developed a failing system, continuing to make imprisonment a sanction of first resort rather than a last resort."[531] The Green Paper on Mental Health adopted a progressive approach to diversion, which acknowledged the need to develop mental health services for defendants and offenders with MHPs. However, the White Paper on Mental Health questioned the desirability of the courts referring persons engaged in criminality to general psychiatric services. The reservations expressed in the White Paper, reflect an attitude that has prevented the development of diversion provisions, processes and initiatives for defendants with MHPs. The fear that the presence of defendants and offenders with MHPs in general psychiatric services is based on a fear of undermining the recovery ethos of general psychiatric services. Such a view is clearly in contravention of the obligations to provide for the right to health and the right to habilitation and rehabilitation as contained in the CRPD.

The explanation for the omission of diversion provisions in the *Mental Health Act 2001*, on the basis of realising the terms of the friendly settlement in the ECtHR case of *Croke v Ireland* is unsatisfactory. Given that the Report of the Henchy Committee contained a very comprehensive Bill, detailing how powers of diversion would be linked to mental health legislation, it is not clear why these provisions were not provided for in the Bill. Surely the extensive work by the Henchy Committee on drafting statutory provisions would have made inclusion of diversion provisions possible, given that the other provisions in the legislation were crafted from the draft board. While the Minister intended "to return to the issue after the Bill has been enacted", this did not happen. It seems likely that the absence of statutory provisions on

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[530] See Chapter 2: Literature Review, Part 1.

[531] "The Whitaker Report 20 Years On: Lessons Learned or Lessons Forgotten" (Dublin: Irish Penal Reform Trust, 2007) at page 100.

forced community treatment and the concerns flowing from the Gallagher controversy may partially explain the failure to provide for diversion.

The insanity defence may be at odds with Article 12 of the CRPD, as it restricts the legal capacity of the persons relying on the defence. In the judgment in *People (DPP) v Redmond*, it was held that the decision to raise the defence for the defendant. This it is argued suggests that the insanity defence in Ireland is closer to compliance with the CRPD, than other jurisdictions that provide for the imposition of the defence through substitute decision-making by the trial judge. Nonetheless the core human rights issue with the insanity defence remains unresolved in Ireland – that is indefinite detention. While there have been improvements in the procedural safeguards, particularly independent regular review, afforded to persons detained in the CMH under the 2006 Act, significant problems remain. These problems were illustrated by the critique of Sheehan J in *People (DPP) v B*, where he identified that the psychiatrist in the CMH failed to develop a therapeutic relationship with B. This critique calls into question the extent to which the right to health, habilitation and rehabilitation and recovery is embedded in mental health practice in the CMH. The case also points up the need to address the divergence in procedural safeguards surrounding the detention of patients involuntarily detained under the *Mental Health Act 2001* and the *Criminal Law (Insanity) Act 2006*. The on-going review of the 2001 Act is taking a more robust approach to the rights of persons subject to the legislation, which is likely to result in a more robust piece of legislation. As such it is essential that improvements in respect 2001 Act be reflected as robustly in the 2006 Act.

Dangerousness and risk considerations are now the dominant value in informing law and policy in other jurisdictions. As such it was suggested that while there is much attention given to the therapeutic jurisprudence approach, concerns with dangerousness and risk prevail as evidenced by the proliferation of indeterminate sentencing, which has been described in terms of "reverse diversion". However, while there has been a sharp increase in the Irish prison population since the 1990s the extent to which the dangerousness and risk concerns can explain this is unclear. Kilcommins et al have suggested that it remains to be seen whether Ireland has entered into the "criminal complex" as the punitive shift requires commitment and planning at the political

level, which they consider has not yet happened in Ireland. The reality is that public policy in Ireland is considered to be flexible with and not guided by a rigid ideological philosophy. As criminal justice such policy remains "fluid and subject to U-turns with a similar pattern for evident on other policy arenas".[532] Given this policy environment it is argued that Irish law and policy can be reformed to provide for diversion provisions, processes and initiatives that are framed positively and are in line with the principles set out in the CRPD (see Chapter 2: Literature Review, Part 2). However, a more cynical view of penal policy was articulated by the former Inspector of Prisons suggesting that the DOJ's "obsession with power, control and secrecy" and aversion to criticism make the resolution of problems such as the over-representation of persons with MHPs in prison insurmountable. The human rights of persons with MHPs in the civil system are vindicated robustly, in contrast to a weak pursuit of the human rights of persons with MHPs in contact with the criminal justice system. This is evidenced by the failure of NGOs, with the exception of IPRT, to advocate meaningfully for the diversion of defendants and offenders with MHPs. It is contended that without a powerful lobby the "grave defects" identified by Henchy in not providing for diversion will continue for many more decades.

One of the research questions to be answered in this chapter is why Ireland is unique in failing to develop diversion provisions, processes and initiatives similar to those that operate in other jurisdictions.[533] The discussion of the relevant law and policy in this chapter suggests that there are many possible explanations for the failure. The discussion reveals that key moments presented, where opportunities opened up to develop diversion programmes (EG the Henchy Report and the formation of the *Mental Health Act 2001*). There is some evidence that psychiatrists have opposed proposals for legislative powers of diversion for judges. Given psychiatrists' centrality to and ownership of policy development through expert review, arguably it is unlikely that a formalisation of diversion processes is likely to happen in the near future. It is similarly contended that the National Forensic Mental Health Service's opposition to the diversion programmes earlier in the criminal justice process (before in-reach in remand centres) will stall

[532] *Ibid*.

[533] See Chapter 1: Introduction.

progress in developing diversion programmes envisaged in "A Vision for Change".

Diversion must be reconceptualised in order to comply with the CRPD. Choice and non-coercion have to be central and diversion to the community has to form the thread that stitches diversion policy together. Diversion cannot force mental health treatment on persons who seek reasonable accommodation in the form of participation in a diversion programme. It is argued that a clear policy on diversion has to be adopted by the DOJ and has to have at its heart principles that reflect the emerging rights based approach being adopted in the review of the *Mental Health Act 2001*. However, it is acknowledged that the stigma associated with persons accessing mental health services through the criminal courts means that the dangerousness and risk concerns will pose difficulties in developing human rights based diversion programmes that respect choice and autonomy.

There is a dearth of research involving defendants and offenders with ID in Ireland. The examination of law and policy in relation to defendants and offenders with ID indicates a visibility issue. It is contended that in line with trends in other jurisdictions defendants and offenders are dealt with informally in residential services. This raises concerns from a human rights perspective, as restrictions on and deprivation of liberty are not subject to safeguards. Independent inspection of residential services commenced for the first time in 2013. It is hoped that development of forensic mental health services for persons with ID might enhance the visibility of persons with ID within the criminal justice system. HIQA, in exercising its new powers of inspection of public, private or voluntary bodies or organisations providing residential services and or residential respite services for persons with ID, has an opportunity to address the invisibility of persons dealt with informally in services. HIQA should examine how every service responds to service users in contact with the criminal justice system, in line with implicit powers in their inspection standards in this area. In its inspection work HIQA should pay particular attention to restrictions on the liberty of service users. The information should be collated in a thematic way and published in its reports. The literature suggests that persons with "moderate" ID are over-represented in the Irish prison population. Additional research is needed to identify the needs of this group and the accommodations required to overcome the barriers they experience as participants in the criminal justice

system. It is argued that the current provision of special measures, for the questioning of suspects with ID are insufficient, falling well short of the requirements to provide accommodations in line with Article 13 of the CRPD.[534]

It has been argued that the failure to provide diversion programmes, processes and initiatives at the different points of the criminal justice system has necessitated the establishment of programmes such as the High Support Unit in Mountjoy. It is also suggested in this chapter that there is no concrete commitment to a policy of diversion in the criminal justice system, despite commitments in "A Vision for Change" (a health policy) to diversion. Diversion as understood by the National Forensic Mental Health Service is based on diverting people from the criminal justice system to mental health services. It has been argued that "protecting the interests and promoting the rights of the mentally ill" requires "postures of professional autonomy and insularity… to be abandoned and strategies for collaboration between law and mental health need to be devised".[535] This has not occurred in Ireland regarding the human rights of offenders with MHPs. There is a risk that professionals replace the state as "disempowering bodies" and that collaboration extends "to non-professionals voluntary groups and patients with mental illness".[536] A very insular approach to policymaking has prevailed in Ireland with mental health professionals controlling and setting the agenda.

In 2003 as work on what was to become the *Criminal Law (Insanity) Act 2006* progressed, the Minister for Justice Michael McDowell acknowledged the delay in bringing forward the legislation.[537] The Minister, in acknowledging the work of Henchy J and his Committee, apologised to him for the delay. However, the Minister did not see fit to apologise to the persons who were detained in the CMH, with weak

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[534] See Chapter 2: Literature Review, Part 2.

[535] Dhanda *Legal Order and Mental Disorder* (New Dehli: Sage Publications, 2000) at page 319.

[536] *Ibid*.

[537] "Criminal Law (Insanity) Bill 2002: Second Stage" (Dublin: Seanad, 19 February 2003, Vol. 171 No. 10) at paragraph 794. "Mr. Justice Henchy was a fine jurist. He was probably one of the best, if not the best mind to sit on the Supreme Court. I apologise to him that 25 years after he commenced work in this area, the relevant legislation is only beginning its passage through the Oireachtas."

safeguards of their deprivation of liberty, nor did he see fit to apologise to (presumably) a significant number of defendants, who fell short of the threshold for raising the insanity defence and were unable to avail of the partial defence of diminished responsibility recommended in 1978 and not provided for in the intervening 28 year period.

As acknowledged in the White Paper on Mental Health referring to diversion "Ireland was unusual among European Countries"; Ireland continues to be very unusual in respect of other European Countries in its lack of provision for diversion. The CPT endorsed the recommendations of the Henchy Committee and the proposals in the Green Paper and asked the Government to keep the Committee informed of progress in enacting the proposals. The failure to make significant progress with diversion provisions, processes and initiatives calls into question effectiveness of human rights law in prompting reform of law and policy. It is of note that the focus in the Green Paper and the Henchy Report was on offenders/defendants before the courts. There was no discussion of diversion or response earlier in the process, though the Henchy Report did refer to the power of the court to intervene/respond as early as possible. When reading the Green Paper you might be forgiven for thinking that the development of Irish mental health law has been very influenced by the case law of the ECtHR and the MI Principles, as the "Green Paper on Mental Health" detailed the "international thinking" on mentally ill offenders relied heavily on the case law of the ECtHR and the UN Principles.[538]

It is argued that the failure to develop procedures, processes and initiatives aimed at diverting persons with MHPs from the criminal justice system, has resulted in human rights abuses for prisoners with MHPs. The Irish courts have been ineffective when called upon to intercede on behalf of prisoners, in circumstances where the state has failed to provide adequate services for both mental and physical health. The discussion of the case law in this chapter reveals that beyond protecting narrow procedural and due process matters that courts have not taken opportunities to vindicate rights of prisoners with MHPs. As was seen in the *State (C) v Frawley* the court refused to require the Executive to provide specialised treatment for the applicant. In these judgments there was no consideration of ordering the prisoners

[538] "Green Paper on Mental Health" (Dublin: Department of Health, Pl 8918, 1992) at page 99.

release as an alternative to making orders requiring services in line with our evolving understanding of reasonable accommodation. The *State (C) v Frawley* and the *IPRT v The Governor of Mountjoy Prison* case highlight the difficulties and barriers facing persons with MHPs in Irish prisons. Diversion at different points of the system is clearly a better approach, and underscores the need to develop a range of effective diversion procedures, processes and initiatives. The promotion of the rights of persons with MHPs and ID in prison is unlikely to be achieved through litigation on constitutional and ECHR rights. As Whyte has suggested the "political route to reform cannot be avoided".[539] The CRPD as suggested in Chapter 2: Literature Review, Part 2 can play an important role in informing the different types of diversion systems, which place a premium on community living and facilitates access to services that realise the rights to recovery, health and habilitation and rehabilitation.

[539] *Ibid*.

Chapter 4: England and Wales

1. Introduction

There is no other jurisdiction that has influenced reform of Irish law more so than England and Wales. This is evidenced by the processes of formal law reform, the legislation establishing the Law Reform Commission in the 1970s drew heavily from the model in England Wales and consideration of updating areas of Irish law invariably involves close examination of the approaches in England and Wales.[1] This chapter is divided into two parts. Part 1 of this chapter outlines the background to diversion in England and Wales and sets out the diversion provisions, processes and initiatives. There is also a consideration of the effectiveness of the diversion system in England and Wales. Part 2 of this chapter identifies the competing rationale and objectives of diverting defendants and offenders with MHPs and ID from the criminal justice system. In addition there will be a consideration of the barriers to achieving an effective diversion system in England and Wales. The extent to which the diversion system in England and Wales complies with the CRPD is also considered.

2. Background

The deinstitutionalisation movement has been the "hallmark of public policy" over the last number of decades in the UK, which has seen significant structural change.[2] However, persons with MHPs are over-represented in the prison population and diversion has emerged as the main policy response to address the over-representation and respond to defendants and offenders with MHPs and ID. Some of the earlier studies on offenders with MHPs in England and Wales are interesting from the Irish perspective. In research published in 1970 psychiatrists expressed concern that a large number of their hospital order patients had committed minor public order offences that were linked directly to

[1] See Keane "Thirty Years of Law Reform 1975-2005" (Dublin: Thirtieth Anniversary of the Law Reform Commission, 2005) at page 4. Former Chief Justice Keane noted that institutional law reform models in other common law jurisdictions were also drawn upon EG Scotland and Australia.

[2] See Hamlin and Oakes "Reflections on Deinstitutionalization in the United Kingdom" (*Journal of Policy and Practice in Intellectual Disabilities*: 5(1), 2008, pages 47-55).

their MHP such as shouting at voices.[3] It was suggested in the study that the patients appeared to have passed through the courts and remand centre unnecessarily and made a number of recommendations at improving liaison between the police and psychiatric services. Other researchers reported that a number of persons who had committed serious crimes were not prosecuted.[4]

The interaction of persons with MHPs with the criminal justice system has received significant attention in England and Wales for many decades in the academic literature and as a policy issue. The Report of the Committee on Mentally Abnormal Offenders 1975 (Butler Report) was established under wide terms of reference.[5] They included all of the different aspects of the pathway travelled by defendants and offenders with MHPs. In an interim Report published in 1974 the Committee recommended that Regional Medium Secure Units be created, to alleviate the overcrowding in high security special hospitals. In its final Report published in 1975 the Committee adopted a number of principles. These principles included that offenders with MHPs should receive treatment at the earliest possible stage and that treatment should be availed of in the most appropriate setting.[6] Treatment was a key principle as was diversion with the Report recommending that diversion should happen as soon as possible and that the greatest possible flexibility should be applied at the disposal stage.[7] The Report stated that "[t]he overriding need was to provide the best possible treatment for the patient's mental disorder and he should have full access to treatment in the best location to suit his needs. Ultimately in individual cases this must depend on clinical

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[3] See Whitehead and Ahmad "Chance, Mental Illness, and Crime" (*Lancet*: 1(7638), 1970, pages 135-137). This study involved an examination of all cases admitted to a psychiatric hospital from the courts or prison over a two-year period.

[4] Walker and McCabe *Crime and Insanity in England: Volume II: New Solutions and New Problems* (Edinburgh: University Press, 1973) citied in Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 151.

[5] "Report of the Committee on Mentally Abnormal Offenders" (London: Presented to Parliament by the Secretary of State for the Home Department and the Secretary of State for Social Services by command of Her Majesty, October 1975). The Report also considered the law governing the insanity defence and fitness to plead.

[6] *Ibid*, at paragraph 1.21.

[7] *Ibid*.

judgment, but in general policy we hope humane counsels will prevail".[8]

In the 1975 Report there was an emphasis placed on pre-sentence inquiry by the court, in accessing medical reports, so that it was in full possession of all of the relevant material relating to a defendant with a MHP so that the appropriate disposal would be made. The Report also highlighted the need to foster "closer relationships among the various services responsible for treating the mentally disordered offender and to improve mutual understanding".[9] Throughout the Report there are numerous other references to the need to connect defendants and offenders with MHPs to social and medical services and encouragement for greater use of the existing therapeutic disposals. The Report also recommended the creation of a number of different remand and disposal options that would expand the scope for defendants and offenders to access treatment and care. The approach was to recommend greater access to treatment and supervision as an alternative to a custodial sentence – namely "an overtly penal disposal should be excluded".[10]

The *Mental Health Act 1983* contains a number of measures that seek to divert offenders with MHPs away from the criminal justice system into health and social services. During the 1980's there was a perception that these powers were not sufficiently availed of so the Conservative Government 1979-1997 introduced an unambiguous policy of diversion in the early 1990's aimed at facilitating greater use of the powers contained in the 1983 Act.[11] Effectively the Conservative Government 1979-1997 introduced a number of measures that sought to divert offenders with MHPs from the criminal justice system at different points of the process. The approach was based on a medical model perspective of mental illness. As such diversion in England and Wales involves diverting people from custody to mental health services and social services. As Laing has pointed out the policy of diversion was predicated on interagency diversion schemes operating in courts

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[8] *Ibid*.

[9] *Ibid*, at paragraph 20.1.

[10] See paragraphs 10.27-9.

[11] For an in depth discussion of the history of diversion policy in England and Wales see Laing *Care or Custody* (Oxford: Oxford University Press, 1999) at page 46.

and police stations across the country.[12] This policy of diversion was subsequently embraced by New Labour 1997-2010 and now by the Conservative / Liberal Democrat coalition.

From the literature there seems to be a broad consensus that diversion from custody to mental health services is the appropriate response to defendants and offenders with MHPs in England and Wales. For example, it has been argued that offenders with MHPs should receive "special care and treatment" including access to health and social services.[13] However, attempts to deliver on diversion "have been thwarted due to the lack of adequate funding and facilities and the absence of inter-agency-co-operation between the different agencies involved".[14] Laing describes diversion as "an inherently offender orientated process" that focuses primarily on the needs of the offender, however, this approach it has been suggested poses a risk that other principles within the criminal justice system may suffer.[15] The principles that Laing identified as being put at risk include public safety and the rights of victims. The problem of large numbers of persons with MHPs being inappropriately picked up and processed through the criminal justice system in England and Wales still persists despite the official policy of diversion operating for over two decades. This will be discussed in greater detail below.

The Home Office in 1990 Home Office issued a Circular to promote effective inter-agency relations with a view to ensuring that "mentally disordered offenders" receive care and treatment from health and social services as opposed to being processed through the criminal justice system.[16] According to the Circular "it is government policy that, wherever possible, mentally disordered persons should receive care and treatment from the health and social services."[17] The Circular was complemented by a statement from the DOH that set out the Government's commitment to diversion and emphasised the need for

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[12] *Ibid*, at page v.

[13] *Ibid*.

[14] *Ibid*.

[15] *Ibid*.

[16] "Provision for Mentally Disordered Offenders" (Home Office Circular 66/90, 1990).

[17] *Ibid*.

health and social services facilitated diversion through assessment and the provision of effective services. The Circular emphasised the existing powers available and encouraged the police to use powers under the *Mental Health Act 1983*. In particular, the Circular urged senior police officers, to ensure that in all cases they considered alternatives to the prosecution of "mentally disordered offenders", including taking no further action where appropriate. Senior officers were also urged to ensure that there were effective links with local health and social services, so that there was prompt collaboration when an offender with a mental health is taken into custody. This policy has been further developed in the revisions to the Code of Practice to the *Mental Heath Act 1983*.[18] The Circular also called on the Crown Prosecution Service to exercise its power to discontinue prosecution of a "mentally disordered offender" if it did not serve the public interest to continue with the prosecution.

Chapter 4: England and Wales, Part 1

1. The Diversion System in England and Wales

As discussed in Chapter 2: Literature Review, Part 1 the diversion provisions, processes and initiatives differ significantly from jurisdiction to jurisdiction and for the purposes of this thesis a broad approach is taken as to what qualifies as diversion. Diversion includes but is not limited to diversion in the community; diversion following arrest; diversion before the trial; diversion at the court and diversion following conviction.[19] The purpose of this section of the chapter is to outline the framework for diversion in England and Wales. As will be seen from the discussion below diversion in England and Wales is "deeply embedded" in the legal process to a greater extent than other jurisdictions.[20]

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[18] See Laing *Care or Custody* (Oxford: Oxford University Press, 1999) at page 160.

[19] See Chapter 2: Literature Review, at Part 1.

[20] See "Placement and Treatment of Mentally Ill Offenders: Legislation and Practice in EU Member States" (Manheim: European Commission, Central Institute of Mental Health, Final Report 2005) at pages 122-135.

In England and Wales the issue of criminal responsibility of adults is not a material consideration in disposal by the courts with the exception of defences raised in homicide cases.[21] As such the criminal responsibility of the person is not assessed (with the exception of homicide cases) in making decisions about disposal of defendants and offenders.[22] As discussed in Chapter 2: Literature Review one of the main objections to diversion from the perspective of the CRPD is that it encroaches upon the legal capacity of the defendant.[23] This objection is mitigated to some extent in that diversion does not require a curtailment of the persons' legal capacity. The *Mental Health Act 1983* as amended by the *Mental Health Act 2007* provides that a person convicted of a criminal offence(s) who meets the criteria for treatment under the legislation can be sent to hospital by the courts as opposed to being sent to prison and the links with the criminal justice system are disengaged.[24] It has been suggested that in a majority of cases treatment for a MHP is equated with the sentence for persons with a "serious mental illness".[25] James has suggested that court based diversion as provided for by the mental health legislation is "non-contentious" and unlike "special psychiatric defences" is not disputed between the defence and prosecution.[26]

In England and Wales there are a number of different elements to the diversion system.[27] One of the main elements involves interaction amongst the criminal justice system and health care system as provided for by the mental health legislation and sentencing policy.[28] The

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[21] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 241.

[22] *Ibid*, at page 242.

[23] See Chapter 2: Literature Review, Part1 and Part 2.

[24] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

[25] *Ibid*.

[26] *Ibid*.

[27] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 241.

[28] *Ibid*.

system of diversion also involves the provision of health services within prisons and the "development of 'add-on' initiatives, which provide additional links in the system to fast-track cases, avoid bottle-necks or accelerate individuals out of the system altogether".[29] The range of diversion provisions in England and Wales revolve around contact with the criminal justice system (after an offence is committed) at the police stations, the courts and in the remand prisons.[30] The diversion system in England and Wales is to a large extent replicated in NI and the greatest differences in the systems are with Scotland.[31]

The powers of diversion in the 1983 Act have been described as "… therapeutic remand and disposal powers, which enable mentally disordered offenders to be given access to hospital care and treatment during the prosecution process."[32] As such these powers have been further classified as enabling diversion "in its narrowest sense".[33] Chapter 33 of the "Code of Practice: Mental Health Act 1983" provides guidance on the use of the 1983 Act in arranging treatment for "mentally disordered people" when they come into contact with the criminal justice system.[34] The principle of equivalence of care and access to treatment is expressly set out in the Code of Practice.[35]

The Code of Practice states that where possible persons who appear to the court to be "mentally disordered" should at the earliest possible opportunity, have their treatment needs considered by the "court mental health assessment scheme" if such a scheme is operating.[36] The

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[29] *Ibid*.

[30] *Ibid*.

[31] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 241.

[32] Laing *Care or Custody* (Oxford: Oxford University Press, 1999) at page 46.

[33] *Ibid*.

[34] "Code of Practice: Mental Health Act 1983" (London: Department of Health, 2008) at page 298.

[35] *Ibid*. The Code of Practice states: "People who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as anyone else. Any person who is in police or prison custody or before the courts charged with a criminal offence and who is in need of medical treatment for mental disorder should be considered for admission to hospital."

[36] *Ibid*.

approach in the Code is a concession to the "vulnerability" of suspects who "… may be at greatest risk of self-harm while in custody" and "… access to specialist treatment may prevent significant deterioration in their condition and is likely to assist in a speedier trial process, helping to avoid longer-term harm or detention in an unsuitable environment."[37] The Code attempts to ensure that treatment is provided even in circumstances where criminal proceedings are discontinued.[38] The Code suggests that it may be appropriate for the relevant Local Social Services Authority (LSSA) to arrange for an approved mental health professional (AMHP) to consider making an application for admission under Part 2 of the Act, which deals with involuntary admission and guardianship.[39]

The Code contains a section outlining the agency responsibilities in respect of persons with MHPs in contact with the criminal justice system. Primary Care Trusts (PCTs) are required to provide the courts, when requested (under section 39 of the 1983 Act), with comprehensive information on the range of facilities available for the admission of patients subject to the criminal justice process. One of the important elements of this process is the potential to identify services in the community.[40]

The rules in Part 4 of the 1983 Act concerning medical treatment of detained patients does not apply to patients remanded to hospital under section 35 for a report on their mental condition.[41] Therefore, treatment can be administered only with there is consent, or, in the

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[37] *Ibid*.

[38] *Ibid*.

[39] *Ibid*.

[40] In particular, the Code requires primary care trusts to provide the courts with comprehensive information regarding child and adolescent mental health service (CAMHS) beds that are or could be made available for patients. The primary care trusts are also required to appoint a named person to respond to requests for information and to ensure that prompt medical assessment of defendants is provided for in order to facilitate prompt completion of the trial process and the most suitable disposal for the offender. Section 39A of the 1983 Act requires an LLSA to inform the court, when requested, whether it or any person approved by it, is willing to take an offender into guardianship and how the guardian's powers would be exercised. The LLSA is required to appoint a named person to respond to requests from the courts about mental health services provided in the community, including those provided under guardianship.

[41] *Ibid*, at page 304.

case of a patient aged 16 or over who lacks capacity to consent, in accordance with the *Mental Capacity Act 2005*.[42] In circumstances where a patient is remanded under section 35 (Remand to hospital for report on accused's mental condition) of the Act is thought to be in need of medical treatment for mental disorder that cannot otherwise be given, the Code requires that the patient be referred back to court by the clinician in charge of their care as soon as possible.[43] The Code states that if there is a delay in acquiring a court date, consideration ought be given to whether the patient meets the criteria for detention under Part 2 of the Act to permit compulsory treatment to be given. However, treatment runs concurrently with the remand and is not a replacement.[44] It is important to note that the new definition of mental disorder under the *Mental Health Act 1983* has been extended to include "learning disability" and persons with "personality disorders", who can now be detained if their disorder is of a nature or degree that it would be appropriate for them to be detained for treatment.[45]

The following is an outline of the different diversion provisions, processes in England and Wales. It is of note that Mental Health Courts are not a key component of the diversion system in England and Wales. However, there has been some consideration of the role they could play in England and Wales.[46]

2. Pre-Arrest Diversion

In England and Wales there is little literature on diversion in the community, in comparison to the literature on diversion at the other stages of the process. James suggests "there is a strong case for diversion efforts to include intervention before offences are committed", however, he notes that there is little formal provision for

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[42] *Ibid*.

[43] *Ibid*. This should also include an appropriate recommendation and with an assessment of whether the defendant is in a fit state to attend court.

[44] *Ibid*, at page 305.

[45] See Part 1 of the *Mental Health Act 1983*. See Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 254.

[46] For example the mental health court model was piloted at the Magistrates' Courts in Stratford, East London, Brighton and Susse. See Pakes, Winstone, Haskins and Guest "Mental Health Court Pilot: Feasibility of an Impact Evaluation" (London: Ministry of Justice, Research Summary 7/10, 2010).

diversion to extend to this earlier stage in England and Wales.[47]

2.1. Community Mental Health Services

The modernisation of mental health services and the development of community based mental health services have been progressing for a much longer period than in Ireland.[48] The Care Programme Approach (CPA) as part of mental health policy in England and Wales is of particular note from the perspective of diversion. The CPA was first introduced in the early 1990s and is used across the National Health Service (NHS) to provide a co-ordinated approach to the assessment, planning and review of care for people with a range of MHPs. This approach was introduced on a mandatory basis in England and Wales in 1992. The CPA can be seen as part of the diversion process, in so far as it can facilitate access to mental health services in the community, before a person becomes embroiled in the criminal justice system. The CPA seeks to "help manage the personal risks posed by offenders with complex clinical features".[49] The origin of the Care Management Approach was from case management strategies that were used in the US in the 1970s.[50] The introduction of the programme was also motivated by the findings of the Spokes Inquiry, which established that there had been a breakdown in the delivery of services to Sharon Campbell, which contributed to the homicide of her social worker.[51] The recommendations of the Spokes inquiry included recommendations to address the discharge of persons with MHPs from hospital and aftercare and to reform the organisation of services. There was a concern with patients who did not receive follow-up and the Care

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[47] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

[48] For a discussion on the development of community mental health services in the UK see Wright, Bartlett and Callaghan "A Review of the Literature on the Historical Development of Community Mental Health Services in the United Kingdom" (*Journal of Psychiatric and Mental Health Nursing*: 15(3), 2008, pages 229-237).

[49] Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 183.

[50] *Ibid*, at page 186.

[51] "Report of the Committee of Inquiry Into the Care and After-Care of Miss Sharon Campbell" (London: Department of Health and Social Services, 1988).

Programme Approach sought to address these concerns. While the Care Management Approach seeks to draw on the strength's of the patient there is an element of control and the process has been described as capable of being "assertive when need to prevent harm".[52]

Any person who has a MHP is entitled to an assessment of their needs. This involves meeting with a mental healthcare professional who will carry out the assessment and draw up a care plan and who will keep the plan under review.[53] The CPA also involves a community care assessment that is carried out by the person's local authority. The community care assessment will examine the persons "social care needs".[54] The Care Plan Approach also involves providing support across a range of different areas such as; diagnosis of a severe mental disorder, risk of suicide, self harm, or harm to third parties.[55] Assessment also seeks to identify support for persons who "tend to neglect themselves and don't take treatment regularly are vulnerable".[56] The assessment looks for factors for disengagement with treatment or neglect such as physical or psychotically abuse and poverty. There is also an assessment of drug or alcohol misuse and as to whether the person has an ID.

The CPA has not been explored in the literature to any great extent as part of the process of diversion. The Bradley Review noted that while it was envisaged that the NHS was to take responsibility for health services in prison satisfactory functioning of CPA within prisons this not been achieved.[57] An assessment of in-reach services reported that only

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[52] Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 186.

[53] For more information on Care Plan Approach see: http://www.nhs.uk/CarersDirect/guide/mental-health/Pages/care-programme-approach.aspx. <Last accessed 10 November 2013>

[54] Provided that the person subject to the assessment consents a carer can be involved and informed about the care plan and their review.

[55] For more information on Care Plan Approach see: http://www.nhs.uk/CarersDirect/guide/mental-health/Pages/care-programme-approach.aspx. <Last accessed 10 November 2013>

[56] *Ibid*.

[57] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the

27% of in-reach clients were on the enhanced level of CPA.[58]

2.2. The Fixated Threat Assessment Centre

One of the more notable aspects of the diversion system in England and Wales has been the establishment of the Fixated Threat Assessment Centre (FTAC).[59] The FTAC is an award winning "diversion" programme that in 2009 picked up the Association of Chief Police Officers' Excellence in Policing Award. It has been described as a "new form of diversion mechanism" that "arose out of a government-financed research project to examine how to assess and manage threat to public figures from lone individuals with intense, pathological fixations (the 'fixated'), the majority of whom are mentally ill".[60] There has been some criticism of the establishment of the FTAC. For example, some media reporting suggested that the creation of the Centre "raises questions about why thousands of mentally ill individuals have been allowed back into the community - including some who have attacked and killed members of the public - while VIPs are being given special protection".[61] The project operates from the position that "inappropriate attention to public figures was a powerful new tool for identifying seriously ill people in the community who had fallen through

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Home Office, 2009) at page 110. The Care Programme Approach obviously has significant potential in connecting prisoners to services and supports in the community upon release. However, the Bradley Report noted that there were significant barriers to the implementation of the CPA, which included: prisoners not having an address upon release; liaison difficulties with external agencies; difficulties with the geographical distance between prison and area of release; prison bureaucracy; and problems with the ICT facilities.

[58] "Refocusing the Care Programme Approach: Policy and positive practice guidance" (London: Department of Health, 2008).

[59] For description of the Centers work see James et al "Attacks on the British Royal Family: The Role of Psychotic Illness" (*Journal of the American Academy of Psychiatry and the Law*: 36, 2008, pages 59-67); James, et al "Stalkers and Harassers of Royalty: The Role of Mental Illness and Motivation" (*Psychological Medicine:* 39(9), 2009, pages 1479-1490); James et al "The Fixated Threat Assessment Centre: Preventing Harm and Facilitating Care" (*Journal of Forensic Psychiatry and Psychology*: 21(4), 2010, pages 521-536).

[60] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 246.

[61] Lewis "Revealed: Blair's secret stalker squad" (London: Daily Mail, 27 May 2007). See also Summers "How Do the Police Keep an Eye on VIP Stalkers?" (London: British Broadcasting Corporation, 16 September 2010).

the care net".[62] The FTAC takes a "population approach to the issue of risk" that does not rely on undertaking a large number of risk assessments.[63] The FTAC operates from the premise that it reduces risk without having to predict, "which individuals might go on to engage in severely disruptive or violent behaviour".[64]

As will be seen below one of the major impediments to the effective and proper functioning of different processes of diversion in England and Wales was the lack of coordination between different agencies in the health, social services and criminal justice system.

The FTAC is a model of good practice in terms of the way the different agencies work together. This project has been heralded as the "first joint police–NHS unit in the UK, a significant innovation".[65] The modus operandi of the FTAC goes far beyond co-operation between the organisations as the Centre works together as a team (police and mental health professionals) researching cases that are referred to it.[66] The police refer cases to the Centre or "the offices of protected persons" and the team then carry out risk assessments and decide upon interventions.[67]

The caseworkers in the Centre have access not only to standard policing information resources but also access to NHS databases.[68] This means that the health workers can access highly confidential medical information of the Centre's targets without breaching the requirements of confidentiality. This obviously facilitates a very speedy assessment of the risk posed by a person and also facilitates the speedy development of a "management plan".[69] While this type of "diversion"

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[62] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 246.

[63] *Ibid*.

[64] *Ibid*, at page 247.

[65] *Ibid*.

[66] *Ibid*.

[67] *Ibid*.

[68] *Ibid*.

[69] *Ibid*.

could be classed as a type of "pre-arrest" programme it is important to note that the work of the FTAC does involve arrest on some occasions, however, in the majority of cased the type of intervention involves connection to mental health services. There is nonetheless liaison with the local police force. It has been suggested that the presence of psychiatrists on the team of the FTAC serves to remove bureaucratic barriers that the police would generally face.[70] The FTAC works nationally following up cases and travels throughout the UK for case conferences. The available data on the FTAC indicates that of the first 100 cases that the Centre was involved in, 85 persons were "taken on" by the psychiatric services and 55 were subject to compulsory admission.[71]

The FTAC is being couched in terms of a diversion programme that seeks to detect persons who are psychotic and have fixated on public figures. A number of the dynamics that Garland identified in creating a culture of control in the UK and the US appear to underlie the creation of the FTAC.[72] In particular, the notion that above all else the public must be protected and new management styles in criminal justice policy. Indeed the persons involved in the FTAC team feel that the joint police–NHS model has wider possible applications".[73] The wider application envisages modification of the role of the NHS police liaison psychiatric nurses, who would "become embedded in police responses at borough or county level in order to perform an enabling role, to the benefit of individual patients and of public protection".[74] One of the other benefits identified with the Center is that it enables "more efficient and effective risk assessment and management between agencies"; this again fits within Garland's thesis on the prominence of new management styles.[75] Thus it is clear that the motivation of the Centre is to manage risk with the focus on public protection and

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[70] *Ibid*.

[71] See James et al "The Fixated Threat Assessment Centre: Preventing Harm and Facilitating Care" (*Journal of Forensic Psychiatry and Psychology*: 21(4), 2010, pages 521-536).

[72] See Chapter 2: Literature Review, Part 1. Garland identified a number of themes that characterise the crime complex.

[73] James et al "The Fixated Threat Assessment Centre: Preventing Harm and Facilitating Care" (*Journal of Forensic Psychiatry and Psychology*: 21(4), 2010, pages 521-536).

[74] *Ibid*.

[75] *Ibid*.

facilitates involuntary detention and treatment.

3. Diversion and Liaison at Police Stations in England and Wales

The law and policy in England and Wales concerning diversion and liaison in police stations is significantly developed when compared to the situation in Ireland.[76] This section critically considers the different legislation provisions and processes that operate in England and Wales.

Section 135(1) of the 1983 Act empowers a Magistrate in England and Wales to issue a warrant authorising a police officer to enter a private residence to remove a person to a place of safety (using force if necessary). The person is brought to a place of safety with a view to making an application under Part 2 of the 1983 Act or for other arrangements to be made in relation to treatment and care. There are a number of safeguards around the use of section 135.[77]

The powers provided to police under section 136(1) of the *Mental Health Act 1983* are very broad in scope and have been the subject of much commentary and case law. The available statistics on the use of section 136 are patchy, only hospitals admissions keep central records, while other places of detention do not. However, the available statistics for 2005-2006 indicate that there were approximately 5,600 detentions in hospitals with 11,500 detained in the same period in police stations.[78] The section empowers the police to remove to a place of safety any person who is in a "place to which the public have access". This removal can be done provided that the person appears to the police to be suffering from a mental disorder, and is in immediate need of care and control, and that the removal is considered necessary in the

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[76] See Chapter 3: Ireland.

[77] For example, a warrant can only be issued in circumstances where information has been provided on oath by an approved mental health professional outlining that there is reasonable cause to suspect that a person is suffering from mental disorder has been or is being ill-treated, neglected or otherwise kept than under proper control, or is living alone and unable to care for themselves. When a police officer is executing a warrant under section 135 there is a requirement that they are accompanied an approved mental health professional and a doctor.

[78] See Docking, Grace and Bucke "Police Custody as a ""Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983" (London: Independent Police Complaints Commission, IPPC Research and Statistics Series: Paper 11, 2008).

person's best interests or for the protection of others. In exercising this power the police officer does not have to suspect that a criminal offence has been committed. Hale points out a number of other safeguards that are not present such as no requirement for a "magistrate's warrant, written application or medical evidence" that normally would be required if a person was on a private premises.[79] What constitutes "place to which the public have access" is quite broad.[80] There is evidence that the police have enticed people out of private premises in order to detain.[81] A place of safety is defined as either a hospital or police station. There is a consensus that a police station is not a suitable place to detain persons with MHPs. The Royal College of Psychiatry recommends that the "custody suite should be used in exceptional circumstances only".[82] The Independent Police Complaints Commission have noted that where there is good multi-agency cooperation and available alternatives the police seemed to be able to avoid using section 136.[83]

As section 136 is technically a power of arrest under *the Police and Criminal Evidence Act 1984* (PACE) the person detained is entitled to have another person informed, and if held in a police station entitled to legal advice and PACE Code C applies. As Hale notes persons detained under section 136 are likely to have their rights under PACE explained to them but are less likely to understand their situation under the *Mental Health Act 1983* and "none of this is likely to improve their mental health".[84] The MHA Code provides that persons can no longer be detained if the custody officer decides that the detention is no longer appropriate. As Hale notes this means that there is an unknown number of detainees that are released without any assessment,

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[79] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 146.

[80] It includes railway station platforms, car parks, shops, public houses and anywhere the public is generally admitted.

[81] See for example Independent Police Complaints Commission 2008, at page 18.

[82] See "Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983" (London: Royal College of Psychiatrists, Position Statement PS2/2013, April 2013) at page 4.

[83] Docking, Grace and Bucke "Police Custody as a ""Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983" (London: Independent Police Complaints Commission, IPPC Research and Statistics Series: Paper 11, 2008) at pages 30-34.

[84] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 147.

although it has been suggested that it is unlikely that a custody officer would reach this decision without appropriate advice.[85]

Amongst the safeguards detailed in the *Mental Health Act 1983* Code is an obligation placed on the police, health and social services to put in place clear policies with regard to the operation of section 136.[86] Nonetheless Hale is critical of the use of section 136 as its use is very significant given that it is "an informal and unregulated procedure".[87] She is also critical of section 136 as its purpose is unclear. In *Carter v Metropolitan Police Commissioner*[88] section 136 was used, as Hale describes it as a "convenient but possibly discriminatory way of diffusing a situation".[89] In this case police were responding to strange behaviour that was causing a disturbance, an African Caribbean woman with no history of mental illness was taken to hospital by police officers, when they found her on a communal landing with excrement on her hands following a dispute with neighbours. Hale questions whether it is acceptable that a person can be detained on the basis of a perception of being mentally ill, without any medical or professional advice.[90]

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[85] *Ibid*. Hale also points out that while a doctor assessing a detained under section 136 should be an "Approved Mental Health Profession" few police surgeons are. There is provision in section 136(3) for the transfer of a detained person to from one place of safety to another. This can be done prior, during or following an assessment of the person. However, the benefits of the transfer need to be weighted against the delay and distress that the transfer might cause the detained person. Section 3.16 of the MHA Code provides that once the assessment has been carried out and the arrangements made in respect of the detained person then the detention lapses. Where the doctor assesses that the detained person does not have a mental disorder then the detainee should be released immediately. The MHA Code at paragraph 10.33 provides that were a doctor assesses a person detained under section 136 the detainee should still be seen by an approved mental health professional even where the doctor does not consider that involuntary detention is required. The involvement of the approved mental professional is necessary as alternative arrangements may be necessary. The maximum period of detention is 72 hours from when the detainee reached the first place of safety under section 136(4). Detention under section 136 cannot be considered as detention under the *Mental Health Act 1983*, and there is no power to impose medical treatment without the consent of the detainee. See *Mental Health Act 1983* section 56(2), (3)(b).

[86] See "Code of Practice: Mental Health Act 1983" (London: Department of Health, 2008) at paragraphs 10.16-10.19.

[87] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 148.

[88] [1975] 1 WLR 507.

[89] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 148.

[90] *Ibid*.

Section 136 essentially provides the police with a way of responding to persons they come into contact with, whom they consider to be mentally ill. It has been suggested that it is nearly always open to the police to arrest a person for breach of the peace or a more serious criminal offence.[91] It has also been suggested that there is a risk that the provision is underused, as it is operationally easier for the police to process an arrest, compared to processing a detention under section 136.

James notes when "mentally disordered persons" are arrested and brought to the police station custody suite, in theory sufficient resources should be available to facilitate the assessment and transfer of the person, to the appropriate health services.[92] However, as is evident from the 2012 judgment of the ECtHR in *MS v United Kingdom*, this clearly is not always the case.[93] This case concerned a man who had been arrested and detained under section 136 of the 1983 Act.[94] The local psychiatric intensive care unit was unable to admit him.[95] The applicant remained in police custody for more than 72 hours, locked up in a cell where he was very distressed shouting, removing his clothing, banging his head on the wall, drinking from the toilet and smearing himself with food and faeces. On the second day of his custody, the prosecution service concluded that there was insufficient evidence to charge him. After more than three days in detention, and on the advice of the consultant forensic psychiatrist, the applicant was taken in handcuffs to the clinic where he received treatment. The ECtHR held unanimously that there had been a violation of Article 3 of the ECHR on prohibition of inhuman or degrading treatment. The Court found that the applicant's prolonged detention, without appropriate psychiatric treatment had diminished his human dignity, even though there had been no intentional neglect on the part of the police, and amounted to degrading treatment.

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[91] *Ibid*.

[92] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 244.

[93] Application no. 24527/08, Judgment 3 May 2012.

[94] Following his arrest he was assessed by a psychiatric specialist who determined he was suffering from a mental illness of a nature or degree that warranted detention in hospital in the interests of his health and safety and for the protection of others.

[95] However, there was an attempt to place the applicant in a clinic with a medium secure unit.

In *R (Anderson) v HM Coroner for Inner North Great London* it was held that the powers contained in section 136 of the 1983 Act, mandated the administration of some form sedation and permitted police officers to use reasonable force to restrain a violent person.[96] *In Munjaz v Mersey Care NHS Trust* Baroness Hale stated "[t]here is a general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm".[97] Therefore, in England and Wales there are powers under common law and the *Mental Capacity Act 2005* to make decisions in the persons best interests and administer sedatives "provided they are a proportionate response to the need to prevent the person harming her or himself or others."[98]

Section 136 of the 1983 Act is a controversial section that confers powers on the police to deprive persons with MHPs of their right to liberty. It is considered to be an essential component of the diversion system. Police stations are frightening places and persons detained under section 136, who are brought to a police station, are likely to be processed in the same manner as any other person that has been arrested. This is likely to give the person the impression that they are suspected of having committed a crime, and will impact their cooperation with the assessment of their mental health.[99] As Hale points the provision is unlikely to improve a persons mental health. Section 136 may serve to connect persons with MHPs to services in the community. However, the power is coercive and at odds with the principles of the CRPD.[100]

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[96] [2004] EWHC 2729. The Court held that section 136 requires "that the person be kept in safe in the sense that harm to himself or others is prevented until he can be seen by a doctor and, if necessary, give some form of sedation… A police officer in exercising his powers under s 13 is entitled to use reasonable force. If some one is violent, he can be restrained."

[97] [2003] EWCA Civ 1036, at paragraph 46. She goes on to say that this general power applies regardless of whether the patient, lacks the capacity to make decisions for himself. In circumstances where the patient is considered to lack capacity, Hale held there is a power to provide the person with" whatever treatment or care is necessary in his own best interests"

[98] Fennell "Powers of the Police and Decision to Prosecute" in Gostin, McHale, Fennell, Mackay and Bartlett (eds) *Principles of Mental Health Law and Policy* (Oxford: Oxford University Press, 2010) at page 712.

[99] "Code of Practice: Mental Health Act 1983" (London: Department of Health, 2008) at paragraph 10.24.

[100] See Chapter2: Literature Review, Part 2.

The police after they connect persons with MHPs to mental health services, can decide not to pursue charges, however, they can also caution, charge or bail a person. In circumstances where detention in custody is inevitable, for example, due to the seriousness of the offences the police ensure that the person is issued with a form that provides the court with notification about their MHP. Diversion at the police station has great potential for development in Ireland and elsewhere.[101] However, it has been noted that this system of diversion at police stations in England and Wales is "rarely worked".[102] James has suggested that the main reasons for the limited use of this system is because decisions are dependent on the custody sergeant, who generally speaking has "limited knowledge" of mental disorder.[103] The other main impediment to the proper functioning of police diversion is that the custody sergeant is concerned with "legal matters", and the focus is on disposing, as quickly as possible, persons held in custody.[104]

James has suggested that the role of the Forensic Medical Examiner (FME) "tends to be narrowed, in a brief interview, to making judgements about fitness to be detained and fitness to be interviewed, rather than conducting a full mental state examination".[105] It is also suggested that the delays in acquiring the services of an Approved Mental Health Practitioner (AMHP) discourage initiating assessments under the 1983 Act. Two studies from the 1990s in police station surveys in London suggested that 1.2% to 1.6% of persons arrested showed signs of serious mental illness.[106] However, this did not result

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[101] See Chapter 2: Literature Review, Part 2.

[102] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 244.

[103] *Ibid*.

[104] *Ibid*.

[105] *Ibid*.

[106] See "The management of people with mental health problems by the Paddington police" (London: Revolving Doors Agency, 1994); Robertson, Pearson and Gibb "The entry of mentally disordered people to the criminal justice system" (London: Home Office, 1995); Robertson, Pearson, Gibb "The entry of mentally disordered people to the criminal justice system" (*British Journal of Psychiatry*: 169, 1996, pages 172-180). These studies were based on based on records or on observational study.

in the police connecting persons with health and social services.[107] The failure to connect persons at the police station, who committed minor offences, is considered to be a missed opportunity as people are diverted "back onto the streets" with no connection to supports and services.[108]

The development of different diversion and liaison schemes over the past number of decades has been a notable feature of diversion in England and Wales. These schemes involve psychiatric nurses from the NHS system, which are assigned to police custody suites.[109] The role of these nurses is to identify detained persons who may have a mental disorder.[110] This is done by taking a detailed history of the person and by undertaking an examination of their mental health and by obtaining information on the person's health records.[111] These liaison schemes in the police station also seek to make decisions about what interventions should happen, including assessment for detention under the 1983 Act.[112] One of the roles of nurses in these initiatives is to prepare reports and to track cases by sharing information with other relevant agencies.[113]

It has been suggested that police liaison schemes such as these should not be seen in isolation "but rather as part of an integrated spectrum of services at police stations courts and prisons".[114] The research suggests that these schemes can play an effective role in the diversion

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[107] See "The management of people with mental health problems by the Paddington police" (London: Revolving Doors Agency, 1994);

[108] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 244.

[109] See for example Chung, Cumella, Wensley, and Easthope "A Description of a Forensic Diversion Service in one city in the United Kingdom" (*Medicine, Science and the Law:* 38, 1998, pages 242-250).

[110] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, pages 241–248) at page 244.

[111] *Ibid*.

[112] *Ibid*.

[113] James "Police Station Diversion Schemes: Role and Efficacy in Central London" (*Journal of Forensic Psychiatry*: 11(3), 2000, pages 532-555).

[114] *Ibid*.

system in England and Wales. [115] However, despite their potential, they have not been "properly established".[116] However, there is much potential to ensure effective co-ordination between existing services.[117] Though, there is also the danger that information sharing between agencies and risk assessment may negatively impact persons participating in these schemes.

4. Investigation and Decisions to Prosecute

There is much greater transparency around decisions to prosecute persons with MHPs in England and Wales compared to Ireland.[118] The decision-making around prosecution in England and Wales is based on a clear policy of weighing up the decision not to prosecute with the public interest. Principles of therapeutic jurisprudence and principles of reasonable accommodation arguably motivate this weighing process (EG the factors that need to be taken into account are the impact of the prosecution on person's physical and mental health and their age). This is in contrast with the situation in Ireland, where there is little guidance for Gardaí and DPP in making decisions to prosecute persons with MHPs or ID.

In England and Wales a decision to prosecute in the first instance will be taken by the police. In that regard the police will make decisions based on what is in the public interest as articulated in the Code for Crown Prosecutors.[119] Where a person is to be prosecuted a special interview procedure will apply and may lead to use of special procedures at the trial stage, and may also involve decisions about

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[115] *Ibid*. This study of London schemes examined 1.1% of all custody cases at three police stations were over a period of 31 months. The need for admission was identified in 34% of referrals, which was achieved in 31%. Additionally there were community referrals to a range of different health and social bodies in 32% of cases. The study showed that 91% of admissions were achieved on the day of assessment.

[116] *Ibid*.

[117] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 244.

[118] See Chapter 3: Ireland.

[119] "Code for Crown Prosecutors" (London: Crown Prosecution Service, February 2010).

criminal responsibility and "may culminate in the use of a hospital rather than a penal disposal".[120]

In making the decision to prosecute the CPS require information and evidence in relation to MHPs as early as possible, if they are to review the case in light of the Code for Crown Prosecutors. Clearly the police have an obligation to provide this information and guidance for the police is set out in Home Office Circular 12/95.[121] The Circular supplements Home Office Circular 66/90 and provides that where the police have been advised of the defendant's condition and prognosis by the Social Services, Probation Service, psychiatrists or other professionals, who may advocate a particular approach or disposal, the advising agency should be encouraged to make their views known in writing.[122]

The CPS will normally have responsibility for making decisions in relation to whether a prosecution should proceed and for what offences. The CPS in deciding to prosecute a suspect will base its decision on the likelihood of securing a conviction and on whether the prosecution is in the public interest. The Code for Crown Prosecutors provides that amongst some of the common public interest factors tending against prosecution (meaning that a prosecution would be less likely to be required) include consideration of whether the person is a mentally disordered offender.[123] If the criminal offence that a person

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[120] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at pages 226.

[121] "Mentally Disordered Offenders: Inter-Agency Working" (London: Home Office Circular, No 12/95, 1995).

[122] It also provides that in circumstances where this is not possible, the police should synopsise any views that are expressed to them orally. The circular also provides that the police should include on the file a brief summary of their reasons for initiating their proceedings or their views as to whether the suspect should be prosecuted. The Circular also states that the Crown Prosecution Service should be informed if the defendant has seen a psychiatrist or of the arrangements put in place for an assessment. The Circular also stipulates that the period of bail should be kept to a minimum if the police want to release the defendant on unconditional bail on the basis that the suspect will accept certain conditions such as treatment or residence. The Circular specifies that it would be preferable for the defendant to be bailed to the next available court for bail arrangements to be reviewed as soon as possible and that any informal conditions of bail should be plainly stated on the Crown Prosecution Service file.

[123] "Code for Crown Prosecutors" (London: Crown Prosecution Service, February 2010) at paragraph j, pages 14-15. The Code for Crown Prosecutors states "… the suspect is, or was at the time of the offence, suffering from significant mental or physical ill health, unless the offence is serious or there is a real possibility that it may be repeated. Prosecutors apply Home Office

with a MHP allegedly committed is not serious and it is unlikely to be repeated, then the public could be considered adequately safeguarded, if that person is admitted as a voluntary patient in lieu of prosecution.[124]

5. Appropriate Adults and "Vulnerable" Detainees

In addition to the range of diversion provisions, processes and initiatives special measures have also been placed on a statutory footing. These measures seek to safeguard the rights of defendants who are considered to be vulnerable. Code C of the PACE deals with the detention, treatment and questioning of persons by the police. The police, in investigating a crime allegedly committed by a person with a MHP, are required to comply with a number of safeguards. Amongst the safeguards provided for is the requirement for an "appropriate adult" to be present during police questioning.[125] Code C provides that "[i]f an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as such for the purposes of this Code".[126]

Under the initial action heading of the Code there is specific guidance on "detained persons – special groups". Section 3.12 deals with detainees that appear to be deaf or have hearing or speaking impairments or language difficulties and effective communication cannot be established.[127] The custody officer is also required to ask the

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guidelines about how to deal with mentally disordered offenders and must balance a suspect's mental or physical ill health with the need to safeguard the public or those providing care services to such persons". See also "The Director's Guidance On Charging 2011: Revised Arrangements" (London: 4th edition, January 2011).

[124] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at pages 226. It is noteworthy also that the decision of the police to investigate a criminal offence will be made with reference to Code for Crown Prosecutors and the decision to divert as opposed to prosecute will pivot on the seriousness of the alleged offence.

[125] Code C provides for these safeguards.

[126] "Code of Practice For the Detention, Treatment and Questioning of Persons by Police Officers" (Code C, Police and Criminal Evidence Act 1984 (PACE), January 2008).

[127] *Ibid*, at page 11. Juveniles are also dealt with under the special groups heading, as are "mentally disordered" persons. Section 3.20 of the code similarly deals with detainees who are blind, seriously visually impaired or unable to read (see page 12). Section 3.15 provides that if the detained persons is a "… juvenile, mentally disordered or otherwise mentally vulnerable, the custody officer" is required as soon as practicable to inform the appropriate adult … of the grounds for their detention and their whereabouts (see page 12).

appropriate adult to come to the police station to see the detainee. In the Code's notes on guidance it is recommended that in cases involving "mentally disordered or otherwise mentally vulnerable" persons it "may be more satisfactory if the appropriate adult is someone experienced or trained in their care rather than a relative lacking such qualifications. But if the detainee prefers a relative to a better qualified stranger or objects to a particular person their wishes should, if practicable, be respected."[128] The notes on guidance also provide that a detainee, in addition to the appropriate adult should be allowed to consult with a solicitor without the presence of the "appropriate adult" if requested.[129] The custody officer is required to remind the "appropriate adult" and the detainee of the right to legal advice and record any reasons for waiving it.[130]

The term "mentally vulnerable" is defined in the Code as applying "… to any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies".[131] The definition of mental disorder is taken from the definition in the *Mental Health Act 1983* in section 1(2) as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind".[132] The code also requires the custody officer to call an "appropriate adult" in circumstances where they have any doubt about the mental state or mental capacity of a detainee and that they should be treated as mentally vulnerable.[133]

The role of the "appropriate adult" is not simply a passive role. The "appropriate adult" when present at an interview is informed they are not expected to act simply as an observer and the rationale for their involvement is to "advise the interviewee", "observe whether or not the interview is being conducted properly and fairly" and "facilitate

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[128] *Ibid*, at page 6.

[129] *Ibid*. It is important to note that the "appropriate adult" is not subject to legal privilege.

[130] *Ibid*, at page 7.

[131] *Ibid*, at page 6.

[132] *Ibid*.

[133] *Ibid*.

communication with the interviewee".[134] Code C places an obligation on the custody officer to ensure that a person receives appropriate clinical attention as soon as reasonably practicable, if the person appears to be suffering from a mental disorder or in urgent cases immediately call the nearest health care professional or an ambulance.[135] This requirement applies even if the detainee does not request clinical attention and regardless of whether they have already received clinical attention elsewhere.

Code C also factors in the relevance of the mental health legislation. The Code requires that a "mentally disordered" or otherwise "mentally vulnerable" person detained under the *Mental Health Act 1983*, section 136 be assessed as soon as possible. It provides that if that assessment is to take place at the police station, an approved social worker and registered medical practitioner should be called to the station as soon as possible in order to interview and examine the detainee.[136] Following this interview and examination of the detainee, suitable arrangements have to be made for their treatment or care and they can no longer be detained under section 136 of the 1983 Act.[137] The Code provides that a detainee should be immediately discharged from detention if a registered medical practitioner concludes that they are not mentally disordered, within the meaning of the 1983 Act.[138]

Procedurally the role of the "appropriate adult" is very important in that a "mentally disordered" or otherwise "mentally vulnerable" must be cautioned in the presence of an appropriate adult.[139] Where the person is cautioned without their presence the caution must be repeated in their presence.[140] Similarly, a mentally disordered or otherwise mentally vulnerable person cannot be interviewed or asked to provide or sign a written statement in the absence of the

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[134] *Ibid*, at pages 40-41.

[135] *Ibid*, see pages 29-30.

[136] *Ibid*, at page 12.

[137] *Ibid*.

[138] *Ibid*.

[139] *Ibid*, at page 36.

[140] *Ibid*.

"appropriate adult" subject to a number of exceptions.[141]

Code C also has safeguards in relation to the continued detention of "mentally disordered" or otherwise "mentally vulnerable" persons. It requires that when detention is being reviewed by a review officer or a superintendent, the "appropriate adult" if available must be given an opportunity to make representations to the officer regarding the need for continued detention.[142] If the custody officer charges "mentally disordered" or otherwise "mentally vulnerable" persons with an offence or takes such other action this has to be done in the presence of the "appropriate adult" and written notice embodying the charge must be given to the "appropriate adult".[143]

Unlike the sparse provisions in Ireland there are a number of procedures around intimate or strip search of "mentally disordered" or otherwise "mentally vulnerable" persons and on the use of restraints.[144] These provisions to a greater extent seek to accommodate and minimise the impact of invasive elements of the criminal justice system on PWDs. In that vein the role of the "appropriate adult" can be viewed as a type of reasonable accommodation for the detainee considered disabled, even though the procedures are not articulated as such. The rationale for underlying the "appropriate adult" centres on the perceived vulnerability of the detainee and supposedly safeguards against the application of undue influence.[145] The purpose of the

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[141] *Ibid*, see sections 11.1, 11.18 and 11.20. Questioning under these exceptions cannot continue in the absence of the "appropriate adult" once sufficient information to avert the risk has been obtained.

[142] *Ibid*, at page 48.

[143] *Ibid*, pages 53-54.

[144] *Ibid*. Such searches can only take place in the presence of the "appropriate adult" of the same sex, unless the detainee specifically requests the presence of a particular adult of the opposite sex (see page 66 and 67-68.). A strip search can take place in the absence of an appropriate adult only in cases of urgency when there is a risk of serious harm to the detainee or others. The Code provides that "… no additional restraints should be used within a locked cell unless absolutely necessary and then only restraint equipment, approved for use in that force by the Chief Officer, which is reasonable and necessary in the circumstances having regard to the detainee's demeanour and with a view to ensuring their safety and the safety of others" (see page 27). The Code also provides that if a detainee is deaf, "mentally disordered" or otherwise "mentally vulnerable", particular care must be taken when deciding whether to use any form of approved restraints.

[145] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 227.

provision on the provision of legal advice is described in the Code as protecting "… the rights of a mentally disordered or otherwise mentally vulnerable detained person who does not understand the significance of what is said to them."[146]

Interestingly the notes for guidance concede that "[a]lthough people who are mentally disordered or otherwise mentally vulnerable are often capable of providing reliable evidence, they may, without knowing or wanting to do so, be particularly prone in certain circumstances to provide information that may be unreliable, misleading or self-incriminating".[147] The notes for guidance go on to sate as a result of this special care should always be taken during questioning such persons, and the "appropriate adult" should be involved if there is any doubt about a person's mental state or capacity.[148] The notes for guidance also state that given "… the risk of unreliable evidence, it is important to obtain corroboration of any facts admitted whenever possible".[149]

In *R v Aspinall*[150] the police conducted an interview with a man who they knew to have a diagnosis of schizophrenia and on regular medication, without an appropriate adult, as they considered that he was lucid and fit to be interviewed alone. The Court of Appeal set down a test in respect of whether the breach of the PACE code rendered statements inadmissible. The statements according to the Court of Appeal would only be inadmissible if the absence of the "appropriate adult" with all of the safeguards that was designed to bring had such an adverse effect upon the fairness of the interview that it should be excluded. In *R v Gill and others*[151] the judge was entitled

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[146] "Code of Practice For the Detention, Treatment and Questioning of Persons by Police Officers" (Code C, Police and Criminal Evidence Act 1984 (PACE), January 2008) at page 80.

[147] *Ibid*.

[148] *Ibid*.

[149] *Ibid*. On the basis of this perceived risk it is necessary for "appropriate adults" to be present during questioning in order to minimise the risk. There is a discretionary power for officers at the rank of superintendent and above to proceed with interview in the absence of an "appropriate adult" but "… only in exceptional cases, if it is necessary to avert an immediate risk of serious harm."

[150] [1999] 2 CR App R 115.

[151] [2004] EWAC Crim 3245.

to conclude that the presence of an "appropriate adult" would have made no difference to the questioning. A survey of prisoners with learning disabilities and learning difficulties reported that less than a third of prisoners received support from an appropriate adult during police interview.[152] In addition a number of prisoners reported that they "had been beaten or handled roughly by the police and felt manipulated into agreeing to a police interview without support".[153]

6. Confessions by "Mentally Handicapped Persons" at Trial

Section 77 of the *Police and Criminal Evidence Act 1984* deals specifically with the admission of confession evidence by persons considered to "mentally handicapped". It has been noted that there is a divergence between Code C, which refers to mental disorder and mental vulnerability and section 77, which refers to the narrower concept of mental handicap.[154] "Mental handicap" is defined under section 77(3) as meaning "… a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning". The case law requires that the evidence as to the defendants "mental handicap" be based on medical evidence.[155]

Section 77(1) of the PACE provides that where a case against an accused depends wholly or substantially on their confession and the court is satisfied that the defendant is "mentally handicapped" and the confession was not made in the presence of an "independent person" the court is required to warn the jury that there is special need for caution before convicting the accused in reliance on the confession. The court is also required to explain to the jury that this is necessary as the case against the defendant depends on their own confession and that they have a mental handicap and made the statement in the absence of an "independent person". This safeguard does not apply exclusively to trial on indictment but also applies in section 77(2) to

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[152] Talbot "Prisoners' Voices Experiences Of The Criminal Justice System By Prisoners With Learning Disabilities And Difficulties" (London: Prison Reform Trust, 2008) at page v.

[153] *Ibid*.

[154] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 229.

[155] *R v Ham* (1995) 36 BMLR 169.

cases tried summarily. The court hearing such cases "… shall treat the case as one in which there is a special need for caution before convicting the accused on his confession." The same requirement applies to trial on indictment without a jury by way of section 77(2A). In *R v Moss*[156] it was decided that the direction to the jury alone was not sufficient to ensure that the conviction was safe. This case involved a man with an ID who was considered to be just above the "mental handicap" level. He was convicted exclusively on the basis of confessions he made in 9 police interviews that he was in police custody over 9 days, without any legal advice.

Section 76(2) of the PACE deals with confessions and provides for the exclusion of confessions where "… the prosecution proposes to give in evidence a confession made by an accused person, it is represented to the court that the confession was or may have been obtained by oppression of the person who made it … or in consequence of anything said or done which was likely, in the circumstances existing at the time, to render unreliable any confession which might be made by him in consequence thereof". However, there is an exception to the exclusion "… in so far as the prosecution proves to the court beyond reasonable doubt that the confession (notwithstanding that it may be true) was not obtained as aforesaid." The failure of the custody officer to secure the presence of an "appropriate adult" is unlikely to be sufficient to amount to "oppression" under section 76(2) of PACE, "… unless there is a strong degree of hectoring of a mentally vulnerable suspect."[157] However, the failure to secure the presence of an "appropriate adult" could constitute "anything said or done which was likely, in the circumstances existing at the time, to render unreliable any confession which might be made by him in consequence thereof".[158]

Section 78 of the PACE regulates the exclusion of unfair evidence. Section 78(1) provides that "… any proceedings the court may refuse to allow evidence on which the prosecution proposes to rely to be given if it appears to the court that, having regard to all the circumstances,

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[156] (1990) 91 CR App R 371

[157] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 229.

[158] The case law indicates that this is the case – see *R v Everett* [1988] Criminal Law Reports 826, CA and *R v Moss* (1990) 91 Criminal Appeal Reports 371, CA.

including the circumstances in which the evidence was obtained, the admission of the evidence would have such an adverse effect on the fairness of the proceedings that the court ought not to admit it." Section 78(1) has been used with varied success to argue that the failure to provide an "appropriate adult" contravenes the principles of fairness.[159]

6.1. Expansion of Special Measures

While the range of special measures available in England and Wales is impressive when compared to Ireland, there remains an imbalance of fairness for vulnerable persons.[160] There has been an extension of special measures under the *Coroners and Justice Act 2009*. The 2009 Act provides that adult defendants with a "mental impairment" are eligible to make an application to testify via live link and with the support of a third party.[161] The 2009 Act provides that witnesses to violent crimes where firearms or knives are now automatically eligible for special measures.[162] Hoyano is critical of the *Coroners and Justice Act 2009* as it provides eligibility gaps between child witnesses and child defendants and between child defendants and vulnerable adult defendants and suggested that there has been a lack of justification for these demarcations, as a result Hoyano suggests that the legislation is vulnerable to challenge on the basis of equality under Article 6 of the ECtHR.[163] It has been suggested that the "unspoken but unmistakable premise in the *C&JA 2009* is that defendants, whatever their age, are

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[159] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 230.

[160] See "Fair Access to Justice? Support for Vulnerable Defendants in the Courtroom" (London: Prison Reform Trust, 2012). See also Cooper and Wurtzel "A day late and a dollar short: in search of an intermediary scheme for vulnerable defendants in England and Wales" (*Criminal Law Review*: 1, 2013, pages 4-22).

[161] Hoyano "Coroners and Justice Act 2009: Special measures directions take two: entrenching unequal access to justice?" (*Criminal Law Review*: 5, 2010, pages 345-367). Hoyano is critical of the Coroners and Justice Act 2009 as it provides eligibility gaps between child witnesses and child defendants and between child defendants and vulnerable adult defendants. It has been suggested that there has been a lack of justification for these demarcations and as a result Hoyano suggests that the legislation is vulnerable to challenge on the basis of equality under Article 6 of the ECtHR.

[162] *Ibid*.

[163] *Ibid*.

somehow less deserving of assistance to give their best evidence than are other witnesses with the same communication difficulties".[164]

7. Other Diversion Provisions Under the Mental Health Act 1983

The courts in England and Wales have jurisdiction to transfer sentenced prisoners and defendants held on remand to psychiatric hospitals in order to receive treatment.[165] It is important to note that the transfer can be reversed when the person's mental health improves. However, many persons will complete their sentences in the NHS psychiatric hospitals "often for pragmatic reasons".[166] There is no provision in the *Mental Health Act 1983* as amended for forced treatment in prisons. As James notes prisons in England and Wales contain "health care wings", however, these wings are not recognised as hospitals and there is no provision of psychiatric wards within the prison system.[167] This contrasts with the crisis-motivated response of creating the High Support Unit in Ireland's largest prison Mountjoy.[168] The *Mental Health Act 1983* also provides for the admission to hospital from both the courts and prisons of persons considered to have learning difficulties and personality disorders.[169]

8. Sentencing and Offenders with MHPs

The effect of a MHP on criminal responsibility or fitness for trial, has limited application only being considered in a small number of

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[164] *Ibid*, at page 265.

[165] There are a number of other provisions that are relevant also. Remand powers under the 1983 Act under sections 36, 36 and 38. Interim hospital orders under section 38, a guardianship order under section 37, transfer to hospital od sentenced prisoners under sectiond 47 and 49 and hospital directions and restriction directions under section 45A of the 1983 Act.

[166] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

[167] *Ibid*.

[168] See Chapter 3: Ireland.

[169] For a discussion on this see James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

cases.[170] However, the effect of a MHP sentencing stage is more significant, where it may be relevant in thousands of cases.[171] In many cases an offender may not receive a custodial sentence with the court opting instead to admit to hospital under Part 3 of the *Mental Health Act 1983*. Where a person is convicted of a criminal offence it is open to the judge to give the offender a community disposal, a prison sentence or indeed a hospital order. It is also open to the court to divert an offender with a MHP to the psychiatric system under the *Mental Health Act 1983* by way of a hospital order or guardianship order or through a community order as provided for in section 177(1)(h) of the *Criminal Justice Act 2003*. The use of hospital orders discussed above has been a "key method of disposal of mentally disordered offenders" in England and Wales since the *Mental Health Act 1959*.[172] In deciding to impose a hospital order, a key issue is whether the offender is suffering from a mental disorder at the sentencing stage, as opposed to considering whether there was a presence of a mental disorder at the time of the commission of the offence. The only important consideration is the offenders' need for psychiatric treatment in hospital and at the time of sentencing. The 1983 Act also provides for the transfer of offenders with MHPs, either serving sentences or held on remand, from prison to hospital on the basis of a warrant issued by the Home Secretary.

The *Criminal Justice Act 2003* also introduced a framework for the sentencing of offenders, with disposals that range from the imposition of community sentences, to specific provisions to deal with offenders considered to be dangerous. Section 142(1) of the *Criminal Justice Act 2003* requires the court to have regard to the following sentencing purposes: the punishment of offenders; the reduction of crime including its reduction by deterrence; the reform and rehabilitation of offenders, the protection of the public, and the making of reparation by offenders to persons affected by their offences.[173]

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[170] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 247.

[171] *Ibid*.

[172] *Ibid*.

[173] This section does not apply to offenders under the age of 18, offenders convicted of murder and other serious crimes that require custodial sentences and who were subject to Chapter 5 of the 2003 Act. In addition this section does not apply to cases where the court makes a hospital order or an interim or a hospital direction under Part 3 of the 2003 Act.

Community orders ought not to be used unless the court is of the opinion that such an order would be insufficient and the offence is so serious that a fine alone or in combination with a community sentence. Section 177(1)(h) provides for community orders to include "a mental health treatment requirement". It is important to note that a court cannot impose a "mental health treatment requirement" unless it is satisfied on the evidence from a doctor that the MHP requires and is receptive to treatment but does not require a hospital or guardianship order.[174]

The court must be satisfied also that arrangements can be made for the treatment specified in the order and that the offender has expressed a willingness to comply with the requirement. This does raise concern from the perspective of the CRPD, as diversion under these circumstances can only be availed of if the offender is willing to agree to psychiatric treatment, and given the alternative, can be seen as coercive psychiatric treatment.[175]

9. Mental Health Treatment Requirement

The Mental Health Treatment Requirement is one of twelve options that

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[174] See section 12 of the *Mental Health Act 1983*.

[175] See Chapter 2: Literature Review, Part 2. A "mental health treatment requirement" involves an offender presenting for the specified period in the order to treatment that will be supervised by a doctor or psychologist or both with a view to improve the offenders mental health. The community order may require the offender to avail of treatment on an outpatient basis and the offender is compelled to comply with the treatment stipulated in the order. It may also be the case that an offender is required to avail of treatment on a residential basis within a nursing home or care home within the meaning of the *Care Standards Act 2000* but this does not extend to a high security hospital. Outside these requirements it is not open to the court to stipulate the type of treatment to be administered in the order. The 2003 Act also provides powers to respond to offenders who breach community orders. Section 179 and schedule 8 of the 2003 Act provide that where the responsible office is of the opinion that the offender failed to comply with the community order and they do not have a reasonable excuse then they must issue a warning setting out the breach and that a further breach within a 12 month period may result in the offender being brought before the court. Where a second breach does occur within the 12-month period then the responsible officer is required to bring the matter before the court. This does not necessarily mean that the court will impose a custodial sentence – the court may decide to attach greater conditions to the order. However, it will be open to the court to impose a custodial sentence if the original sentence was punishable by imprisonment. In circumstances where an adult aged over 18 has persistently failed to comply with a community order it will be open to the Magistrates Court and the Crown Court to impose up to a 51-week sentence even where the original offence was not punishable by imprisonment.

are available to magistrates and judges in circumstances where they secede to issue a Community Order.[176] The requirement for a Mental Health Treatment Order is that the person has a MHP that is prone to treatment. It has been noted that there has been little use of this provision and its use represents less than 1% of all requirements attached to Community Orders.[177] It has been suggested that greater use of this provision would facilitate offenders to "engage with appropriate treatment and support. Wider use of the MHTR could result in improved health outcomes and reduced reoffending, cutting the costs of crime for the wider community".[178] One of the main barriers to greater use of Mental Health Treatment Requirement in imposing community sentencing has been identified as a lack of certainty as to who should receive this type of requirement.[179] It has been suggested that professionals have blocked certain persons such as persons with personality disorders or with a diagnosis of depression or anxiety.[180] Another barrier has been identified, as the prerequisite of the availability of treatment and the "high thresholds" required by mental health services for access to treatment. For example, it has been suggested that psychiatrists would not recommend Mental Health Treatment Requirements for persons requiring talking therapies or psychological treatment as the effectiveness of these treatments were dependent upon voluntary engagement.[181]

These barriers highlight the coercive and medicalised approach to offenders with MHPs in England and Wales, where law and policy is

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[176] The 12 requirements include unpaid work (10-300 hours), supervision (up to 36 months), accredited programmes (in association with supervision), drug rehabilitation (6-36 months) alcohol treatment (6-36 months), mental health treatment (up to 36 months), residence (up to 36 months), specified activity (up to 60 days), prohibited activity (up to 36 months), prohibited activity (up to 36 months), exclusion (up to 36 months), curfew (between 2-12 hours daily for up to 6 months), attendance (12-36 hours with up to 3 hours per attendance). See Criminal Justice Act 2003.

[177] Scott and Moffatt "The Mental Health Treatment Requirement: Realising a Better Future" (London: Sainsbury Centre for Mental Health, November 2012) at page 2.

[178] *Ibid*.

[179] Scott and Moffatt "The Mental Health Treatment Requirement: Realising a Better Future" (London: Sainsbury Centre for Mental Health, November 2012) at page 12.

[180] Khanom, Samele, and Rutherford "A Missed Opportunity? Community Sentences and the Mental Health Treatment Requirement" (London: Sainsbury Centre for Mental Health, 2009).

[181] Scott and Moffatt "The Mental Health Treatment Requirement: Realising a Better Future" (London: Sainsbury Centre for Mental Health, November 2012) at page 12.

informed by responses to minimising risk and managing dangerousness. Nonetheless the Mental Health Treatment Requirement is designed to operate on the basis of consent of the offender. The reluctance of mental health professionals to recommend these orders due to concerns about a lack of compulsion highlights the challenges in embedding CRPD principles in diversion policy.

The failure to use Mental Health Treatment Requirements for a broader range of persons, beyond persons with severe and enduring MHPs, for example, persons with moderate or mild mental illness is short sighted. Another problem with the operation of Mental Health Treatment Requirements is that professionals working in the courts, probation and health services did not have direct experience of the mental health requirements and there was a lack of awareness of it.[182] Other reasons for the lack of use of Mental Health Treatment Requirements included vagueness amongst professionals on deciding whether a person breached the requirement and how this should be dealt with.[183] The "biggest practical barrier to the effective use of the MHTR" has been identified as the necessity to obtain a formal psychiatric report, which takes a long time and is expensive and can result in offenders spending a long period of time detained on remand waiting for the report.[184]

The Centre for Mental Health have argued that in order to overcome the barriers to the use of Mental Health Treatment Requirements it was essential to have flexibility in responding to breaches of the requirements.[185] In addition it was suggested that liaison and diversion services needed to "facilitate information sharing between courts, probation and health services and … promote more effective inter-agency working" and that diversion and liaison services had "considerable untapped potential to fulfil a vital bridging function between these very different services and professional cultures".[186] It

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[182] Khanom, Samele, and Rutherford "A Missed Opportunity? Community Sentences and the Mental Health Treatment Requirement" (London: Sainsbury Centre for Mental Health, 2009).

[183] Scott and Moffatt "The Mental Health Treatment Requirement: Realising a Better Future" (London: Sainsbury Centre for Mental Health, November 2012) at page 15.

[184] Khanom, Samele, and Rutherford "A Missed Opportunity? Community Sentences and the Mental Health Treatment Requirement" (London: Sainsbury Centre for Mental Health, 2009).

[185] Scott and Moffatt "The Mental Health Treatment Requirement: Realising a Better Future" (London: Sainsbury Centre for Mental Health, November 2012) at page 17.

[186] *Ibid*, at age 18.

was suggested that it was also essential that there was practical guidance and training professionals working in the criminal justice and health systems on Mental Health Treatment Requirements.[187] Perhaps most crucially the provision and availability of services is vital if the courts are going to dispose of offender's case by way of community disposal. In that regard the recommendation of the Bradley Report is relevant where it was recommended that the "courts, health services, the Probation Service and the Crown Prosecution Service should work together to agree a local service level agreement for the provision of psychiatric reports and advice to the courts". [188]

The use of Mental Health Treatment Requirement as a means of responding to offenders with MHPs would be a positive approach that would comply with the principles set out in the CRPD. Unlike other orders and aspects of the diversion system that operate on compulsion Mental Health Treatment Requirement is not designed to achieve forced treatment as the consent of the offenders requires their consent in advance of the order being made. A person "cannot be forced to comply with any treatment by clinical staff while on an MHTR" and the issue of enforcement arises in circumstances where consent has been given and there is a breach of the persons Community Order.[189]

10. Hospital Orders

Hospitals orders are provided for under section 37 of the *Mental Health Act 1983* as amended. Section 37 empowers the courts to order hospital admission and is the most commonly used disposal by the courts in England and Wales.[190] Section 37 applies in circumstances

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[187] *Ibid*. The problem with obtaining reports ought to be addressed by section 73 of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012*, which removed the requirement for a report by a section 12 approved registered medical practitioner before a court can issue an MHTR.

[188] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) see page 73.

[189] *Ibid*.

[190] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

where the defendant has been found guilty of any criminal offence where a custodial sentence could be imposed. However, these hospital orders can be made in both the Crown and Magistrates Courts. One of the positive elements of section 37 is subsection (3), which provides that the Magistrates Courts can impose a hospital order without having to record a conviction against the accused person even where they are satisfied that he/she did the act or made the omission charged. The court can make a hospital order without restrictions meaning that the patient's "responsible clinician" (RC) can discharge the patient without having to seek approval from a "higher authority" and detention is renewed in the same way as section 3 of the 1983 Act.[191] If a restriction order is imposed by the Crown Court this is done automatically without any time limit and the RC is not required to renew the persons detention.

The form of diversion provided for involuntary detention and treatment comes into conflict with our emerging understanding of the CRPD, in particular Articles 12, 14 and 17. The diversion provided for in section 37 of the *Mental Health Act 1983* provides for involuntary treatment without consent subject to the procedural safeguards provided for in Part IV of the 1983 Act. Treatment without consent is provided for under sections 5 and 6 of the *Mental Capacity Act 2005* where the person is considered to lack the mental capacity and treatment is considered to be in the persons "best interests".[192] A person whether or not they lack capacity can be treated without consent under the common law in circumstances where it is necessary to prevent harm to others.[193]

Before a court imposes a hospital order it is required to base its decision upon medical evidence from two medical practitioners one of whom must be a psychiatrist (approved by section 12 of the *Mental Health Act 1983*). The requirement is that they must have a "mental disorder" that is "of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment". The other requirement is the availability of appropriate treatment for the person

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[191] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 252.

[192] *Ibid*.

[193] *Ibid*, at pages 252-253.

subject to the hospital order. Despite meeting these criteria the court still has considerable discretion in deciding to make the hospital order. As Fennell points out the court can also consider other options to the order and the dangerousness posed by the person.[194] James notes that the criterion for "hospital disposal" in England and Wales is "almost wholly medical in nature".[195] This is illustrated by the judgment in *R v Birch*. Interestingly in this case the court emphasised that the position of a person subject to a hospital order is nearly the equivalent status of a patient detained under the civil system.[196] The court in *Birch* also emphasised that a hospital seeks to facilitate recovery and is not about punishment.[197]

The Court of Appeal in *R v Birch* also provided some guidance regarding the circumstances in which imprisonment would be the appropriate disposal, of a person with a mental disorder. One of the factors would be where the person was considered to be dangerous, and there was no available bed, another factor would be where the person was culpable for the criminal offence and punishment was necessary. This reasoning is at odds with the suggestion that diversion in England and Wales should be based on the notion that criminal responsibility is not a factor unless a "psychiatric defence" for a homicide is raised.[198] In *R v Birch* the Court of Appeal stated the lack of a connection between the mental illness and offence would be a factor in not making a hospital order, as would circumstances where the persons responsibility for the defence "is diminished but not distinguished".[199]

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[194] *Ibid*, at page 253.

[195] *Ibid*.

[196] [1989] 11 Cr App R (S) 202.

[197] *Ibid*. "Once the offender is admitted to hospital pursuant to a hospital order without restriction on discharge, his position is almost exactly the same as if he were a civil patient. In effect he passes out of the penal system and into the hospital regime. Neither the court nor the Secretary of State has any say in his disposal … A hospital order is not a punishment… Questions of retribution or deterrence are immaterial. The sole purpose of the order is to ensure that the offender receives the medical care and attention which he needs in the hope and expectation that the result will be to avoid the commission by the offender of further criminal acts".

[198] See discussion above.

[199] For a discussion on this see Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 253.

In *R v Drew* the House of Lords considered *inter alia* whether section 37 of the *Mental Health Act 1983* was compatible with Article 3 of the European Convention on Human Rights.[200] In coming to this conclusion it relied on the judgment of the ECtHR in *X v United Kingdom* where the Commission (as it was called then) rejected the admissibility of the applicant's (a person with a MHP) case who argued that he should be held in a psychiatric hospital and not in a prison.[201] The House of Lords in *R v Drew* stated that there would be strong grounds for challenging the compatibility of the legislation if the legislation was read to deny "a mentally-disordered defendant qualifying for an automatic life sentence the medical treatment which his condition required".[202] The House of Lords considered that such treatment would amount "to unnecessary suffering, humiliation, distress and deterioration of his mental condition could properly be regarded as inhuman or degrading treatment or punishment".[203] However, the House of Lords (as it was then) did point out that section 37 of the 1983 Act (as it was then) empowered the Home Secretary to transfer a defendant sentenced to imprisonment to a hospital where they will receive the necessary medical treatment. The House of Lords in *R v Drew* also affirmed the judgment in *Keenan v United Kingdom* by stating that if a mentally-disordered defendant was held in prison and that had the effect of not facilitating access to necessary treatment available in the hospital setting, which was necessary and this resulted in "suffering serious consequences as a result of such denial, he would have grounds for seeking judicial review of the Home Secretary's failure to direct his transfer to hospital under section 37 of the 1983 Act".[204]

The judgment in *R v Drew* points up the restrictive and limited use of Article 3 in advancing the rights of persons with MHPs in contact with the criminal justice system. In Chapter 2: Literature Review it was argued that there was potential to use the CRPD to lead to a more nuanced and comprehensive interpretation of Article 3 of the ECHR. Namely that diversion and the legal processes around diversion should

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[200] [2003] UKHL 25.

[201] Application No 5229/71, Judgment 5 October 1972.

[202] R v Drew [2003] UKHL 25, at paragraph 18.

[203] *Ibid*.

[204] *Ibid*, at paragraph 19.

incorporate a reasonable accommodation approach in considering the rights of persons with MHPs. In *R v Drew* the House of Lords considered that the interruption of the appellant's medication in the 8 days following the sentence did not reach "sufficient severity to engage the operation of Article 3".[205] A more robust approach could have prevented the disruption in medication through reasonably accommodating the applicant and facilitating an equivalence of care.[206] The courts in taking a more robust approach could reference the meaning of "appropriate treatment", which covers care, psychological treatment, habilitation and rehabilitation and is also defined as alleviating and inhibiting the deterioration of the person's mental health.[207] These principles based in statute echo principles contained in the CRPD, such as the right to health, rehabilitation and rehabilitation.[208]

There are a number of procedural elements to section 37 of the *Mental Health Act 1983*. The first being that there is a 28-day period in which the court must be satisfied arrangements can be made for the admission of the patient. The admission of the patient had to take place within this 28-day period in line with section 37(4) otherwise the validity of the order no longer has effect. This point is illustrated by *R (DB) v Nottinghamshire Healthcare NHS Trust*.[209] It is also important to note that while hospitals do not have discretion as to the admission of persons found not guilty by reason of insanity or being considered unfit to plead, it is the case that they have discretion as to the admission of persons detained under hospital orders. It has been noted that under the *Mental Health Act 1959* this discretionary power to refuse admission of "mentally disordered patients" to hospital resulted in custodial sentences.[210] However, section 39 of the *Mental Health Act 1983* permits the court to make enquiries and obtain reports from a range of health care providers about the arrangements that can be put

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[205] *Ibid*.

[206] See Chapter 2: Literature Review, Part 2.

[207] See Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at pages 253-254.

[208] For a discussion on these rights see Chapter 2: Literature Review, Part 2.

[209] [2008] EWAC Civ 1354.

[210] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 254.

in place to provide for the admission of the persons who may become the subject of a hospital order.[211] The 1983 Act obliges the PCT or the Health Authority to comply with the courts request for admission information.

The hospital order is essentially on par with the procedural elements for the admission of persons who have not committed offences.[212] As one commentator points out once a person is placed on a hospital order, the courts retain no powers at all in respect of the person.[213] A persons' detention in the hospital is subject to regular independent review under section 20 of the 1983 Act, and patients are entitled to make an application to be discharged, on the same basis as other persons involuntarily detained.[214] The Mental Health Review Tribunal is entitled, when reviewing the "patients" detention, to order their discharge, including where the treating psychiatrists advice is against release. The major difference in treatment of "mentally disordered offenders" is that they are not entitled to make this application within the initial 6 months from the commencement of the hospital order. As Fennell notes the other important difference with detention under a hospital order, is that closest relation cannot discharge the person.[215]

In England and Wales there is no strict separation between psychiatric units that cater for the general public and those that specialise in the treatment of offenders. General hospitals units may admit patients from the courts and prisons, and forensic units can admit people detained under the civil provisions of the mental health legislation.

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[211] This includes the Primary Care Trust or the Health Authority where person lives or most recently lives.

[212] See section 3 of the *Mental Health Act 1983*.

[213] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

[214] Leave is the decision of the treating psychiatrist alone. The psychiatrist may discharge the patient at any time, as may the managers of the hospital. The patient may only be detained for six months, unless the treating psychiatrist renews the order. This can only be done if certain conditions, which resemble those, which were satisfied when he was admitted, are fulfilled. After detention for six months, the patient may appeal to an independent Mental Health Review Tribunal, constituted under Part V of the *Mental Health Act 1983*, which has the power to discharge from hospital against the advice of the supervising psychiatrist.

[215] See Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 254

Placement is determined by assessments of the clinical and security needs of the individual. However, where a person has been convicted of a serious offence, the sentencing judge in a Crown court has the power to add to a treatment order under section 37 a so-called "restriction order" under section 41 of the 1983 Act. This has the effect of removing from the treating psychiatrist the power to release the patient from hospital. Release is determined by the Justice Ministry, or by an independent Mental Health Review Tribunal. The decisions of the Tribunal concerns whether cases meet strictly defined criteria set out within the legislation.[216]

In order for the Court to impose a restriction order, it must be the judgment of the court that the imposition of the order is necessary "for the protection of the public from serious harm", this being "having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large". This is therefore a provision based mainly upon considerations of public safety/protection. The decision to impose a restriction order is not based on the gravity of the offence, but rather upon a judgement as to the perceived dangerousness and prognosis, based in part upon the defendant's previous record, (EG offending history and co-operation with treatment). It remains possible (and indeed not unusual) both for patients to be released from hospital after a relatively short period, despite having committed a very serious offence. It is also common for patients to be kept in hospital for longer periods than they would have served, if they had been given a prison sentence. This is because discharge is determined principally by medical outcome and related issues of risk.

The Court of Criminal Appeal have been willing in certain circumstances to overturn the decision of the Crown Court not to grant a hospital order. This was the case in *R v Simpson* where a sentence of life imprisonment with a minimum term of six years was quashed and replaced with a hospital order.[217] This was done on the basis that the person's mental disorder was of a nature or degree that meant it was appropriate for him to be detained in hospital for medical treatment.

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[216] There is no concept of "tariff", or the patient remaining in hospital for longer the more serious the offence.

[217] [2007] EWCA Crim 2666.

11. Restriction Orders Under the Mental Health Act 1983

Restriction orders are ancillary to hospital orders and are made by the Crown Court under section 41 of the 1983 Act.[218] Unlike hospital orders the Magistrates' Court does not have the power to make restriction orders. However, under certain circumstances the Magistrates Court is empowered to commit an offender over the age of 14 to the Crown Court where a restriction order can be made. Restriction orders have a number of important consequences. First psychiatrists are stripped of the power to permit a patient leave into the community, unless there is approval from the Ministry of Justice.[219] Second restriction orders provide only, for the conditional discharge of "patients" subject to them, meaning that "patients" are forced to comply with conditions imposed by either the Ministry of Justice or by a Mental Health Appeal Tribunal.[220] The imposition of conditions will be dependent on whether it was the Ministry of Justice or the Mental Health Appeal Tribunal that mandated the provisional release. As James notes the interpretation of circumstances where a "patient" does not comply with the conditions imposed on their conditional release, or where their mental health is considered to have deteriorated, are "capable of wide interpretation".[221]

The most commonly imposed terms on persons released on restriction orders is that they present at a psychiatric clinic, take medication, maintain regular contact with a social worker and live in a specified place.[222] Conditional discharges from restriction orders are regarded as very strict forms of "compulsory treatment in the community".[223] Psychiatrists play an important role in the imposition of restriction orders; they make recommendations to the court for the need to

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[218] For a discussion on restriction orders see and Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at pages 255-254.

[219] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 242.

[220] *Ibid*.

[221] *Ibid*.

[222] *Ibid*.

[223] *Ibid*.

ensure "after-care" through a restriction order.[224] The decision of the court in making a restriction order is decided with reference to the offence that they committed, the risk that they are considered to pose if released into the community, and the necessity of the restriction order to ensure the safety of the public.[225] However, there are no concrete rules on what constitutes the risk of harm to the public, and it is not limited to personal injury or risk to the public. However, it is suggested that the potential of harm being caused must be serious, and that a high possibility of minor offences, is not sufficient for the imposition of a restriction order.

The courts have demonstrated a willingness to overturn an inappropriate imposition of restrictions orders as evidenced by *R v Osker*.[226] This case involved a woman who was convicted for a public disorder and public nuisance offences.[227] The court held that the imposition of the restriction order was not justified, as there was insufficient evidence to suggest that she met the threshold of posing a sufficient risk of harm to the public and the restriction order was therefore quashed. In *R v Howell* the Court of Criminal Appeal held that where the medical opinion to the court (two doctors) both support a restriction order, a hospital order should not be considered due to the concern with the risks posed by the patient to the public upon release.[228] In circumstances where there is differing psychiatric evidence as to the imposition of a restriction order, the court must make a decision based on the circumstance of the case, and the evidence before the court.[229]

Restriction orders have clearly been developed as a tool to respond to the risks that persons with MHPs are considered to pose. They cannot be considered a form of diversion as defined in Chapter 2: Literature Review as they go beyond diverting people from a custodial sentence

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[224] *Ibid*.

[225] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 255.

[226] [2010] EWCA Crim 955. For a discussion on this case see Stone "Restriction order unwarranted" (*Probation Journal*: 57(4), 2010, page 442).

[227] The case arose following her threat to commit suicide by jumping from a building.

[228] Court of Appeal (Criminal Division), (1985) 306.

[229] See *R v Reid* [2005] EWCA Crim 391.

to the health services. Restriction orders are procedures that serve to impose an enduring restriction on the freedom of persons in the community. The *Mental Health Act 2007* amended the *Mental Health Act 1983* to remove the possibility of having restriction orders that were time limited, which is a regressive amendment, further demonstrating the purpose and rationale of the orders as tools that seek to manage and control the perceived risk of offenders in the community. Persons on restriction orders cannot be granted a leave of absence, be transferred or discharged by their responsible clinician or hospital managers, unless there is consent by the Secretary of State for Justice.[230] These orders represent a significant and enduring restriction on the rights of persons with MHPs and no doubt are at odds with the UKs obligations under the CRPD. In particular, they serve to stigmatise persons with MHPs, restricts the right to liberty and impedes community living.[231]

Persons detained on restriction orders are permitted to access a Mental Health Tribunal to seek discharge. Previously under the *Mental Health Act 1959* patients did not have this right and had to ask the Home Secretary to refer their case to a tribunal and the tribunal did not have the power to release the patient.[232] In *X v United Kingdom*[233] the fact that the tribunal did not have the power to discharge was held to breach Article 5(4) of the European Convention. The 1983 Act provides that the Tribunal can order the full or conditional discharge of a person held on a restriction order where they are of the view that the requirements for involuntary detention under the Act are not satisfied. This is an important development as it introduces the possibility that a tribunal can release a patient in circumstances where the Mental Health Unit (Ministry of Justice) was of the view that release was too risky for the public.[234] This is important as it "removes the absolute control" of

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[230] See Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 256.

[231] See Chapter 2: Literature Review, Part 2.

[232] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 256. The tribunal only had the power to provide advice to the Home Secretary about how to exercise his power to discharge the patient.

[233] (1981) EHRR 188.

[234] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 256.

the Ministry of Justice in deciding on the length of the detention of persons detained on restriction orders.[235]

The role of the Mental Health Tribunal in reviewing restriction orders has resulted in some concern that dangerous people would be released into the community. This is evidenced by the case of *R v IA* where the Court of Appeal were asked to consider the lawfulness of imposing a life sentence (as opposed to a restriction order) as a response to the perceived risk of a tribunal prematurely releasing the person.[236] The Court of Criminal Appeal held that this was not the proper basis on which to refuse a restriction order, as such it quashed and replaced the sentence with a hospital order with indefinite restriction.[237] The conditional discharge provisions attached to the restriction order are seen as an "effective means of risk management".[238]

12. Diversion, Treatment and Transfer of Prisoners with MHPs

The MHA Code of Practice provides detailed guidance on the transfer of prisoners to hospital.[239] The Code places a premium on identifying as early as possible the need for in-patient treatment and that equivalence of care is provided for prisoners.[240] The Code also states that "unacceptable delays" in the transfer of defendants after identification of need ought to be vigorously monitored and investigated.[241] There are two main elements to the transfer of

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[235] *Ibid*.

[236] [2005] EWCA Crim 2077.

[237] *Ibid*, at paragraph 43.

[238] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 257.

[239] The Code states that the "… need for in-patient treatment for a prisoner should be identified and acted upon quickly, and prison healthcare staff should make contact immediately with the responsible PCT". See "Code of Practice: Mental Health Act 1983" (London: Department of Health, 2008).

[240] *Ibid*. The Code states that the responsible NHS commissioners must "… aim to ensure that transfers of prisoners with mental disorders are carried out within a timeframe equivalent to levels of care experienced by patients who are admitted to mental healthcare services from the community."

[241] *Ibid*. The Code requires prisoners who receive a diagnosis of "severe and enduring mental disorder" who have given informed consent to treatment ought be considered for transfer to hospital for treatment in circumstances where the prison environment is thought to be

prisoners with mental serious health problems. First is that of prisoners with serious MHPs who need to be identified and the process for transfer needs to take place from the prison environment.[242] The second element is the provision of treatment for less serious MHPs, substance abuse and personality disorder within the prison.[243] England and Wales have undergone a very significant change in the way that health care is provided in prisons. When the NHS was first developed in post World War II the provision of health care in the prison system remained outside its control and was instead financed by the Home Office. The prison system as a result developed its own primary care system and the prison requested secondary psychiatric services from the NHS.[244]

As James notes the standards in the prison healthcare system lagged behind those of the NHS and treatment in hospital settings required transfer from the prison. Research from the 1990s in England and Wales revealed the extent of the problem with high levels of psychiatric morbidity in the prison population.[245] It was reported that 90% of prisoners suffered from a psychosis, a neurosis, a personality disorder, or had substance abuse problem.[246] The incidence of psychosis was estimated to be at 9% amongst male remand prisoners and 4% in

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contributing to their disorder. Prisoners who are transferred to hospital under sections 47 or 48 of the 1983 Act according to the Code should not be sent back to prison unless clinical staff from the hospital and prison have met and planned the future care that the prisoner will receive. This consultations is commonly referred to as a called a "section 117 meeting". The Code provides that the appropriate staff from the receiving prison ought to be invited to attend this review meeting in advance of the prisoner being discharged back to prison (see page 305). Patients transferred from prison subject to special restrictions under section 47 of the 1983 Act, if remain detained in hospital after their release date cease to be restricted patients. Rather according to the code they remain detained as if on a hospital order without. The RC's options under the Act are consequently modified and the patient can be discharged onto supervised community treatment restrictions (see page 306).

[242] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 243.

[243] *Ibid*.

[244] *Ibid*.

[245] See Brooke, Taylor, Gunn and Maden "Point prevalence of Mental Disorder Unconvicted Male Prisoners in England and Wales" (*British Medical Journal*: 313, 1996, pages 1524-1527) and Singleton, Meltzer and Gatward "Psychiatric morbidity amongst prisoners in England and Wales" (London: The Stationery Office, 1998).

[246] Singleton, Meltzer and Gatward "Psychiatric morbidity amongst prisoners in England and Wales" (London: The Stationery Office, 1998).

sentenced male prisoners.[247] The incidence of psychosis was estimated to be at 21% amongst female remand prisoners and 10% in sentenced female prisoners.[248] This high prevalence is reflected in more recent albeit smaller studies.[249]

The Government for England and Wales in the 1990s adopted the human rights principle of equivalence of care available to prisoners on par with care available in the community.[250] Following the publication of a number of reviews and reports it was accepted that the principle of equivalence could not be achieved if the responsibility and delivery of health services to prisoners was to remain outside of the NHS. As such since April 2006 the NHS has responsibility for the delivery of health care for prisoners and also is responsible for the budget.

The structure of the health services now in prisons in England and Wales operates on a primary care level, with general practitioners delivering primary care.[251] Secondary care is delivered in hospitals either through outpatient appointments, or the provision of services in hospitals. There are no hospitals in prisons in England and Wales; as such any medical condition necessitating acute hospital treatment requires transfer from the prison to a NHS hospital. James suggests that while the prison health service has "been undergoing the most ambitious re-organisation in its history… the manner in which this has occurred, as far as mental health is concerned, was initially beset with problems, and this has impaired the ability of the system to achieve the aims of change".[252] The efficacy of the NHS policy of transferring the care of all psychiatric problems (with the exception of "acute psychosis" to general practitioners has been called into question as it is suggested

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[247] *Ibid*.

[248] *Ibid*.

[249] See "The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs" (London: HM Inspectorate of Prisons, Ministry of Justice, 2007); Stewart "The problems and needs of newly sentenced prisoners: Results from a national survey" (London: Ministry of Justice, 2008).

[250] See Chapter 2: Literature Review, Part 2.

[251] For a comprehensive discussion on this see James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at pages 243-244.

[252] *Ibid*, at page 243.

that they do not possess the time and expertise to successfully administer this responsibility.[253]

A number of problems with the provision of treatment to prisoners with MHPs have been identified.[254] One of the areas that has been identified as causing difficulties has been the Primary Care Trusts (PCTs) that are now responsible for delivering services vary from prison to prison, and there is no coherent and consistent approach nationally, which has led to variations in the services delivered.

Current prison policy dictates that prisoners should be dispersed nationally, meaning that they are detained away from their localities and the psychiatric service that the prisoner will be receiving services on release.[255] As James notes this clearly leads to problems in liaising between the relevant psychiatric services in terms of organising transfers and case hand over, when a sentence comes to an end.[256] This is a very significant issue for prisoners with MHPs, as only a small number of prisoners stay in one prison for the entire length of their sentence and treatment is disrupted or discontinued when prisoners are transferred.[257]

It has also been noted that PCTs have tended to buy different components of their in-reach services from different organisations.[258] For example, general psychiatry services, forensic psychiatry services, and drug/alcohol treatments are commissioned separately. It has been suggested this has resulted in "a lack of co-ordination and coherence in attempts to provide comprehensive care".[259] A further problem with

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[253] *Ibid*, at page 244.

[254] See James, "Concepts and procedures concerning mental disorder in prisons in England and Wales" in Salize, and Dreàing (eds) *Mentally disordered persons in European prison systems: Needs, programmes and outcomes* (Lengerich: Pabst, 2009) and James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 243.

[255] *Ibid*, at page 243.

[256] *Ibid*.

[257] *Ibid*.

[258] *Ibid*.

[259] *Ibid*.

the provision of treatment in prison is that local general adult psychiatry services have in many areas been required to provide services in the prison environment, "which is alien to them, to a population with which they have little sympathy".[260] James suggests that while forensic psychiatric services operate with a view to detecting prisoners to transfer to hospital, general psychiatric services "tended to the opposite stand-point" seeking reasons not to transfer to hospital as such it is suggested that there is a "conflict in ethos".[261]

Another problem identified with transferring persons with MHPs from the prison system is a shortage of beds in the NHS psychiatric hospitals, both in forensic units and in general adult psychiatric units.[262] James has suggested that there is an "appreciable tendency" to change a prisoner's diagnosis depending upon the availability of beds.[263] Persons with a dual diagnosis (of a MHP and addiction) face significant barriers in accessing community mental health services in Ireland.[264] This is also a significant issue in England and Wales, where a dual diagnosis is "sometimes put forward as an exclusion criterion to hospital transfer".[265] In addition to these problems there are few treatment options available for persons with a diagnosis of a personality disorder either within the prison system in England and Wales or in the community, and there are very limited services for prisoners with "non-psychotic mental disorders".[266]

The prison culture in England and Wales has also been identified as an impediment to introducing "defensible standards of care".[267] Mental health professionals charged with delivering in-reach services, face

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[260] *Ibid*.

[261] *Ibid*.

[262] *Ibid*.

[263] *Ibid*. The example given by James was that a diagnosis of schizophrenia would be altered to that of a personality disorder or drug abuse.

[264] See Chapter 3: Ireland.

[265] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 244.

[266] *Ibid*.

[267] *Ibid*.

significant barriers, as prison management are focused on security.[268] In addition overcrowding in prisons in England and Wales impedes the delivery of services.[269] From a practical perspective Rickford and Edgar also note that patients' appointments with psychiatrists in some clinics have a non-attendance rate of 35%, due to inadequate levels of staffing to facilitate patients to move across the prison to their appointments.[270] James has indicated that prison governors have discretion to interfere with the delivery of mental health services, which are "subject to the whim or personal interests of each prison governor".[271] Given the current levels of imprisonment in England and Wales and the current economic environment the principle of equivalence may not be achievable.[272] This suggestion is supported with the current criminal justice policy environment in England and Wales that seeks to privatise the prison system and makes cuts to current levels of expenditure.

What is very striking from this foregoing discussion on England and Wales is that there is very comprehensive and robust legal provision in the mental health legislation, regulating the transfer of prisoners with MHPs. James suggests that in light of all of these problems with the provision of treatment to prisoners in England and Wales, the solution is the development of initiatives to "circumvent blocks in the system or to prevent mentally disordered individuals entering it in the first place".[273] What is also very striking from the foregoing discussion is not only the problems with the provision of services to prisoners with serious MHPs, but also with lack of provision for the needs of prisoners with dual diagnosis, personality disorders and prisoners with MHPs that are "non-psychotic" in nature.

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[268] *Ibid*.

[269] *Ibid*.

[270] Rickford and Edgar "Troubled Inside: Responding to the Mental Health Needs of Men in Prison" (London: Prison Reform Trust, 2010).

[271] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 243.

[272] *Ibid*, at page 244.

[273] *Ibid*.

13. Diversion: Fitness to Plead, the Insanity Defence and Diminished Responsibility

In this section there is a discussion of fitness to plead, the insanity defence and the defence of diminished responsibility. For the purposes of this thesis these processes and defences are considered part of diversion.[274] The insanity defence in England and Wales is seldom raised. The disposal options for persons who successfully raise the defence are the same for persons who are found guilty.[275] However, the provisions on fitness to plea "remains a central concept" in England and Wales.[276]

13.1. Fitness to Stand Trial

Most cases where fitness to plead is considered will result in transfer to a NHS hospitals where treatment is administered within the scope of the 1983 Act.[277] Treatment is provided so that the person can reach the threshold of being considered fit for trial. James suggests that when a person is found unfit "there is not necessarily an expectation that they will be returned to court for trial once they do become fit".[278] However, he suggests that in practice it is difficult to avoid returning a person for trial "as the system is resistant".[279]

In England and Wales the common law has developed tests to determine whether a defendant is unfit to stand trial on the basis of the presence of a mental disorder or indeed on the basis that they are "deaf mute". The leading case was *R v Pritchard*[280] the test for fitness to be tried was based on whether the defendant "was of sufficient intellect

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[274] See Chapter 2: Literature Review, Part 1 and Part 2.

[275] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (International Journal of Law and Psychiatry: 33, 2010, at pages 241–248) at page 243.

[276] *Ibid*.

[277] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 243.

[278] *Ibid.*

[279] *Ibid.*

[280] (1836) 7 C and P 303.

to comprehend the course of the proceedings in the trial so as to make a proper defence". The defendant in this case was deaf and dumb, and the court focused on the cognition and ability of the defendant to understand the court proceedings. The modern articulation of test was set out in *Robertson*[281] and *Friend*[282] as the ability to give, receive and comprehend communications regarding the criminal trial, which is essentially a functional test of mental capacity (see *Mental Capacity Act 2005*).

The *Criminal Procedure (Insanity) Act 1964* provides that where there is any question as to the fitness of a defendant to plead, that fitness should be determined before any other matter. The *Criminal Procedure (Insanity and Fitness to Plead) Act 1991* added to the procedure outlined in the 1964 Act, by requiring that in circumstances where a person is found unfit to plead the court must undertake a "trial of the facts". While the discretionary power still exists to defer the determination of fitness to plead in practice, the procedure provided for in the 1991 Act is adopted in "almost all cases".[283] Where a defendant is determined to be fit to plead the trial will proceed, however, if the defendant is determined not to be fit to plead then another jury is empanelled and a trial will proceed to determine if the defendant "did the act or made the omission charged against him as the offence". The law on fitness to plead is currently being considered by the Law Commission for England and Wales and the provisional approach of the Commission to the reform of this area will be considered below.

13.2. The Insanity Defence and Diminished Responsibility

The English law on insanity has been hugely significant in developing law and policy throughout the common law world. The requirements for the defence were set down in the *M'Naghten's* case.[284] In circumstances where a defendant is considered to have capacity to stand trial their mental disorder will be of relevance as to their defence.

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[281] [1968] 1 WLR 1767.

[282] [1997] 2 All ER 1012.

[283] *Ibid*.

[284] (1843) 10 Cl & Fin 200.

In England in Wales (as in all other jurisdictions that operate the insanity defence) medical evidence is crucial in determining whether the defendant was so mentally disordered that they were not liable for the crimes that they committed. Section 1(2) of the *Criminal Procedure (Insanity and Unfitness to Plead) Act 1991* necessitates the evidence of at least two doctors one of which needs to be an experienced psychiatrist. However, as in Ireland the test is ultimately not a medical one, but rather a legal test. The concept of mental disorder as articulated in the 1983 Act is a "broad concept … few would maintain that all those who fall within one of the four classes of disorder under the Act should be exempted from criminal liability."[285] As in Ireland the criminal law in England and Wales has adopted a much more restricted approach as to what constitutes "insanity" and proof is required to arrive at a verdict of "not guilty by reason of insanity".

A successful use of the insanity defence in England results in mandatory and indefinite detention in a psychiatric setting until the *Criminal Procedure (Insanity and Unfitness to Plead) Act 1991* was enacted. The available research indicated that even though detention was mandatory and indefinite, approximately 20% of defendants were released within 9 months.[286] However, the "inevitable consequence of the insanity verdict" was sufficient to push many defendants to plead guilty as opposed to raising the defence hoping for a more positive disposal by the court at sentencing.[287] The 1991 Act reformed this practice and increased the options that were open to the trial judge when a defendant was determined not fit to plead. Thus under the 1991 Act a defendant who successfully raised the insanity defence could be absolutely discharged, given a hospital order, placed under supervision or brought under guardianship. Importantly these disposals are not available to a trial judge in circumstances where a defendant successfully raised the insanity defence in respect of a murder charge. However, the law in England and Wales remains that even though a person successfully raised the insanity defence, they can

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[285] Ashworth *Principles of Criminal Law* (Oxford: Oxford University Press, 4th edition, 2003) at page 208.

[286] See Mackay and Kearns "More Fact(s) About the Insanity Defence" (*Criminal Law Review*: 1999, pages 714-725).

[287] Ashworth *Principles of Criminal Law* (Oxford: Oxford University Press, 4th edition, 2003) at pages 208-209.

be deprived of their liberty and detained in psychiatric settings. The available evidence indicates that the courts are willing to opt for community-based options. In research published in 1999 it was indicated that over 50% of disposals under the 1991 Act were community based (either absolute discharge or supervision).[288]

Section 6 of the *Criminal Procedure (Insanity) Act 1964* deals with evidence by the prosecution in relation to insanity or diminished responsibility. Section 6(a) provides that where on a trial for murder the accused contends that at the time of the alleged offence they were insane, so as not to be responsible according to law for his actions or were suffering from abnormality as is specified in the *Homicide Act (diminished responsibility) 1957* the court shall allow the prosecution to adduce or elicit evidence tending to prove the other of those contentions, and may give directions as to the stage of the proceedings at which the prosecution may adduce such evidence. What this effectively means is that if a defendant raises diminished responsibility then the prosecution can raise the issue of the insanity of the defendant. This differs from the legal position taken in Ireland by the Supreme Court in *People (DPP) v Redmond* where in a majority decision it was decided that the defendant was entitled to decide on the defence that he wanted to put forward and this decision-making was not vulnerable to interference by a trial judge.[289]

In England and Wales the discourse around the reform of the insanity defence has seemed to centre focus on the narrow question of definition of the defence and also on protective measures regarding a persons successfully raising the defence. It has been suggested that the protective measures issue has driven the definition of the defence, which has been "… expanded to include persons against whom compulsory measures are thought to be necessary."[290] This dynamic has changed slightly in that mandatory detention in a psychiatric setting is no longer compulsory by virtue of the *Criminal Procedure (Insanity and Unfitness to Plead) Act 1991* with the exception of murder cases.

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[288] Mackay and Kearns "More Fact(s) About the Insanity Defence" (*Criminal Law Review*: 1999, pages 714-725).

[289] [2006] 2 ILRM 182.

[290] Ashworth *Principles of Criminal Law* (Oxford: Oxford University Press, 4th edition, 2003) at page 209, at pages 210-211.

The use of the insanity defence while used with greater frequency still remains very low in England and Wales.[291] As discussed in Chapter 2: Literature Review, Part 2 the insanity defence may be open to challenge on the basis that it does not accord with ECtHR jurisprudence on Article 5(1)(e) of the ECHR.[292]

Section 2 of the *Homicide Act 1957* provides for the plea of diminished responsibility to a charge of murder and has been recently amended by the *Coroners and Justice Act 2009*.[293] The defence of diminished responsibility could arguably be considered as a type of reasonable accommodation, as the criminal justice system, seeks to respond to the defendants' impairment or perceived impairment. The burden is on the defence in raising the defence and if successfully raised the defendant will not receive a mandatory life sentence for murder rather they will be subject to a discretionary sentence for manslaughter to be imposed by the trial judge.

14. Court Diversion Programmes in England and Wales

An important element of the diversion system in England and Wales has been the development of court diversion programmes. The first programme began in central London in 1989.[294] There are approximately 650 courts in England and Wales, 400 are Magistrates' courts and diversion schemes are located in these lower courts with the exception of a pilot scheme in the Crown Court.[295] The logic for basing diversion schemes in the Magistrates Court in England and Wales is similar to that for basing the in-reach scheme in Cloverhill in Dublin.[296] Namely that the Magistrates Court works with a number of

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[291] See Mackay and Kearns "More Facts About the Insanity Defence" (*Criminal Law Review*: 1999, 714).

[292] In Ireland as in England and Wales the requirement that a person ought to be detained indefinitely in a psychiatric setting does not sit well with the ECtHR judgment in *Winterwerp v Netherlands* (1979) 2 EHRR 387.

[293] For a discussion on this Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at pages 240-243.

[294] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (International Journal of Law and Psychiatry: 33, 2010, pages 241–248) at page 244.

[295] *Ibid*.

[296] See Chapter 3: Ireland.

different police stations and concentrates cases from a particular geographical area, as such it presents "an efficient place in the system to which to commit resources".[297] In some cities where a number of different Magistrates Court operate, the court diversion programme is based in one central court and other courts can refer cases for assessment.[298] In some cities where there are many magistrates' courts, the court diversion schemes are centred at one central court, to which the other courts can cross-remand cases for assessment, resulting in a further improvement in efficiency.

These schemes facilitate use of the diversion powers contained in the mental health legislation. They assess persons appearing before the court and determine how to respond to their MHP. The provision in the mental health legislation for civil admission is used when the offences are minor. James has categorised the emergence of two different types of diversion system. The first type are "liaison schemes", operate when there is a low referral rate and are generally led by nurses who generally seek to link people to psychiatric services with a focus on community provision of services.[299] The second type of scheme operates where there is a greater need; the developed schemes are consultant led with a number of different psychiatrists, nurses, social workers and an administrator.[300] These types of schemes have "dedicated and well-equipped offices in the cell areas at court, with their own interview facilities".[301]

James notes that persons who commit more serious offences will be admitted to forensic psychiatric units, while placement in general psychiatric services is used for persons who commit less serious offences.[302] Persons who carry out minor offences are admitted to hospital in lieu of a prison sentence, or if the criminal proceedings are

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[297] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (International Journal of Law and Psychiatry: 33, 2010, pages 241–248) at page 244.

[298] *Ibid*.

[299] *Ibid*, at page 245.

[300] *Ibid*.

[301] *Ibid*.

[302] *Ibid*.

discontinued.[303] With more serious offences before the Crown Court "admission to hospital will be organised pending trial after assessment by court schemes, often through Ministry of Justice warrants, rather than through court powers".[304] Where there is no scheme in place the Magistrate remands a person to prison in order to obtain reports, where the prison requests the NHS consultant to visit the person in the remand prison.[305] James is critical of the operation of this process, as the consultant will not have access to the person's medical history or the documentation form the prosecution service.[306] James argues that it would be beneficial to "short-circuit this system" with a court diversion programme, which is more efficient and facilitates access by the psychiatrist to all of the relevant information to the court, avoids delays and allows the psychiatrist to appear in court to clarify any issues around their reports.[307] One of the weaknesses of the current diversion system is that it relies on referrals and there is evidence that questionnaires improve detection of persons with MHPs.[308] Another criticism of the court diversion programmes in England and Wales is that some of them only operate on certain days of the week, resulting in some referrals necessitating remand into custody.[309] Obviously this poses human rights issues in terms of deprivation of liberty on the basis that someone is perceived to have MHPs. It is also problematical as it "may act as a disincentive to the referral of appropriate cases" and means that the right to health, habilitation and rehabilitation are not realised.[310] The available research indicates that the development of "mental health in-reach services still fall short of community equivalence and there is wide variation in service arrangements that cannot be explained by prison size or function".[311]

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[303] *Ibid*.

[304] *Ibid*.

[305] *Ibid*.

[306] *Ibid*.

[307] *Ibid*.

[308] *Ibid*.

[309] *Ibid*.

[310] *Ibid*.

[311] See Forrester, Exworthy, Olumoroti, Sessay, Parrott, Spencer and Whyte "Variations in prison mental health services in England and Wales" (*International Journal of Law and Psychiatry*: 36(3-4), 2013, pages 326-332). The methodology for this study was a telephone interview with senior staff in prisons. 73% of prisons took part in the survey, 13% of prisons has no in-reach

14.1. Effectiveness of Court Diversion Schemes

In England and Wales there is a lot of research on the effectiveness of court diversion schemes in terms of identifying persons with MHPs. For example, in one study it was shown that there was a 4 times increase in compulsory admissions following the introduction of a diversion scheme.[312] There are a number of other schemes that reflect these findings.[313] However, no estimates are available as to the overall efficacy of court diversion schemes in England and Wales because "data collection in many is poor".[314] Another study researched the outcomes from persons admitted through court diversion schemes.[315] Its main findings included that admissions through court diversion (when compared to admissions from the community) were no less likely to complete their admissions; had comparable durations of stay; were no more likely to be violent and were no more likely to abuse substances in hospital.[316] Other findings revealed that they were less likely to require intensive nursing resources, and attained a similar improvement in their mental health by the time they were discharged, and that they were not readmitted quicker than persons who were admitted through the civil system.[317]

In terms of the efficiency of diversion programmes another study examined the reconviction rates of person admitted through the

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team at all (usually low security establishments). NHS teams delivered the majority of services with a generic CMHT model as opposed to other specialist models.

[312] See James and Hamilton, "The Clerkenwell Scheme: Assessing Efficacy and Cost of a Psychiatric Liaison Service to a Magistrates' Court" (*British Medical Journal*: 303, 1991, pages 282-285).

[313] See Joseph and Potter "Diversion from custody. I: Psychiatric assessment at the magistrates' court II: Effect on hospital and prison resources" (*British Journal of Psychiatry*: 162, 1993, pages 325-334) and Purchase and Kennedy "Liaison Between Prison, Court and Psychiatric Services) (*Health Trends*: 29, 1997, pages 26-29).

[314] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 246.

[315] See James et al "Outcome of psychiatric admission through the courts" (London: Home Office: RDS Occasional Paper, 2002, 79). This was a comprehensive study that was case controlled and funded by the Home Office. The study compared a sample of 214 admission cases through diversion with 214 compulsory admissions from the community under *Mental Health Act 1983*. The cases were matched in terms of hospital and the month of admission.

[316] *Ibid*.

[317] *Ibid*.

diversion system, which revealed that in the two years following discharge persons were more likely to be convicted.[318] However, there were some positive findings in this study. First the data suggested that were significant reductions in the number of convictions in the two-year period after admission when compared to the convictions recorded in the two years prior to admission.[319] Second, the reconviction rate for the court diversion admissions in two years following discharge was low at a figure of 28%.[320] This compared favourably with the two-year reconviction statistics for "national cohorts of similar composition" of 56% for discharged prisoners and 58% for persons given community sanctions.[321] The available research suggests that the reduction in offending related primarily to theft and other comparable offences.[322] This has led the researchers to put forward the premise that the reduction in offending as a result of admission through diversion could be explained in that persons were connected to housing, social welfare payments and received care and support in their communities.[323]

The research then indicates that persons being diverted through the courts represented a similar population to persons admitted through the civil system.[324] It was concluded that court admission through diversion was effectively a different type of process for people to access psychiatric services, which was similar to the way that some persons access treatment in general health services, through accident and emergency services as opposed to general practice clinics.[325] This analogy in the research is an accurate but troubling one in that access and passage through the criminal justice system for a significant number of persons is necessary, in order to access mental health services.[326]

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[318] "Reconvictions of offenders sentenced or discharged from prison in 1995, England and Wales" (London: Government Statistical Service, 1999, Statistical Bulletin 19/99).

[319] *Ibid*.

[320] *Ibid*.

[321] *Ibid*.

[322] See James et al "Outcome of psychiatric admission through the courts" (London: Home Office: RDS Occasional Paper, 2002, 79).

[323] *Ibid*.

[324] *Ibid*.

[325] *Ibid*.

[326] *Ibid*.

The number of diversion schemes operating in England and Wales has declined in recent years. In 1999 there were 150 court diversion and liaison schemes operating in England and Wales as of 2009 there are approximately 100 schemes.[327] The decline in the number of these diversion programmes has been explained by the failure to provide sufficient funding and staffing for the programmes to function properly.[328] 78% of the diversion programmes that were examined reported that there could not collect statistical information; 50% had no contribution from a psychiatrist and 72% a shortage of beds as an obstacle to the effective functioning of their programme.[329] These difficulties were borne out by the Bradley Report, which reported that of the 100 schemes in operation at courts or police stations; only 13 were frequently able to achieve excellent scores on the basis of performance criteria.[330]

15. Compulsory Treatment Orders

Compulsory Treatment Orders have emerged as an international trend in seeking to control persons with MHPs outside of the hospital setting.[331] The evidence as to the effectiveness of community treatment orders is unclear.[332] Nonetheless community treatment orders have been the major development in English and Welch mental health legislation. The *Mental Health Act 2007* provided for supervised community treatment in sections 17A to 17G into the 1983 Act.[333]

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[327] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 246.

[328] See "Findings of the 2004 survey of court diversion/criminal justice liaison schemes for mentally disordered offenders in England and Wales" (London: National Association for the Care and Resettlement of Offenders, 2005).

[329] *Ibid*.

[330] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 87.

[331] See Chapter 2: Literature Review, Part 1. For a discussion on community treatment in England and Wales see Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at chapter 8.

[332] See Burns et al "Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial" (*The Lancet*: 381(9878), 2013, pages 1627-1633).

[333] These sections effectively replace sections 25A to 25J, which made provisions for supervised discharge of patients, which are now repealed by the *Mental Health Act 2007*.

Community treatment orders while controversial from a human rights perspective and outside the scope of this thesis are nonetheless important elements of the legislative framework for mental health legislation in England and Wales. A recent study investigated whether these orders reduced admissions compared with use of section 17 leave "when patients in both groups receive equivalent levels of clinical contact but different lengths of compulsory supervision".[334] The study interpreted its findings as meaning that in well-coordinated mental health services "the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty".[335]

At any rate the important point to note is that the provisions for community treatment orders and the range of other orders under the 1983 Act that provide for the control of the person benefiting from diversion. Similar provisions are not contained in Irish mental health legislation, which may partially explain failure to develop diversion provisions (see Chapter 3: Ireland).

16. Defendants and Offenders with ID

This section considers the relevant law and policy in England and Wales as it relates to defendants and offenders with ID and the scope for diversion in England and Wales. The de-institutionalisation movement has meant that larger numbers of persons with ID engaged or suspected of committing criminal offences in the community are being processed through "regular legal channels".[336] From an examination of the literature on diversion in England and Wales there appeared to be a gap in the research on diversion as it relates to defendants and offenders with ID. However, there is a growing concern about the over-representation of persons with ID in the criminal justice system in

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[334] See Burns et al "Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial" (*The Lancet*: 381(9878), 2013, pages 1627-1633). This study assessed 442 patients, 336 patients were randomly assigned for discharge from hospital either on a community treatment order (167 patients) or a section 17 leave (169 patients).

[335] *Ibid*.

[336] See Lindsay and Taylor "A Selective Review of Research on Offenders with Developmental Disabilities: Assessment and Treatment" (*Clinical Psychology and Psychotherapy*: 12, 2005, pages 201–214). See also Chapter 2: Literature Review.

England and Wales. There is also a gap in the research on female defendants and offenders with ID.[337] The Prison Reform Trust ran a three-year campaign entitled "Troubled Inside" that focuses on publicising the experiences of offenders with "learning disabilities" when they come into contact with the criminal justice system.[338] This campaign and the work of the trust in this area sought to address the invisibility of prisoners with ID in the UK.

In England and Wales it has been noted that professionals working in the areas of health and social services are increasingly engaged in providing support to persons with ID who are involved in proceedings through the criminal justice system.[339] It has also been noted that these professionals are increasingly involved with offenders with ID after the criminal proceedings and are involved in preventing re-offending.[340] The literature estimating the prevalence of ID differs greatly from 2% to 40%.[341] It has been suggested that these differences can be explained by "definitional variations" and discrepancies in the criminal justice system process.[342] In addition the use of very different "diagnostic and classification criteria" may also explains the different rates of prevalence suggested in the research.[343]

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[337] See Kendall "Female offenders or alleged offenders with developmental disabilities: A critical overview" in Lindsay, Taylor and Sturmey (eds) *Offenders with developmental disabilities* (Chichester: Wiley, 2004) at pages 265–288.

[338] See the Prison Reform Trust website at: http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/TroubledInside. <Last accessed 10 November 2013>

[339] Lindsay and Taylor "A Selective Review of Research on Offenders with Developmental Disabilities: Assessment and Treatment" (*Clinical Psychology and Psychotherapy*: 12, 2005, pages 201–214) at page 211.

[340] *Ibid*.

[341] See Holland "Challenging and offending behaviour by adults with developmental disabilities" (*Australia and New Zealand Journal of Developmental Disabilities*: 17, 1991, pages 119-126); Noble and Conley "Toward an epidemiology of relevant attributes" in Conley, Luckasson, and Bouthilet (eds) *The Criminal Justice System and mental retardation* (Baltimore: Paul Brookes, 1992) at pages 17-53) and Lindsay, Law, and Macleod "Intellectual disabilities and crime: Issues in assessment, intervention and management" in Needs and Towl (eds) *Applying psychology to forensic practice* (Oxford: British Psychological Society Books / Blackwell Publishing, 2002).

[342] Jones "Persons With Intellectual Disabilities in the Criminal Justice System: Review of Issues" (*International Journal of Offender Therapy and Comparative Criminology*: 51(6), 2007, pages 723-733).

[343] *Ibid*, at page 724.

The research also indicates that persons with ID face difficulties in understanding cautions and comprehending their rights at the time of arrest and interrogation, despite the availability of special measures.[344] The research also suggests that even when the text used to caution is made more accessible through making it more succinct "simply condensing the information has not been of any help".[345] Given the difficulties it has been suggested that it is vital that suspects are supported with "good quality legal advice" in advance and during police questioning and during the court proceedings.[346] In England and Wales it has been suggested that without adjustments to accommodate suspects with ID there is potential for miscarriages of justice.[347] Research also suggests that persons with ID who present with physical aggression or "diversity of past problem behaviour" are more likely to be referred to a secure service.[348] In addition persons considered to have a moderate to severe learning disability (IQ of 50 or more) have an increased probability of referral to community services.[349]

Research internationally and in the UK adopt a narrow definition of "learning disability", which is based on measurements of IQ of 70 or below and encompasses dyslexia with restricted reference to other "learning difficulties".[350] It is not clear from the literature as to whether

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[344] See Clare, Gudjonsson and Harari "Understanding of the current police caution (England & Wales)" (*Journal of Community and Social Psychology*" 8, 1998, pages 323-329).

[345] *Ibid*, at page 327.

[346] *Ibid*, at page 328 and Gudjonsson "Psychological vulnerability: suspects at risk" in Morgan and Stephenson (eds) *Suspicion and Silence: The Right to Silence in Criminal Investigations* (London: Blackstone Press, 1994).

[347] Gudjonsson "Psychological vulnerability: suspects at risk" in Morgan and Stephenson (eds) *Suspicion and Silence: The Right to Silence in Criminal Investigations* (London: Blackstone Press, 1994).

[348] Carson et al "Referrals Into Services for Offenders with Intellectual Disabilities: Variables Predicting Community or Secure Provision" (*Criminal Behaviour and Mental Health*: 20, 2010, pages 39-50).

[349] Carson et al "Referrals Into Services for Offenders with Intellectual Disabilities: Variables Predicting Community or Secure Provision" (*Criminal Behaviour and Mental Health*: 20, 2010, pages 39-50) at page 48 and Lindsay et al "Pathways Into Services for Offenders with Intellectual Disabilities: Childhood Experiences, Diagnostic Information, and Offense Variables" (*Criminal Justice and Behaviour*: 37(6), 2010, 678-694).

[350] Loucks "No One Knows: Offenders with Learning Difficulties and Learning Disabilities: Review of Prevalence and Associated Needs" (London: Prison Reform Trust, 2007) at page vii.

persons with "intellectual impairments" or "learning difficulties" commit more offences than persons without such impairments.[351] It is suggested that both social and biological factors seem relevant in relation to persons with "borderline intellectual functioning".[352] However, even when narrow definitions of "learning disability" and "learning difficulty" are used there are no established levels of prevalence.[353]

It has been identified that the provision of health and social support to persons with ID who engage in anti-social or criminal behaviour is a challenge for services in the UK.[354] Research suggests that persons with ID who engage in anti-social or criminal behaviour are referred to "community teams for adults with learning disabilities".[355] However, the referral rates of these cases represent a "small proportion of the cases known to these services".[356] The research indicates that of the number referred the profile of "individual and behavioural characteristics" included similar numbers of men and women who were considered to mainly have mild ID.[357] The research also indicates that community teams for adults with learning disabilities respond over a long period of time to persons who were mainly known to their service.[358] This finding led the researchers to suggest that there are "two quite distinct populations" of offenders with ID.[359] One group that are known to services and the other a "sub-population" of young males with "borderline" ID with high rates of substance abuse, who are in prison.[360]

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[351] *Ibid*.

[352] *Ibid*, at page 1.

[353] *Ibid*.

[354] See Wheeler et al "Community Services and People with Intellectual Disabilities who Engage in Anti-social or Offending Behaviour: Referral Rates, Characteristics, and Care Pathways" (*Journal of Forensic Psychiatry and Psychology*: 20(5), 2009, pages 717-740).

[355] *Ibid*, at page 736. Multi-disciplinary community ID Services are generally known as "community teams for adults with learning disabilities". These multi-disciplinary teams are a joint initiative between health and social services that typically work in supporting adults with ID to live independently in the community. These teams may consist of psychiatrists, psychologists, care managers, nurses, therapists and administration personnel.

[356] *Ibid*.

[357] *Ibid*.

[358] *Ibid*.

[359] *Ibid*.

[360] *Ibid*.

It has been suggested that there is an underuse of different referral mechanisms to facilitate contact with community teams for adults with learning disabilities and that opportunities to refer through the criminal justice system are missed.[361]

A survey of 173 prisoners with "learning disabilities and learning difficulties" published in 2008 mapped the experiences of persons with ID in the UK.[362] It reported that prisoners were nearly twice as likely (as the comparison group) to be unemployed.[363] Over half had gone to a special schools and were three times more likely to be excluded from school when contrasted to the comparison group.[364] The survey identified serious deficits with the current supports for persons with ID in courts.[365] It reported that over a fifth of prisoners did not understand the court proceedings, and that some of the sample did not know why they were in court or did not know what they did wrong.[366] Most prisoners reported that simpler language in court would have facilitated their comprehension of the proceedings.[367]

The survey also identified significant barriers for persons with ID in prison, with most prisoners reporting problems in reading and understanding prison information.[368] The lack of accessible information meant that they were unaware of what was expected of them in prison.[369] Difficulties in filling out prison forms resulted in missed visits from families and access to the gym and other difficulties.[370] The prisoners also reported that they had difficulty in making others understand them and accessing offending behaviour

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[361] *Ibid*.

[362] Talbot "Prisoners' Voices Experiences Of The Criminal Justice System By Prisoners With Learning Disabilities And Difficulties" (London: Prison Reform Trust, 2008) at page v.

[363] *Ibid*.

[364] *Ibid*.

[365] *Ibid*.

[366] *Ibid*.

[367] *Ibid*.

[368] *Ibid*, at pages 26-57.

[369] *Ibid*.

[370] *Ibid*.

programmes, which resulted in isolation in the prison.[371] Prisoners with ID were also reported to be five times more vulnerable to the imposition of restraint practices in contrast to the comparison group and three times more likely to spend time in segregation.[372] The report identified that prisoners with "possible learning or borderline learning disabilities" reported a lack of support persons in assisting them making plans in advance of release and were most likely to express worries about leaving prison and being readmitted.[373]

In order to address the deficits with the current response to defendants and offenders with ID, it was recommended by the Prison Reform Trust to identify persons with learning disabilities when they come into contact with the criminal justice system.[374] In order to achieve this they recommended augmentation of reciprocal information sharing between criminal justice agencies, health, social services and education.[375] The Trust also recommended the development of a needs led approach and mandatory multi-agency working at the local level, to prevent offending and re-offending by persons with ID.[376] They also recommended that a key component would involve enhanced awareness-raising through training on ID and augmentation of specialist services.[377]

Diversion was also identified as a key component of a better response to defendants and offenders with ID.[378] However, the Trust identified that there is an element of confusion as to the application of current policy on diversion to persons with ID.[379] The Trust suggested that there is disagreement between police officers, health and social care workers and legal practitioners, and others stakeholders about the

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[371] *Ibid*.

[372] *Ibid*.

[373] *Ibid*.

[374] Talbot "Prisoners' Voices Experiences Of The Criminal Justice System By Prisoners With Learning Disabilities And Difficulties" (London: Prison Reform Trust, 2008) at pages 59-76.

[375] *Ibid*.

[376] *Ibid*.

[377] *Ibid*.

[378] *Ibid*, at page 72.

[379] *Ibid*.

suitability of diversion of persons with a "learning disability".[380] This disagreement apparently stems for a "lack of clarity in current policy and guidance on the application of the concept of criminal responsibility to these individuals".[381] Other arguments that oppose diversion of persons with ID include a belief that inclusion in the community requires a duty to obey by the law and if the *mens rea* for the crime is established then punishment should follow.[382] Flowing from this rationale is that persons with ID should be punished for crimes, in order to avoid the commission of future more serious offending.[383]

Beyond these theoretical and policy impediments to the diversion of persons with ID in England and Wales it was identified that practical issues also impede diversion.[384] For example, there are limited places where persons can be diverted. Concerns have been expressed about diversion, as powers to ensure compliance have not been developed. The work of the Prison Reform Trust identifies many impediments to the diversion of defendants with ID.

The *Mental Capacity Act 2005* is of relevance here, in that guardianship may be used to restrict persons with ID in circumstances where their conduct is considered risky. The Code of Practice on the *Mental Health Act 2005* and the Code of Practice on Deprivation of Liberty Safeguards do not provide guidance on the use of the legislation to control persons engaged in risky behaviour.[385] However, given the premium placed on acting in the person's best interests under the Act, the use of the substitute decision-making powers could be used to control persons engaged in criminal or risky conduct. This is illustrated in *D Borough Council v AB* where the local authority sought a declaration from the Court of Protection that AB did not have capacity to consent to

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[380] *Ibid*.

[381] *Ibid*. See also Jacobson "Police Responses to Suspects with Learning Disabilities and Learning Difficulties: A Review of Policy and Practice" (London: Prison Reform Trust, 2008).

[382] *Ibid*.

[383] *Ibid*.

[384] *Ibid*, at page 73.

[385] See "Mental Capacity Act 2005: Code of Practice" (London: Ministry of Justice, 2008) and "Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice" (London: Ministry of Justice, 2008).

sexual relations.[386] The application appeared to be motivated by AB's inappropriate sexual conduct on a bus and the reluctance of the police to proceed with charges.[387]

17. Female Defendants and Offenders with MHPs

Unlike Ireland there has been greater consideration of responding to female defendants and offenders with MHPs in England and Wales.[388] However, despite greater awareness and research around the imprisonment of female prisoners there has been an increase in the number of women being committed to prison in England and Wales.[389] This increase has been described as "a side effect of a generally tougher climate".[390] Many female prisoners are sent to prison for short periods of time, either under remand or for a short custodial sentence.[391] It has been suggested that many women held on remand are acquitted or serve sentences for non-violent crimes.[392] Short prison sentences for women have increased, as have reconviction rates and short sentences are disruptive to women, their family life and they receive little support in prison.[393] It has been suggested that female offenders with dependent children face the additional risk having their children being taken into care.[394]

The research indicates poor mental health is a "common and significant feature" and most prisoners in one study strongly reported the

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[386] [2011] EWHC 101 COP.

[387] *Ibid*.

[388] The "Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders" also identifies the need to address mental illness as part of addressing offending by women in England and Wales. See "Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders" (London: Ministry of Justice, 2010).

[389] For a discussion on this see Hedderman "Empty Cells or Empty Words?: Government policy on reducing the number of women going to prison" (London: Criminal Justice Alliance, April 2012).

[390] *Ibid*, at page 11.

[391] *Ibid*

[392] *Ibid*

[393] *Ibid*.

[394] "Diversion: The Business Case for Action" (London: Centre for Mental Health, Rethink and the Royal College of Psychiatrists, 2011) at page 2.

presence of depressive illness and anxiety.[395] The research also suggests that poor health was directly linked to offending, "acquisitive crime" was carried out to fund prolonged addiction and MHPs were directly linked to offences.[396] The literature suggests that some female prisoners with drug addictions used drugs as "self-medication" for MHPs and as such imprisonment and detoxification was a "powerful and unwelcome emergence of disturbing thoughts and feelings".[397] The inadequacy of supports and treatment for women has been reported and it has been suggested that segregation units have "been used inappropriately to hold women with MHPs for long periods of time".[398] In addition female prisoners diagnosed with MHPs criticised the availability of treatment, suggesting it was often difficult to obtain and that the response of mental health services were not sufficiently responsive or proactive.[399]

The Corston Report identified that community mental health services in England and Wales failed to adequately address the mental health needs of women.[400] Baroness Corston, in particular, identified the lack of mechanisms to divert women into healthcare at arrest or at the court stage, as a significant barrier and the scarcity of clinicians to assess the needs of defendants and offenders with MHPs, and the scarcity of women-only community day care.[401] Since the publication of the Corston Report and indeed the Bradley Report there has been little progress in meeting the needs of female defendants and offenders with MHPs.[402] It remains the case that community services are considered inadequate to respond the needs of women with MHPs,

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[395] Plugge, Douglas, and Fitzpatrick "The Health of Women in Prison Study Findings" (Oxford: Department of Public Health University of Oxford, 2006) at page 48.

[396] *Ibid*.

[397] *Ibid*, at page 57.

[398] *Ibid*, at page 59.

[399] *Ibid*.

[400] "A Report By Baroness Jean Corston of A Review of Women with Particular Vulnerabilities in the Criminal Justice System: The Need For a Distinct, Radically Different, Visibly-Led, Strategic, Proportionate, Holistic, Woman-Centred, Integrated Approach" (London: Home Office, 2007) at page 11.

[401] *Ibid*.

[402] See "Women Offenders: After the Corston Report" (London: House of Commons Justice Committee, Second Report of Session 2013–2014, July 2013) at page 38.

and services are often only accessible following imprisonment.[403] It was reported to the House of Commons Justice Committee that there was insufficient quality and quantity of diversion at the arrest and court stages of the criminal justice system for women.[404] Magistrates reported to the Committee that mental health support ought be available to all female offenders, as they were of the view that the "majority of them have mental health issues".[405] It was suggested that the expansion of diversion and liaison schemes would be particularly beneficial to women. However, there is concern about the "level of gender-specific provision that would be made under diversion and liaison schemes".[406]

Evidence of a greater focus of female offenders with MHPs in England and Wales is also evidenced through the development of an offender personality disorder strategy for women. However, given that this strategy is targeted at female prisoners considered to pose high risk and serious harm to others, it could be argued that this initiative represents a feature of the culture of control that permeates criminal justice policy in England and Wales. In relation to the strategy there is a concern that "the large numbers of women with existing and often undiagnosed mental health conditions, and long trauma histories… in need of treatment and support" will be forgotten.[407] Regardless of the focus of this strategy, like so many other policy initiatives in England and Wales, difficulties in implementation remain. It has been suggested that there has been "no discernible change in service provision since the introduction of the new strategy".[408] It has been suggested that female offenders who accessed regional forensic units in England and Wales "indicated a disconnect between services for

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[403] *Ibid*.

[404] *Ibid*.

[405] *Ibid*.

[406] *Ibid*.

[407] "Prison Reform Trust response to the joint Department of Health and NOMS offender personality disorder strategy for women" (London: Prison Reform Trust, January 2012) at page 1.

[408] See "Women Offenders: After the Corston Report" (London: House of Commons Justice Committee, Second Report of Session 2013–2014, July 2013) at page 38.

mental health and female offenders, particularly those perceived to present significant levels of risk to the public".[409]

18. Training

There has been a greater consideration of PWDs in England and Wales as both victims and offenders.[410] Training for police officers in England and Wales on mental health has been provided to a greater extent than in Ireland. However, the Bradley Report has identified a need for increased training for police to raise awareness about mental health and ID.[411] The extent to which the police in England and Wales are adequately trained to deal with PWDs was called into question in *ZH v Commissioner of Police for the Metropolis*.[412] This case involved a "severely autistic and epileptic young man" who had an ID and who could not communicate by speech. This case arose out of an incident where he went with one of his carers to the local swimming baths. At the time of the incident he was 16 years and during his visit he became fixated by the water and did not move.[413] *ZH* had an aversion to being touched and when the police officer touched his he jumped into the pool. He was removed from the water by the lifeguards and police and was subject to forcible restraint on his back by the side of the pool by up to 7 police officers placed in handcuffs and leg restraints, he was taken to a police van and detained in the cage at the back of the van. This case raises significant issues about the awareness of police officers about PWDs and the need to ensure access to justice and respect for the liberty of PWDs.

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[409] *Ibid*, at page 39.

[410] See "Living in a Different World: Joint Review Of Disability Hate Crime" (London: Criminal Justice Joint Inspection, 2013).

[411] See "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009). See also "The Police and Mental Health" (London: Sainsbury Centre, Briefing Paper 36, 2008), Cummings and Jones "Blue Remembered Skills: Mental Health Awareness Training for Police Officers" (*Journal of Adult Protection*: 12(3), 2010, pages 14-19) and "Police chief: We are not trained for mentally ill criminals" (Express, 6 October 2013). Available at: http://www.express.co.uk/news/health/434649/Police-chief-We-are-not-trained-for-mentally-ill-criminals. <Last accessed 10 November 2013>

[412] [2013] EWCA Civ 69.

[413] This is a common reaction to water of persons who are considered to have autism.

Chapter 4: England and Wales, Part 2

1. Review and Reform of Diversions Practices and Processes in England and Wales

Having outlined the main diversion provisions, processes and initiatives in England and Wales, this chapter now examines the policies that have motivated diversion policy. While diversion has been taking place in England and Wales for many decades, there have been significant barriers to delivering effective diversion. This is evidenced in two major reviews of diversion policies, namely Reed (1992) and the Bradley Review (2009). The Reed Report and the Bradley Report catalogue the obstacles to achieving effective diversion in England and Wales. The failure to create effective diversion is evidenced by a number of civil society movements that are currently campaigning for effective diversion programmes. For example, the Prison Reform Trust and the Women's Institute, supported by a range of other organisations have being running a number of campaigns seeking effective diversion in England and Wales. They have formed the "Care not Custody Coalition" and have been campaigning for the diversion of persons with MHPs from custody into treatment and care.[414] The Prison Reform Trust also ran the "No One Knows Campaign", which sought to address the barriers faced by persons with "learning disabilities" in contact with the criminal justice system.[415]

2. The Reed Report

The Reed Report followed on from the 1990 Home Office Circular in

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[414] See the Prison Reform Trust website at: http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth/CarenotCustody. <Last accessed 10 November 2013>

[415] See the Prison Reform Trust website at: http://www.prisonreformtrust.org.uk/ProjectsResearch/Learningdisabilitiesanddifficulties. <Last accessed 10 November 2013>

1992 (see above).[416] The Reed Report was born out of a Government appointed Steering Committee that was asked to consider the issue of offenders with MHPs. Effectively the Reed Report mapped a "blueprint" for the development and enhancement of services for "mentally disorder offenders" on a national basis.[417]

The Reed Report contained much evidence and information on offenders with MHPs and contained nearly 300 recommendations.[418] A large section of the Reed Report considered the diversion of "mentally disordered offenders" and the Committee was very supportive of diversion schemes recommending that there should be "nationwide provision of properly resourced court assessment and diversion".[419] The Report acknowledged that there was at that time a "growing diversity" amongst the schemes, which was welcomed as the different models ought to respond to local circumstances, and that there ought to be "effective planning and operational links made with other services and disciplines, including social work".[420] The Reed Report recommended greater use should be made of bail information and public interest case assessment systems that would assist the development of diversion and assessment schemes and ensure that the court was provided with all of the relevant information to make the relevant disposal. The Report also recommended that "mentally disordered offenders" should receive appropriate medical care and supervision.[421]

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[416] "Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services (the Reed Report)" (London: Department of Health and Home Office, 1992).

[417] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 247.

[418] The scope of the Steering Committees work was to consider the range of health and social services available to offenders with MHPs, and to make comprehensive recommendations as to the ways that services provision and resource allocation could be improved.

[419] "Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services (the Reed Report)" (London: Department of Health and Home Office, 1992) at paragraph 5.3.

[420] *Ibid*. The Steering Committee also acknowledged that where diversion schemes were established they facilitate, "broader multi-agency focus, which of itself, can make effective disposals easier".

[421] The Review was fed into by a number of different advisory groupings and included the Community, Prison, and Hospital Advisory Groups.

James has suggested that while the while the recommendations of the Reed Report were widely endorsed and accepted by Government, the failure to implement can be explained by a lack of funding to encourage and facilitate implementation.[422] Some of the important recommendations of the Reed Report that were implemented include the incorporation of prison health services within the NHS and the expansion of forensic psychiatry in England and Wales.[423] As mentioned above one of the key recommendations in the Reed Report was to ensure that court diversion schemes operated nationally, as James has commented this is "no nearer to realisation now than in 1992".[424] The failure to implement can also be explained by "the lack of central direction, resulting from a policy of leaving local services to develop their own initiatives according to local need – in effect a recipe for inaction".[425]

3. The Bradley Report

The failure to progress diversion as recommended by Reed, necessitated a further review of diversion in England and Wales. Lord Bradley was asked to examine the extent to which offenders with MHPs and "learning disabilities" could be diverted from prison to other services and the barriers to diversion.[426] He was also asked to make recommendations to government, specifically on the organisation of effective court liaison and diversion provisions, and the services necessary to support court liaison and diversion. The Bradley Report defined diversion for the purposes of its Report in a broad way, placing an emphasis in prevention and early intervention, diversion to treatment balanced against public safety and punishment.[427] Diversion

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[422] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 247.

[423] *Ibid*.

[424] *Ibid*.

[425] *Ibid*.

[426] See "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 9.

[427] *Ibid*, at page 16. Diversion was defined as "…a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best

as defined in the Bradley Review has been described as having a wider sense of meaning.[428] However, the meaning of diversion is based on a medical model approach, envisaging in some circumstances involuntary detention and coerced treatment.

In his introduction to his Report Lord Bradley, reflecting on the recommendations contained in the Reed Report stated, "… it is hard to believe that what was relevant 16 years ago is just as relevant today and that we are still struggling to resolve the same problems."[429] However, he noted that while the issues remain the same he suggested that there was a change in the "political and social context" in which recommendations will be received.[430] Bradley commissioned an estimate of the financial costs and benefits of a number of the reforms recommended in his Review. It was estimated that the cost per prison place came to £23,585 while the cost of a medium high security bed was £150,000. It was been noted that while it is possible to estimate the cost of a hospital bed the "real problem with costs comes from estimating how many offenders would be diverted or re-located from one environment to another were Lord Bradleys recommendations to be implemented, in particular of the critical numbers transferred into hospital beds rather than being dealt with in the community."[431] In that regard it is important to recall the definition of a CRPD compliant diversion model in Chapter 2: Literature Review would have community living as a core principle in the diversion system. As such diversion to costly high security residential services ought not to impede the development of diversion programmes.

In November 2009 the Government published a response to the Bradley Report.[432] Of the 82 recommendations contained in the Report

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placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence."

[428] James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 241.

[429] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 16.

[430] *Ibid*.

[431] See Peay *Mental Health and Crime* (Routledge 2011) at page 108.

[432] "Improving Health, Supporting Justice: the National Delivery Plan of the Health and Criminal Justice Programme Board" (London: Department of Health, 2009).

the Government accepted in principle or stated that the recommendation was under review. The Government also established the Health and Criminal Justice Programme Board, which is comprised of the relevant government departments and agencies. This was done to reflect what Bradley identified as the need for a cross-government approach to system reform in this area.

The DOH subsequently published an important policy document in this area.[433] The DOH's Report is in part is a formal response to Lord Bradley's Review. The central commitment in the Report is to improve mental health support for persons who come into contact with the criminal justice system. The DOH response stated that its approach in implementing the plan is to learn "from and build on services where there is already good practice and innovative approaches."[434]

It is too early to assess whether the DOH's action plan will be sufficient and successful in bringing about the necessary policy coherence that is required to better divert persons with MHPs to the services and supports that they need. The current policy on defendants and offenders with MHPs and ID remains the same as it has for the past number of decades in England and Wales. It remains the same insofar as it seeks to better divert persons with MHPs away from penal disposals into health and social services. However, there has been a generation of failure to realise this policy. It is interesting that the current discourse in England and Wales has not given any substantial consideration to the philosophy underlying the policy of diversion. It seems to be universally accepted by all stakeholders that it is prudent policy to seek to pursue diversion. However, the policy as it is has many features that seek to manage and address risk and there is potential for discrimination on the basis of having a MHP linked to a perception of being dangerous or risky. This is most obviously illustrated by the creation and work of the FTAC.

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[433] See "Improving Health, Supporting Justice: the National Delivery Plan of the Health and Criminal Justice Programme Board" (London: Department of Health, 2009).

[434] *Ibid*, at page 5. The Department of Health Report describes this process as representing the "first comprehensive approach at co-coordinating this work and forming a cohesive and integrated strategy and plan. This delivery plan represents our first objective as the new board and, through our cross-departmental and multi-agency sub-programme boards, we are responsible for overseeing the delivery of the actions included in this plan".

The explanation as to why there has been a failure to achieve more effective diversion seems to come back to the problem of a failure to adopt a joined up approach between the different stakeholders, a problem that is very evident in Ireland.[435] But perhaps there are other reasons underlying the failure to achieve the policy of consecutive Governments in this area and the explanation also involves a reluctance to allow these offenders escape criminal liability. At any rate the Bradley review has generated a momentum in England and Wales to seek more effective responses to the needs of offenders with MHPs. The action plan published by the DOH has clearly defined objectives and measures for success and is accompanied by a timeline for implementation. This is an element that was not in place following previous reviews in England and Wales that may result in the desired reform.

The Bradley Report emphasised the issue of social exclusion and the need for intervention to happen as early as possible in the process. In that regard the Report made a number of recommendations for the development of what has been described above as diversion that falls into the category of "pre-arrest diversion".[436] This is evident from recommendations on the improvement of the identification of MHPs in children and minors in schools. It is also evident from recommendations on community policing teams. The Bradley Report pointed out the need to make improvements across a range of components of the diversion systems and processes in England and Wales. In addition the Report made recommendations on raising awareness of MHPs and the need to provide training for probation staff, members of the judiciary, prison officers. There was also mention of the need for the provision of services for persons with dual diagnosis. The improvements include the need to ameliorate the screening of MHPs at the reception stage in prison and ensuring the continuity of care from the prison to the community. Bradley also recommended that there should only be a delay of 14 days in transferring people for psychiatric treatment from prisons to NHS hospitals.

One of the key themes that emerged from the Bradley Review was that successful diversion programmes required a central focal point that

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[435] See Chapter 3: Ireland.

[436] See Chapter 2: Literature Review: Part 1 and Part 2.

would be responsible for the system as a whole and be accountable for "mentally disordered offenders". As such it was recommended that a National Programme Board ought to be established to manage this area and commissioning within the NHS in all areas of "Criminal Justice Mental Health Teams" should manage every stage of process where a mentally disordered people interacts with the criminal justice system, including community services.[437]

It was recommended that awareness-raising was integral for pre-arrest diversion. In that regard it was recommended that "all staff in schools and primary healthcare, including GPs, should have mental health and learning disability awareness training in order to identify individuals (children and young people in particular) needing help and refer them to specialist services".[438] In addition it was envisaged that community support officers and police officers ought to collaborate with local mental health services with a view to the development of "joint training packages for mental health awareness and learning disability".[439] In terms of pre-arrest diversion, it was recommended that police should utilise their discretion in taking no further action or impose a formal warning. In responding to minor or "petty crimes", where a person has a MHP or ID, it was recommended "the police officer … record the crime but choose to take no further action".[440]

One of the important elements of the Bradley Report was the discourse around adequate training, so that diversion actually took place. Police officers need to be able to identify whether a person has a MHP. This is crucial in establishing connection with appropriate mental health services and other services and supports. Therefore, it is essential that police officers, and in particular custody officers, are provided with sufficient training that will facilitate contact with the available diversion and liaison services.

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[437] For a discussion on this see James "Diversion of Mentally Disordered People from the Criminal Justice System in England and Wales: An Overview" (*International Journal of Law and Psychiatry*: 33, 2010, at pages 241–248) at page 247.

[438] *Ibid*, at page 32.

[439] *Ibid*, at page 36.

[440] *Ibid*.

4. Policy Coherence: Prison and Probation Services

The prison service and probation services have been merged in England and Wales with a view to creating a more efficient system for dealing with offenders. The National Offender Management Service (NOMS) was established in 2008 as an executive agency within the Ministry of Justice.[441] NOMS brought together the headquarters of the Probation Service and the Prison Service with a view to enabling more effective delivery of services. While the two bodies remain distinct they have a "strong unity of purpose" in terms of protecting the public and seeking to reduce reoffending. While NOMS is mandated to ensure that court orders are complied with, it operates under a therapeutic jurisprudence philosophy, in working with offenders to tackle the causes of their offending behaviour.

The DOH and the Ministry of Justice recently conducted a consultation process around the Dangerous and Severe Personality Disorder (DSPD) pilot programme.[442] The DSPD pilot programme sought to provide services within prisons, secure hospital services and the community with a view to reduce the management problems and risk presented by "this small group of sexual and violent offenders."[443] It is clear from the joint Ministerial foreword to this policy document that public protection was a core consideration.[444]

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[441] NOMS has responsibility for commissioning and delivery of adult offender management services in England and Wales and this role extends to both offenders in custody and those living in the community. NOMS works with 260,000 offenders annually in and ensure that punishment ordered by the courts through custodial or community sentences are provided by the prison and probation services. There are 133 prisons in England and Wales, twelve of which are contracted to the private sector partners and the remainder is run by the public sector through Her Majesty's Prison Service. The Probation services in England and Wales are provided by 35 Probation Trusts, who receive their funding from NOMS and to whom they are accountable for their performance and delivery.

[442] "Response to the Offender Personality Disorder Consultation" (London: Department of Health and Ministry of Justice, 16313, 2011) at pages 5-6.

[443] *Ibid*, at page 5.

[444] The respondents to the Offender Personality Disorder Consultation agreed that the National Offender Management Service and the NHS should work in partnership "… to design and implement integrated pathways for managing and treating offenders with severe personality disorders, building on local and regional structures".

5. Green Paper "Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders"

The Green Paper entitled "Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders" is an important document that sets out plans for fundamental changes to the criminal justice system in England and Wales.[445] There was an acknowledgement in the Green Paper that "despite record spending and the highest ever prison population we are not delivering what really matters: improved public safety through more effective punishments that reduce the prospect of criminals reoffending time and time again."[446] The changes take a more restorative justice approach in seeking to "break the destructive cycle of crime and mean that more criminals make amends to victims and communities for the harm they have caused".[447]

The Green paper indicates a reorientation towards rehabilitation.[448] The Green Paper, in line with a number of other policy documents that preceded it, commits itself to the concept of diversion. It states that in "some cases, the criminal justice system is not the best place for them. This is particularly the case for offenders with MHPs."[449] There is a commitment to the problem solving approach "with the DOH and the Home Office to pilot and roll out liaison and diversion services nationally by 2014 for mentally ill offenders" and increasing "the treatment capacity for offenders who present a high risk of harm where this is linked to severe personality disorders".[450] The Green Paper is to be welcomed in endorsing the recommendations of the Bradley Review and further endorses the need for properly structured and resourced liaison and diversion schemes. However, given the inability of similar

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[445] "Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders" (London: Ministry of Justice, 2010).

[446] *Ibid*, at page 5.

[447] *Ibid*.

[448] *Ibid*, at page 24. In chapter 2 it is suggested that the "right way to improve public safety and reduce the number of victims is to reduce reoffending. We will always punish offenders appropriately. Offenders on community sentences or on release from custody will face a tough and coordinated response from the police, probation and other services. This means offenders must tackle the problems which fuel their criminal activity, but it also means they will be quickly caught and punished if they commit further crimes".

[449] *Ibid*, at page 36.

[450] *Ibid*.

policy initiatives in the past to deliver effective diversion and responses to defendants and offenders with MHPs and ID its effectiveness remains to be seen. It will be interesting also see whether the White Paper will remain as committed to the notions of rehabilitation and the final policy position that is adopted in relation to offenders with MHPs.

There has been some criticism of the Green Paper.[451] However, the commitments in the Green Paper have been widely endorsed and welcomed.[452] However, there is a clear scepticism at the likelihood in implementation of the Bradley Review's recommendations. This scepticism is evident in the Centre for Mental Health's establishment of an independent Commission to undertake a five-year-on review of the implementation of the Bradley Review, which is expected to publish a final report in 2014.[453]

The current conservative liberal coalition have been keen to portray a tough stance on crime, as evidenced by their recently published policy document "Swift and Sure Justice: The Government's Plans for Reform of the Criminal Justice System" and may serve as an impediment to the development of diversion in the community.[454] In respect of community sentences it was noted that the Government "already introduced reforms to make prisons places of meaningful work and we have set out proposals to include a punitive element in every

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[451] For a critique of the Green Paper see "Clinks response to the Ministry of Justice's Green Paper: Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders" (Clinks, March 2011). It has been suggested that it is important that the Green Paper failed to consider other issues that needed to be addressed such as accommodation, debt and education. In that regard the voluntary and community sector organisations should be involved "to deliver 'wrap-around' support services in these areas to assist in rehabilitation" (see page 9). In that regard it was suggested that the success of community based 'link worker' schemes where a single individual works with an offender from arrest (or release) through to successful resettlement, has already demonstrated the effectiveness of such innovative voluntary and community service delivery.

[452] For example, see "Prison Reform Trust Submission to the Ministry of Justice: Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders" (London: Prison Reform Trust, March 2011).

[453] See "The Bradley Report Revisited Commission" (London: Centre for Mental Health). Available at: http://www.centreformentalhealth.org.uk/criminal_justice/bradley_commission.aspx. <Last accessed 10 November 2013>

[454] "Swift and Sure Justice: The Government's Plans for Reform of the Criminal Justice System" (London: Ministry of Justice, July 2012) at page 7.

community sentence".[455] This White Paper comes after the speedy response to rioting in England and Wales in the summer of 2011 and represents an attempt by the Government to expand a speedy response to cases.[456]

6. Critical Reflections on the Diversion Model in England and Wales

Unlike Ireland in England and Wales there is legislative precedent for the detention of offenders, for indefinite periods of time, on the basis that they pose a risk to the public. The Halliday Report[457] published in 2001 proposed reform of the sentencing structure in England and Wales and in conjunction with the Home Office's White Paper published in 2002 paved the way for significant law reform introduced by the *Criminal Justice Act 2003*.[458] These provisions have been very controversial.[459] Fennel considers the provisions to be one of the most significant developments in sentencing, which may result in an "enhanced prison sentence" especially for offenders with a personality disorder. [460] The provisions were commenced in April 2005 and amended by the *Criminal Justice and Immigration Act 2008*. If a trial judge considered that an offender posed a significant risk of serious harm as set out in the statutory criteria they were empowered by the 2003 Act to make an order for imprisonment for public protection. Offenders sentenced in this way were required to serve a minimum term for the offence with the Parole Board empowered to assess the case for release. There were over 150 offences on the English statute books that triggered these indeterminate sentences for public

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[455] *Ibid*.

[456] McEwan "Vulnerable defendants and the fairness of trials" (*Criminal Law Review*: 2, 2013, pages 100-113).

[457] "Making Punishments Work: A Review of the Sentencing Framework for England and Wales (Halliday Report)" (London: Home Office 2001).

[458] "White Paper: Justice for All" (London: Home Office, Cm.5563, 2002). Chapter 5 of the 2003 Act provided for the introduction of imprisonment for public protection, which is an indeterminate sentence.

[459] See Peay *Mental Health and Crime* (Routledge 2011) at page 125.

[460] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 247.

protection.[461]

The underlying policy of providing treatment to offenders with MHPs is evident even in relation to provisions of the 2003 Act dealing with dangerous offenders. Section 37(1A) of the 1983 Act provided that nothing in sections 225-228 of the 2003 Act shall prevent a court from making a hospital order under section 37(1) 1983 Act. Therefore, where the court was of the opinion that the criteria for a hospital order were reached the offender did not have to be subjected to preventative detention under Chapter 5 of the 2003 Act.[462]

The introduction of preventative detention laws in Ireland similar to those introduced in England and Wales would face significant difficulties. As noted in Chapter 3: Ireland, sentencing law and policy is heavily influenced by the Irish Constitution, which espouses the principle of proportionality. As such the court is required to tailor every

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[461] Ormerod *Smith and Hogan Criminal Law* (Oxford: Oxford University Press, 12th 2008) at page 4.

[462] However, if an offender committed a "specified offence" and met the criteria of dangerousness the court was required to impose a life sentence, imprisonment for public protection or an extended sentence. Section 229 of the 2003 Act regulated how the court was to assess the dangerousness of an offender, which involves taking into account any information about the offences committed and patterns of behaviour. Section 229(3) introduced a presumption of dangerousness in circumstances where an offender aged over 18 was previously convicted of a similar offence. The 2003 Act required the court to deduce serious harm to the public unless the court after considering the information thinks that it is unreasonable that the offender poses a risk. The 2008 amendment to the imprisonment for public protection legislation sought to ensure a more enhanced seriousness threshold. The amendments were to address concern that these sentences were "spiralling out of control, and contributing further to the growth of an already burgeoning prison system". See Peay *Mental Health and Crime* (Routledge 2011) at page 125. There have been further amendments to the 2003 Act by way of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012*. Clause 113 abolishes Imprisonment for Public Protection (IPP), though leaving in place parts of section 225 and 226 of the *Criminal Justice Act 2003*. Thus it seems that the 2003 extended sentences are now abolished. In its place clause 114 introduces a new section 224A and a new Schedule 15B to the 2003 Act – an automatic life sentence for a second Schedule 15B offence, where the seriousness condition (where the offence merits a 10 year sentence) and the previous offence condition are met. This will be the case unless the court is of the opinion that it would be unjust in all the circumstances. Clause 115 introduces "new extended sentences" through a new provision section 226A. These extended sentences will be available only where the offender has been convicted of a Schedule 15B offence or where the offence merits a four-year sentence. Clause 116 and Schedule 19 to this Act introduces rules on release namely a discretionary two-thirds release for some by the Parole Board and automatic release for other offenders. Clause 117 also confers the Secretary of State with wide powers to change the test for release of existing Imprisonment for Public Protection and extended sentence prisoners.

sentence with reference to the particular facts of the case and the sentence must be proportionate to the crime that was committed.[463] The Irish courts have been very hostile to the notion of preventative detention, which it considers as having no place in the Irish legal system.[464] The rationale underlying preventative detention in England and Wales is public protection, although not specifically targeted at offenders with MHPs. In that regard the legislation was disability neutral and arguably complies with the notion of disability neutral laws as espoused by the OHCHR, even though such laws might raise other human rights concerns.[465] It is foreseeable that if State Parties to the CRPD sought to repeal aspects of the criminal justice system that did not comply with the CRPD requirement of disability neutrality – this English approach may gain some traction in dealing with offenders who were considered to pose a risk to the public. The danger here is that while such laws are disability neutral there is a risk that they could be used to indirectly to detain offenders with MHPs.

Much of the literature on indeterminate sentencing has not examined its impact on offenders with MHPs. However, it has been suggested that indeterminate sentencing has impacted negatively offenders with MHPs. Fennell suggests that the presence of a personality disorder resulted in enhanced prison sentences under the 2003 Act.[466] As discussed in Chapter 2: Literature Review, Part 1 it has been argued that indeterminate sentencing under the 2003 amounts to "reverse diversion".[467]

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[463] On this point see *People (DPP) v Sheedy* [2000] 2 IR 184.

[464] See *People (Attorney General) v O'Callaghan* [1966] IR 501, *People (DPP) v Jackson* (Court of Criminal Appeal, 26 April 1993), *Lynch v Minister for Justice Equality and Law Reform* [2010] IESC 34.

[465] See Chapter 2: Literature Review, Part 2.

[466] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at page 247.

[467] Rutherford "Imprisonment for Public Protection: An example of Reverse Diversion" (*The Journal of Forensic Psychiatry and Psychology*: 20(1), 2009, pages 46-55), Rutherford "Imprisonment for Public Protection: Genesis and Mental Health Implications" (*Mental Health Review Journal*: 13(2), 2008, pages 47-55) and "In the Dark: The Mental Health Implications of Imprisonment for Public Protection" (London: Sainsbury Centre for Mental Health, 2008).

. See also Chapter 2: Literature Review, Part 1. This notion of "reverse diversion" refers to the idea that persons with MHPs who engage in criminal conduct are more likely to receive a prison sentence as a result of criminal justice legislation than benefiting from diversion to mental health services and that the use of indefinite detention rows away from a policy of diversion.

The ECtHR considered indeterminate sentences for the public protection in *James, Wells and Lee v United Kingdom*.[468] It had been recommended that both of the applicants in this case undertake rehabilitative courses in prison, so as to reduce the risk they were considered to pose to the public. As the applicants were initially held in local prisons, where many of the recommended courses were not available, a long delay resulted before they could get access to the courses. They were subsequently transferred to prisons where these courses were available, but only after the expiry of their initial tariffs. It was conceded by the UK that this delay was as a result of the lack of resources and the expansion in the use of indeterminate sentences. The applicants lost their challenge in the House of Lords, where it was held that their detention was not arbitrary or unlawful, as the connection between the rationale for their detention and the detention had not been broken. However, the ECtHR subsequently held that there had been a violation of Article 5(1) of the ECHR by not providing for access to the rehabilitation programmes.

As discussed above there has been widespread criticism of these sentences since their introduction. These concerns led to reforms in 2008 that sought to limit the use of the provisions. The provisions have subsequently been withdrawn by way of the *Legal Aid Sentencing and Punishment of Offenders Act 2012*. However, these reform do not apply persons currently detained on the basis of indeterminate sentences for public protection, which is very concerning as over 6,000 prisoners in England and Wales are subject to these sentences.[469] It is important to note that the ECtHR have not rowed back from their jurisprudence on the lawfulness of indeterminate/preventative sentencing. The ECtHR have upheld the lawfulness of these types of sentences, however, this judgment is being interpreted as "setting a reasonably high threshold for compliance with the "lawfulness" requirement".[470] The ECtHR rejected the UK Governments arguments

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This is considered to be a product of the dangerousness and risk discourse that focuses on identifying risk as opposed to MHPs.

[468] (Application Nos 25119/09, 57715/09, Judgment 18 September 2012).

[469] See "Prisoners: indeterminate prison sentences - possibility of release - provision of rehabilitative courses - *James, Wells and Lee v the United Kingdom*)" (*European Human Rights Law Review*: Case comment, 1, 2013, pages 85-89) at page 87. *James, Wells and Lee v United Kingdom* (Application Nos 25119/09, 57715/09, Judgment 18 September 2012).

[470] *Ibid*.

that rehabilitation did not have to form part of an indeterminate sentencing regime, and that without rehabilitation the connection between the conviction and the detention could be severed quickly. Importantly, the ECtHR also rejected a lack of resources argument for failure to comply with the requirement to make rehabilitation available.

Fennell suggests that criminal justice policy in England and Wales in relation to "mentally disordered suspects" rests on three basic principles.[471] The first principle is that there should be special safeguards around the treatment of "mentally disordered offenders" in police custody as they may be disposed to making false confessions; this principle is evident from the PACE.[472] The second principle is that "mentally disordered suspects and offenders" should be diverted away from prison to the health and social care system; this principle is evidenced by the approach adopted in the Home Office Circular 66/90.[473] The rationale underlying the second principle is that the existence of a mental illness may diminish an offender's culpability for their crime(s) the other rationale is that this category of offenders would be at greater risk of self-harm and suicide.[474] The third principle identified by Fennell is public protection from the risks posed by offenders with MHPs, which he suggests has dominated "the discourse of mental health reform since the early 1990's".[475] Lord Bradley shares this view – in making recommendations in his recent review of diversion acknowledging that while the issues remained the same since the early 1990's; there was a change in the "political and social context".[476]

It has been suggested that the attempts to bring together the mental health legislation and penal policy in England and Wales, while billed as a "joined up government" approach, in fact is "more reflective of

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[471] Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2007) at pages 161-162 and Fennell *Mental Health: The New Law* (Bristol: Jordans, New Law Series, 2nd edition, 2009) at pages 213-214.

[472] *Ibid*.

[473] *Ibid*.

[474] *Ibid*.

[475] *Ibid*.

[476] See "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 9.

criminal justice and risk management concerns than … traditional healthcare concerns".[477] In that regard the relevant law and policy represents "a reaction to increasing concerns about the risks to self and others, but mainly to others, posed by mentally disordered people".[478] The provisions in the *Criminal Justice Act 2003* reflect the desire of Government to manage the perceived risk through the use of preventative detention. The convergence of penal policy and mental health law is illustrated by the broadening of powers that permit the detention on the basis of perceived risk, and has involved the wearing away of patient's rights to privacy and confidentiality, and an obligation to share information of patients thought to be of high risk.[479] It is interesting from a mental health perspective that indeterminate sentencing has become a dominant feature in England and Wales over the past decade. As Fennell points out indeterminate sentencing was once the reserve of the psychiatric system.[480] Hale has also identified that recent penal policies have led to a significant expansion in the prison population and that the "old dichotomy between an open-ended therapeutic disposal and a determinate sentence has been eroded".[481] The result of this erosion has been the high prevalence of MHPs within the prison population.[482] Apart from the public protection rationale underpinning diversion in England and Wales, Hale has identified another reason to be sceptical of diversion in that "[e]ven the most disturbed patient may feel a sense of grave injustice at prolonged detention in hospital without trial".[483]

The UK, in comparison to Ireland has a better track record in providing safeguards for persons involuntarily detained under its mental health legislation. In Ireland the *Mental Treatment Act 1945*, which was repealed and replaced by *Mental Health Act 2001* did not provide

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[477] Fennell "Radical Risk Management, Mental Health and Criminal Justice" in Gray, Laing and Noaks *Criminal Justice, Mental Health and the Politics of Risk* (London: Cavendish Publishing, 2002) at page 69.

[478] *Ibid*.

[479] *Ibid*, at page 70.

[480] *Ibid*, at page 70.

[481] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 145.

[482] See for example "Psychiatric morbidity among prisoners in England and Wales" (London: Department of Health, 13 October 1998).

[483] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 151.

adequate safeguards as to involuntary detention and treatment. The *Mental Health Act 1959* by comparison provided Mental Health Review Tribunals, its role was to examine the lawfulness of detention of persons involuntarily detained and assessed whether continued detention was necessary. Following the unfavourable ruling of the European Court of Human Rights in *X v United Kingdom*[484] the *Mental Health Act 1983* expanded the provision of safeguards to persons involuntary detained, providing greater scope to challenge detention and request the opinion of a second psychiatrist, where involuntarily treated. In addition to due process rights the 1983 Act provided for persons subject to long-term detention a right to access after-care service when released.[485] It has been suggested that the concern with the human rights in this sense EG the due process rights of persons involuntarily detained and treated, has been replaced with human rights in a much broader sense.

The premium placed on the right to life under Article 2 of the ECHR was recently highlighted in *Rabone v Pennine Care NHS Foundation Trust*.[486] In this case the UK Supreme Court considered whether the NHS Trust was under an operational obligation under Article 2 of the ECHR to prevent the applicant's daughter from ending her life and if so whether the Trust had breached the duty owed. The Supreme Court unanimously found in favour of the victims in that the NHS Trust was in breach of its operational obligation under Article 2 of the ECHR. The Supreme Court articulated that the duty was owed not only to involuntary patients but also voluntary patients. So clearly there is a positive duty under Article 2 to take preventative operational measures to safeguard an individual's life in certain circumstances.[487]
It has been noted that while official Government policy in England and

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[484] (1981) EHRR 188.

[485] Fennell "Radical Risk Management, Mental Health and Criminal Justice" in Gray, Laing and Noaks *Criminal Justice, Mental Health and the Politics of Risk* (London: Cavendish Publishing, 2002) at page 70.

[486] [2012] UKSC 2.

[487] *Ibid*, It was interesting that the Supreme Court did not attach much significance to the fact that the patient was a voluntary patient. Lord Dyson in the lead judgment acknowledged "there is a crucial difference between those who are informal patients voluntarily in hospital and those who are detained by the authority of the state. A psychiatric patient who is voluntarily in hospital, like a patient with a physical illness, is free to refuse treatment and leave" (at paragraph 26).

Wales in diverting offenders with MHPs away from prison into the mental health system this reality is at "variance with popular media understandings of mental disorder and criminality, seeing them as natural bedfellows", however this no longer seems to be clearly the case as the goal of diversion is under threat.[488] It has been suggested that the different Circulars, policy documents, legislative instruments and case law "form the doctrinal basis" of diversion policy, which still applies.[489] Diversion is still clearly a policy goal in terms of diversion options available at the different points of the criminal justice system, with no plans to remove the powers of the judiciary to send persons to hospital as opposed to prison.[490] Nonetheless it has been suggested that there has been a "sea change" in the attitude of the Government.[491]

7. Reverse Diversion

It has been suggested that the move towards preventative detention of persons with "dangerous and severe personality disorder" (DSPS) marks a shift in Government policy in England and Wales to a more of a criminalised model than a therapeutic medical model.[492] The first half of the 1990's saw a significant increase in the number of offenders with MHPs transferred from prison to hospitals, while the second half of the 1990's saw the pattern begin to reverse. It has been suggested that this trend in conjunction with the focus on improving mental health services in prison could be interpreted as an abandonment of the policy of diversion, which at any rate was a policy that was always "more honoured in the breach".[493] Bartlett and Sandland suggest that it is unhelpful to describe these "policy shifts in such easy and polarised terms".[494] In that regard they refer to the different categories of offenders within the new risk paradigm, offenders considered a high

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[488] Bartlett and Sandland Mental Health Law: Policy and Practice (Oxford: Oxford University Press, 2003) at page 237.

[489] *Ibid*.

[490] *Ibid*.

[491] *Ibid*.

[492] *Ibid*.

[493] *Ibid*, at page 328.

[494] *Ibid*.

risk to public safety, and offenders considered a low risk. For offenders considered a high risk the 1990's in England and Wales heralded significant expansion of Secure Unit accommodation. In respect of offenders considered to pose a low risk inpatient provision of mental health services was reduced and provision shifted to the private sector. This Bartlett and Sandland suggest marks a "bifurcation in policy, deriving from an economy of risk management, with a tightening of control" for offenders considered to pose a high risk and a "scaling down" of control of offenders perceived to pose a low risk.[495] The result of this policy might be that a greater number of offenders with MHPs will come into contact with the criminal justice system, if the appropriate supports in the community are not available. At any rate it is suggested that Government policy is only one factor that impacts on practice and that "professional discourse and ethics, as well as legal rights are also vital factors".[496] In that regard local practice and initiatives aimed at better detecting offenders with MHPs in police stations and courthouses are important and independent of Government policy.[497] Government policy at any rate is dependent on resources, which are always limited. Indeed, Government policy is still committed to diversion and it is evident that when diversion was more firmly entrenched, there was a failure to implement it, meaning that a move away to a more risk orientated policy will undoubtedly face significant obstacles in implementation.[498] As discussed in Chapter 2: Literature Review there are unresolved questions around the links between MHPs and criminality. Regardless of these unanswered questions "the political reality is that the two concepts are already conflated".[499]

Coid and Ullrich identified further barriers to diversion. In their study they reported that "psychotic prisoners" differed from "psychotic persons in households" in England and Wales in terms of demographic features (EG having personality disorders and substance misuse problems).[500] The research revealed that few psychotic prisoners had

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[495] *Ibid*.

[496] *Ibid*.

[497] *Ibid*.

[498] *Ibid*.

[499] *Ibid*, page 239.

[500] Coid and Ullrich "Prisoners with psychosis in England and Wales: Diversion to psychiatric

been inpatients and "only a minority were receiving any help for MHPs".[501] It has been suggested that proposals to divert more offenders with "severe mental illness" to mental health services in England and Wales may be "unfeasible", given the public expectation that "high risk patients" should be treated in secure inpatient facilities.[502] The other reason for their conclusion of unfeasibility is that "comorbid personality disorder" with substance misuse, and "extensive criminal histories mean that many of these individuals are likely to be highly difficult to manage in a therapeutic setting".[503] In addition the move to reduce the overall number of inpatient bed numbers and the limited number of high security beds, together with "declining throughput in specialist forensic services, means that diverting more psychotic prisoners would overwhelm current inpatient capacity".[504]

Preventative detention and risk management have become treatment and this poses ethical predicament.[505] This is particularly the case in light of the UK's obligations having ratified the CRPD. The Reed Report suggested that where possible "mentally disordered offenders" should be cared for in the community as opposed to institutional settings, and that the security should be tailored to the degree of danger that they present. The Reed Report also recommended that the focus should be on rehabilitation with a view to the offender being able to sustain an independent life in the community, and the offenders should be placed as close as possible to their families. As Hale acknowledges progress since the publication of the Reed Report has been "patchy and slow".[506] Hale suggests that the patchy and slow progress in diverting defendants with MHPs from the criminal justice system can be partly explained by the "competing reality" between fear of crimes by persons with personality disorders who are not susceptible to psychiatric

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inpatient services?" (*International Journal of Law and Psychiatry*: 34, 2011, pages 99–108) at page 106.

[501] *Ibid*.

[502] *Ibid*, at page 107.

[503] *Ibid*.

[504] *Ibid*.

[505] 1981) EHRR 188.

[505] Fennell "Radical Risk Management, Mental Health and Criminal Justice" in Gray, Laing and Noaks *Criminal Justice, Mental Health and the Politics of Risk* (London: Cavendish Publishing, 2002)

[506] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 145.

treatment or "conventional deterrence".[507] The other part of the failure to adequately divert is the "chronic shortage of suitable treatment facilities for offenders with treatable mental disorders".[508]

The Bradley Review highlighted the need to raise awareness of mental illness throughout the criminal justice system. Key to that also was the establishment of local Criminal Justice Mental Health teams. The Review also engaged with the need to improve the treatment that was made available to "mentally disordered offenders". Hale suggests that this indicates that diversion can no longer be seen as "the only answer".[509]

Hale asks the following questions

> "But which would you rather be? Sentenced to a fixed term in a prison where there could be a stimulating range of educational and other opportunities available, smoking is allowed and forcible medical treatment can hardly ever be imposed? Or sentenced to an indeterminate term in a medium or high security psychiatric hospital, where the facilities are less varied, smoking is not allowed, but forcible medical treatment is?"[510]

While the MHA Code of Practice is clearly committed to the diversion, there is a consensus that diversion does not happen as frequently as it should at the different points of the criminal justice system. The reasons for this on-going breakdown include failure to recognise offenders with MHPs and the services needed to treat the disorder may not be in place. As Hale recognises these failures are not legal problems.[511] Concern has been with the renewed commitment to fund diversion and liaison services. For example, the Criminal Justice Alliance has commented that it is essential that "the drive towards a swifter justice system liaison is not bypassed and that each appropriate offender has the appropriate amount of time to be seen by the

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[507] *Ibid*.

[508] *Ibid*.

[509] Hale *Mental Health Law* (Sweet and Maxwell, 5th edition, 2010) at page 145.

[510] *Ibid*.

[511] *Ibid*, at page 185.

respective team".[512] It has been suggested that the recently created role of Police and Crime Commissioner have an important role to play as "local champions of liaison and diversion services, and have the responsibility to ensure offenders with MHPs are supported and dealt with appropriately".[513]

8. The Economic Arguments for Diversion in England and Wales

The provision of mental health services to persons who pass in and out of the criminal justice system has been described as an issue that "drifts in and out of political consciousness".[514] It is not surprising then that Government commitment to diversion as a policy in England and Wales a number of stakeholders have sought to make a business case for diversion with a view to securing implementation of the reforms proposed by Bradley. The reliance on a business case for diversion illustrates the need to engage creatively with Government, to deliver on their policy commitments on diversion. The Centre for Mental Health, Rethink and the Royal College of Psychiatrists produced a document making the business case for diversion.[515] They have made the argument that diversion is particularly cost effective alternative to holding a person on remand as non-custodial sanctions, such as a community order, in conjunction with community-based support services.[516] The Centre for Mental Health, Rethink and the Royal College of Psychiatrists argue that diversion is very cost effective in respect of offenders receiving short custodial sentences, as these offenders commit repeat but non-violent criminal offences.[517] It was

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[512] "Briefing for Police and Crime Commissioner Candidates: Working across the criminal justice system – opportunities to cut crime and reduce reoffending" (Criminal Justice Alliance, October 2012) at page 6.

[513] *Ibid*. For a discussion on police and crime commissioners see Editorial "Police and Crime Commissioners" (*Criminal Law Review*: 11, 2012 pages 821-823).

[514] Pakes and Winstone "Effective Practice in Mental Health Diversion and Liaison"(*The Howard Journal*: 48(2), 2009, pages 158–171) at page 158.

[515] See "Diversion: The Business Case for Action" (London: Centre for Mental Health, Rethink and the Royal College of Psychiatrists, 2011).

[516] *Ibid*, at page 1.

[517] *Ibid*, at page 2. Diversion is particularly cost effective in respect of short-term of short-stay prisoners, as 1 in 5 do not receive any assistance with their MHP. In addition short-term prisoners are unlikely to be in custody for a lengthy enough period of time to access and

estimated that the expenditure on diversion amounted to £10 million annually. This was considered to be an insufficient expenditure and that £50 million was required to ensure that liaison and diversion services were effective and not patchy nationally. It was estimated that despite requiring an upfront investment in liaison and diversion services most if not all of the expenditure could be covered by short-term savings to the criminal justice system.[518]

The Centre for Mental Health, Rethink and the Royal College of Psychiatrists also estimate that there would be significant savings from the resultant reduction in rates of reoffending. This is supported by the available data that show that re-offending by ex-prisoners recently released cost between £9.5 billion and £13 billion.[519] It has been suggested that short-sentenced offenders are responsible for as much as three quarters of this: some £7 billion to £10 billion a year. While the majority of this cost is borne by the public approximately between 20-30% is paid for by the public sector mainly the NHS and the criminal justice system. Unsurprisingly research commissioned by the representative organisation for independent providers of secure mental health facilities has also supported the cost effective nature of diversion.[520]

9. The Compatibility of English Law with the CRPD

The UK has ratified the CRPD and unlike other jurisdictions the UK has not entered a reservation or interpretative declaration in respect of Article 12 of the CRPD.[521] It is clear from its initial Report to the UN

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benefit from prison-based programmes that seek to reduce re-offending.

[518] *Ibid*. It was calculated that a standard six-week period of detention in prison amounted to £5,000 per person. This figure compared to a standard typical one-year community order involving probation supervision and drug treatment, which amounts to £1,400. A "highly intensive" two-year community order that involves twice-weekly connection with a probation officer, 80 hours of unpaid work and mandatory completion of accredited anti-offending programmes costs less than a six-week period of detention in prison at an amount of £4,200.

[519] See "Managing offenders on short custodial sentences" (London: National Audit Office, Report by the Comptroller And Auditor General, HC 431 Session 2009–2010, 10 March 2010) at page 17. This figure is estimated for the year 2007-2008.

[520] See Renshaw "Waiting on the Wings: A Review of the Costs and Benefits of Secure Psychiatric Hospital Care for People in the Criminal Justice System with Severe Mental Health Problems" (Berkshire: Laing and Buisson, 2010).

[521] See Chapter 2: Literature Review, Part 2.

Committee on the Rights of Persons with Disabilities that the UK Government considers diversion programmes in place in England and Wales to be compatible with the CRPD (in addition to the current legislative regimes for mental health law and guardianship). In its initial Report the UK Government reference "intervention options" for defendants or offenders with mental health conditions and liaison and diversion schemes that operate to divert people from prison.[522] Perhaps mindful of the paradigm shift in thinking around articles 12, 14 and 17 the UK Report references the development of "other support services" that "will be available in police custody suites and courts by 2014", which they consider will "ensure that people with mental health conditions are identified at an early stage".[523]

In its Report there are a number of references to offenders with MHPs under the heading dealing with the UKs compliance with of Article 13 (Access Justice) of the CRPD.[524] In terms of fulfilling its obligations under Article 13 the UK Report reference the establishment "of appropriate services to help communication between the police and disabled adults with learning difficulties or mental health conditions during police investigations and interviews."[525] The UK Report also referred to training provided to Her Majesty's Courts and Tribunals Service (the new amalgamation of Her Majesty's Courts Service and Her Majesty's Tribunal Service) and highlighted the provision of training on "reasonable adjustment guidance" for staff.[526] The Report does not engage with the core issues around the compatibility of the relevant mental health law and criminal law with the CRPD.[527]

Article 12 of the CRPD requires reassessment of guardianship laws.[528]

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[522] "UK Initial Report: On the UN Convention on the Rights of Persons with Disabilities" (United Kingdom of Britain and Northern Ireland, First Report to the UN Committee on the Rights of Persons with Disabilities, 2011).

[523] *Ibid*.

[524] *Ibid*.

[525] *Ibid*. In the Report it is noted that these provisions in "England, Northern Ireland and Wales, these services are on a statutory basis".

[526] *Ibid*.

[527] Given that the Report is entitled an initial report it seems likely that a more considered Report will be submitted in advance of the UN Committee scheduled hearing.

[528] See Chapter 2: Literature Review, Part 2.

The functional approach to legal capacity may be compliant as long as it complies with the notion of supported decision-making as now articulated by the UN Committee on the Rights of Persons with Disabilities. The criminal law in England and Wales has operated on an assumption that offenders who successfully raised the insanity were not criminally responsible. The Law Commission for England and Wales recently published documents on fitness to plead and on the insanity defence and automatism.[529]

The Law Commission in the Consultation Paper introduced the functional legal capacity approach in its analysis of the unfitness to stand trial.[530] The approach taken by the Law Commission is to introduce a functional test for legal capacity to stand trial. However, the Commission's conception of capacity is at odds with the emerging understanding of Article 12 of the CRPD. The approach of the Law Commission has the potential to significantly increase the number and type of offenders that may be deemed to lack the capacity to stand trial. While this approach is motivated from a rights perspective, in better ensuring that defendants are able to participate in their defence, it does not sufficiently consider the provision of reasonable accommodations and supports in facilitating participation in the proceedings.

The Law Commission's approach reflects a view that the criteria for the rules on fitness to plead are archaic, particularly when compared to the progressive functional approach taken to determining capacity in modern guardianship legislation.[531] The Commission's commitment of the functional approach is unsurprising, given its work on guardianship, which paved the way for the *Mental Capacity Act 2005*.[532] However,

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[529] Priority has being given to the Discussion Paper of fitness to plead and a Report is expected in 2014.

[530] See "Unfitness to Plead: A Consultation Paper" (London: The Law Commission, Consultation Paper No 197, 2010).

[531] See Shah "Making Fitness to Plead Fit for Purpose" (*International Journal of Criminology and Sociology*: 1, 2012, pages 176-197).

[532] See "Mentally Incapacitated Adults: Decision-Making: An Overview" (London: Law Commission, Consultation Paper 119, 1991), "Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction" (London: Law Commission, Consultation Paper 128, 1993), "Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research"

given the emergence of CRPD since this work was completed it is desirable that the Law Commission considers the evolution in thinking in this area. However, it is unlikely that the Law Commission will refine its approach in its Report on unfitness to plead, as the synthetises of the responses to the Commissions Consultation Paper did not refer to the CRPD.[533]

The Code for Crown Prosecution requires that alternatives to prosecution should be considered when deciding whether or not to prosecute an offence, the alternatives to prosecution could involve a caution or a conditional caution. The Bradley Report noted that the "National Standards for Conditional Cautioning" state that a caution or conditional caution may not be appropriate in circumstances where there is a question as to the reliability of the admissions made, or in circumstances where the persons understanding prevents them from comprehending the consequences of the caution and from giving informed consent to the caution.[534] In that regard the Bradley Report noted that prosecutors are advised not to assume that all offenders with MHPs are ineligible for cautioning or conditional cautioning. However, as the Bradley Report notes there is "no definition of or restriction on the particular form of mental condition or disorder that that may make an admission unreliable".[535] As Fennell notes to make an "attempt at such a definition might risk adopting a status approach to reliability and capacity" and that persons with certain MHPs would be at risk of being presumed to lack capacity to accept a caution.[536] This situation is inconsistent with Article 12 of the CRPD and there is no discussion of ways in which a person with a MHP could be supported to engage with and benefit from the caution process. However, Bradley recommended that the CPS should review the use of conditional

(London: Law Commission, Consultation Paper 129, 1993), "Mentally Incapacitated and Other Vulnerable Adults: Public Law Protection" (London: Law Commission, Consultation Paper 130, 1993) and "Mental Incapacity: Report" (London: Law Commission, Consultation Paper 231, 1995).

[533] See "Unfitness to Plead Analysis of Responses" (London: Law Commission, 2013).

[534] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 42.

[535] *Ibid*.

[536] Fennell "Powers of the Police and Decision to Prosecute" in Gostin, McHale, Fennell, Mackay and Bartlett (eds) *Principles of Mental Health Law and Policy* (Oxford: Oxford University Press, 2010) at page 714.

cautions for persons with MHPs and "learning disability" and issue guidance to the relevant agencies.[537]

Ashworth has described the recommendations in the Law Commission's Discussion Paper on the insanity defence and automatism as "radical". [538] The Commission provisionally recommended the abolition of the insanity defence, to be replaced with a broader defence of "not criminally responsible by reason of a recognised medical condition". [539] To access the defence the defendant needs to establish that the lack of capacity arose from a "recognised medical condition".[540] The term "mental" is deliberately omitted from the defence, and it is envisaged that it will include mental and physical conditions. The Commission also recommended that a defence of automatism should be provided to respond to circumstances where the lack of capacity to control conduct was not the result of a recognised medical condition. According to the Commission the defence is only available to a defendant in circumstances where the court is convinced that there was a complete loss of control. The Commission envisages that when the defence is successfully raised, an ordinary acquittal would follow. The Commission identified three types of capacity, the ability to rationally form a judgment in relation to the relevant conduct or circumstances, an understanding of the wrongfulness of the conduct, and the ability to control physical actions relating to the relevant conduct or circumstances. The approach is very much based on a medical model approach, with expert witnesses providing professional opinion, as to whether the defendant was suffering from a recognised medical condition, and the existence of a casual relationship between the condition and the total lack of capacity.

The foundation of the new defence is based on a notion of non-

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[537] "The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System" (London: Department of Health and the Home Office, 2009) at page 42.

[538] See Ashworth "Editorial: Insanity and Automatism: A Discussion Paper" (*Criminal Law Review*: 10, 2013, pages 787-788).

[539] "Criminal Liability: Insanity and Automatism, A Discussion Paper" (London: Law Commission, 2013)

[540] Ashworth "Editorial: Insanity and Automatism: A Discussion Paper" (*Criminal Law Review*: 10, 2013, pages 787-788).

responsibility when there is a complete lack of capacity; this approach is at odds with the position of the OHCHR and the Draft General Comment and its interpretation of Article 12 as it relates to the insanity defence.[541] In fact the Commission considers that the "defendant's lack of capacity is at the heart of our main proposal and this is its principal strength".[542] The Discussion Paper, while referencing the CRPD in parts did not engage in discussion of the implications of the CRPD for the insanity defence. There was no reference to Articles 12, 14 or 17, which are arguably most relevant to the Commission's work. The Commission's discussion of the CRPD reflected a shallow understanding of the Convention's meaning, scope and potential. For example, the Commission when considering the human rights implications of supervision orders and forced treatment referenced Article 25(2) (health) of the CRPD regarding forced treatment, with no reference to the more germane provision (Article 17). The Law Commission's Discussion Paper gave little consideration to the ECHR, with little discussion of the implications of the new defence from the perspective of Article 5. The Commission considered that there was a risk that persons, who benefited from the insanity defence or equivalent, could pose a risk to the ECHR rights of potential victims (EG Articles 2, 3 and 8).[543] Similarly, the Commission considered that the current limitations to the use of insanity defence were considered to breach the human rights of defendants "who suffered serious illness at the time of the offending" but who could not raise the defence.[544] The consequence of which was detention "rather than receiving treatment in hospital".[545]

The CRPD is driving a worldwide law reform agenda, where State Parties are seeking to bring their domestic law into compliance with the Convention. However, the impact of the CRPD in the area of criminal responsibility is having little to no impact in England and Wales. Indeed Richardson considering the implications of the CRPD has stated

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[541] See Chapter 2: Literature Review, Part 2.

[542] "Criminal Liability: Insanity and Automatism, A Discussion Paper" (London: Law Commission, 2013) at page 46.

[543] Criminal Liability: Insanity and Automatism, A Discussion Paper" (London: Law Commission, 2013) at page 14.

[544] *Ibid*, at page 15.

[545] *Ibid*.

that with "psychiatric disorders, where the overwhelming emphasis has been on risk reduction, it is unrealistic to imagine that any government in England and Wales would adopt a model that removed the link between mental and legal capacity".[546] She considers that such "a move would have enormous implications across not just civil or private law, but across the criminal law as well".[547] Given that the Law Commission are not in any way engaged in the implication of the CRPD for its current work it is unlikely that the paradigm shift in thinking is likely to impact law and policy England and Wales in the immediate future.

10. Conclusions

Since the Butler Report in 1975, there has been a commitment to the principles of diversion, which essentially espouse a therapeutic jurisprudence rationale in responding to defendants and offenders with MHPs. While the Irish *Mental Health Act 2001* was heavily influenced by the *Mental Health Act 1983*, the legislation did not make provision for the range of powers of diversion discussed in Part 1 of this chapter. Statutory powers can facilitate diversion and are supported with processes that seek to identify persons who can benefit from diversion.

The powers conferred on the police under section 136 of the 1983 Act are controversial, lacking a clear articulation of their rationale, depriving persons with MHPs of their liberty. While these powers are considered to be an essential component of the diversion system, problems have persisted for decades. Police stations are frightening places and persons detained under section 136, are likely to be processed in the same manner as any other person that has been arrested. The use of section 136 may in some cases connect persons with MHPs to services in the community. However, it is at odds with the principles underling the CRPD. Nonetheless the literature suggests that it is used inconsistently in police stations, with a lack of awareness about the mental illness needs of persons that the police are in contact with.

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[546] Richardson "Mental capacity in the shadow of suicide: what can the law do?" (*International Journal of Law in Context*: 9(1), 2013, pages 87-105) at page 93.

[547] *Ibid*.

In contrast to Ireland there is much greater transparency around decisions to prosecute persons with MHPs in England and Wales. The decision-making around prosecution in England and Wales is based on a clear policy of weighing up the decision not to prosecute with the public interest. Principles of therapeutic jurisprudence and principles of reasonable accommodation are present in this weighing up process (EG the factors to be taken into account include the impact of the prosecution on person's physical and mental health and their age). In Ireland, there is little guidance for Gardaí and DPP in making decisions to prosecute persons with MHPs or ID, a situation that requires consideration.

There is broad support for court-based diversion in England and Wales. Court-based diversion is not considered contentious compared to diversion following the insanity defence for example. However, it is clear from the discussion of diversion programmes involuntary detention and coercive treatment remains an integral part of the system. The FTAC while billed, as a diversion programme does not accord with the description of diversion as articulated in Chapter 2: Literature Review. The FTAC's focus is on detecting and managing the risks persons with MHPs are considered to pose.

One of the major challenges in implementing effective diversion provisions, processes and initiatives in England and Wales has been the development of relationships amongst the different stakeholders dealing with defendants and offenders with MHPs. This remains a significant problem that needs to be addressed. In the development of a system of diversion in Ireland, it is crucial to map out and define the roles and responsibilities of agencies in the criminal justice system and in the health system. Unlike Ireland there has been a clear policy commitment to diversion in England and Wales over the past number of decades. Nonetheless the Reed and Bradley reviews have illustrated a failure to deliver effective responses. The Reed and Bradley Reports also reveal that a joined up approach is essential to an effectively functioning diversion system. As such coordination across the Irish Prison Service, the Probation Service, the HSE and the Gardaí and community mental health services is essential. There will need to be a central body that will take control of coordinating the diversion system. This lack of central control was a key explanation for the development of ineffective diversion programmes in England and Wales.

The failure to deliver effective diversion in England and Wales cannot be considered legal problems or deficits with legislative provisions. The lack of policy coherence in England and Wales partly explains the reasons for inefficiencies in the diversion system, however, political and social factors undoubtedly also partly explain deficiencies. The conflict in ethos between general psychiatric services and forensic psychiatric services and the associated barriers in accessing treatment echoes concerns in Ireland, and is an issue that requires consideration, if effective diversion is to be developed. While the recommendations of the Reed Report were widely endorsed and accepted by Government, the failure to implement may also be partly explained by a lack of funding to encourage and facilitate implementation. A key recommendation in the Reed Report was to ensure that court diversion schemes operated nationally. However, twenty years later this has yet to be achieved. The Bradley Report emphasised the issue of social exclusion and the need for intervention to happen as early as possible in the process. The Report made a number of recommendations for the development of "pre-arrest diversion" as a key feature of diversion, which will need development in Ireland. Another key recommendation of the Reed Report was the implementation of prison health services within the NHS and the expansion of forensic psychiatry in England and Wales. The delivery of health services in prison and the development of forensic mental health services have to be progressed in order to develop an effective diversion system. Such an approach in Ireland should enhance the likelihood of prisoners benefiting from the equivalence of care in prison, enjoy the right to the highest attainable standard of mental and physical health, and facilitate community living and inclusion in the community.

The literature on Mental Health Treatment Requirements demonstrates that psychiatrists would not recommend requirements for persons requiring talking therapies or psychological treatment; on the basis they required voluntary engagement. This resistance suggests the embedding CRPD compliant practices into diversion processes will be challenging. The diversion system in England and Wales is at odds with the UKs obligations under the CRPD, in particular, Articles 12, 14 and 17. Given that the diversion system in England and Wales is at odds with the CRPD the question then arises as whether it should be considered as a model that could help develop diversion in Ireland. It is argued that the system in England and Wales should be used as a model to develop both law and policy in Ireland. The rationale for this

conclusion is that coercive mental health laws are likely to remain a key feature of Irish law for the foreseeable future. The discussion in Chapter 3: Ireland revealed that persons with MHPs appearing before the courts had difficulty in accessing services in the community. The available evidence on the effectiveness of diversion in England and Wales while identifying decencies in the system, suggests that diversion can nonetheless be an effective way of accessing mental health services for an underserved population. Access to mental health services is required under the right to health and the right to habilitation and rehabilitation and recovery as required by the CRPD (see Chapter 2: Literature Review). The development of statutory provisions of diversion (inserted into the *Mental Health Act 2001*) would need to be considered from the perspective of the CRPD. The focus could be shifted to the positive provisions of the system in England and Wales, such as community disposal and facilitating access to supports in the community. Such an approach could minimise involuntary detention and coercive treatment. As discussed in Chapter 2: Literature Review one of the main objections to diversion from the perspective of the CRPD is that it impairs the legal capacity of the defendant. This objection is mitigated to some extent in that diversion does not require a curtailment of the persons' legal capacity and participation can proceeds on a voluntary basis.

Chapter 5: Scotland

1. Introduction

This chapter considers the relevant law and policy on diversion of defendants and offenders with MHPs and ID in Scotland. The relevant statutory provision of diversion will be examined. The chapter also considers the use of community disposals both at the prosecution stage and at the court stage. This chapter then considers the development of Scottish forensic mental health services, which is of particular interest, as Irish forensic mental health patients have been transferred periodically to Scotland in the absence of corresponding services in Ireland. There is also a consideration of the recent law reform of the insanity defence and the defence of diminished responsibility, with a particular focus on the discourse on the law reform process on the abolition of the defences. The emergence of risk management in Scottish criminal justice policy is also explored.

2. Background

It is important to note from the outset that there is a dearth of literature on diversion in Scotland.[1] The Scottish Government has not commissioned research on diversion nor has there been a broad, systematic review of diversion similar to that of Lord Bradley's Report. In addition most of the available literature on diversion in Scotland tends to "fall under the heading of restorative justice" research.[2] Nonetheless Scotland has much more developed laws and services that facilitate diversion than Ireland and which are worth consideration.

Like Ireland, Scotland introduced new mental health legislation in the early 2000s, with the *Mental Health (Care and Treatment) (Scotland) Act* 2003 commencing in October 2005. The 2003 Act was introduced with a view to making mental health legislation more "flexible" by providing a range of measures including compulsory treatment in the community.[3] Indeed compulsory treatment in the community is one of

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[1] See "Diversion" (Glasgow: The Development Centre for Scotland, Social Work in Youth and Criminal Justice, 2011).

[2] *Ibid*.

[3] For an overview of the Mental Health (Care and Treatment) (Scotland) Act 2003 see Lyons "New Mental Health Legislation in Scotland" (*Advances in Psychiatric Treatment*: 14, 2008, pages 89–97).

the notable features of the legislation; the legislation also introduced a number of procedural safeguards in respect of persons subject to the legislation. The legislation pre-dating the 2003 Act was considered to be out-dated and in need of modernisation.[4] Unlike the Irish legislation the *Mental Health Act 2001*, the 2003 Act made express provision for diversion of persons with MHPs in contact with the criminal justice system. The 2003 Act substantially amended the existing provisions concerning "mentally disordered offenders", which had previously been contained in the *Criminal Procedures (Scotland) Act 1995*.[5]
It has been suggested "people with severe and enduring MHPs will come into contact with the criminal justice system at some time" in Scotland.[6] In recognition of this a range of "policy and legislative safeguards" have been put in place in Scotland aimed at ensuring consideration of the "welfare" of persons with MHPs when in contact with the criminal justice system.[7] The *Mental Health (Care and Treatment) (Scotland) Act 2003* contains a number of provisions that seek to identify and provide treatment for persons with MHPs involved in criminal proceedings.

As will be seen from the discussion of the provision of the 2003 Act below, where an order has been imposed, the order must be kept under review, and the result of this process may be that the defendant is returned to prison to complete their sentence in some cases.[8] Where a defendant is remanded in custody, or receives a custodial sentence in Scotland and there are concerns as to their mental health, there is a "clear expectation in the Act … that their mental health will be kept

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[4] *The Mental Health (Scotland) Act 1984* did not substantially amend the approach taken in the *Mental Health (Scotland) Act 1960*. Before the *Mental Health (Scotland) Act 1960*, Scottish mental health legislation was provided for in the *Lunacy (Scotland) Acts 1857-1913* and the *Mental Deficiency (Scotland) Acts (1913 and 1940). Mental Health (Scotland) Act 1984* was effectively a consolidating piece of legislation that did not introduce any introduce any substantive amendments. It is also of note that the *Mental Health (Amendment) (Scotland) Act 1983* arose from the Scottish Home and Health Department and Social Work Services Group Consultation Paper "Review of the Mental Health (Scotland) Act 1960" published in 1982.

[5] The 2003 legislation and the significant reforms in implemented in Scotland are considered to be "complex". See Lyons "New Mental Health Legislation in Scotland" (*Advances in Psychiatric Treatment*: 14, 2008, pages 89–97) at page 97.

[6] "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons" (Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008) at page 4.

[7] *Ibid*.

[8] See Appendix 1: Statutory Powers of Diversion Scotland.

under review".[9] There are also provisions for circumstances where a defendant requires transfer to a specific hospital for assessment or treatment. The procedures set out in the 2003 Act, provide the legislative basis for all transfers between prison and hospital regardless of the location of the prison or the hospital. Prisoners held on remand can also be transferred on either an Assessment Order (Section 52D) or a Treatment Order (Section 52M) of the 2003 Act. The arrangements for convicted prisoners are set out in section 136 of the 2003 Act, which are called Transfer for Treatment Directions. These Transfer for Treatment Directions set out the eligibility of prisoners for transfer to hospital, the decision-making process around the transfer request and the approval process. The 2003 Act also outlines criteria that apply to admission to the State Hospital. There is a protocol governing the liaison arrangements that apply between Scottish Prison Service and the NHS.[10]

It has been suggested that more than 60% of persons entering prison in Scotland have a MHP in comparison to 16% in the general population.[11] This reflects the international experience of an over-representation of persons with MHPs in the prison population, compared to the general population.[12] Data from an unpublished inspection of High Risk Offenders identified that 30% of prisoners (from a sample) presented with a history of mental illness on admission to prison, with 41% going on to receive some form of support for a MHP in

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[9] "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons" (Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008) at page 4. This expectation is also clearly expressed "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland" Edinburgh: HMSO, The Scottish Office, 1999).

[10] This was agreed in 2006 see "Forensic Mental Health Services" (Edinburgh: The Scottish Executive, Scottish Executive 2006).

[11] Tickle "Is the Prison System Failing Mentally Ill People?" (The Herald Society Supplement, July 2005). "Framework for Mental Health Services in Scotland" (Edinburgh: Scottish Office 1997) (at page 44) reported that more than 20% of adults are affected by MHPs at any time and 30% of general practice consultations involve MHPs. In Scotland 10% of adults are depressed; 5% have anxiety disorders; 0.4% of people living at home have schizophrenia (but many are not registered with a GP); and 0.5-1% have bipolar affective disorders. In addition it was reported that 13% of those with schizophrenia and 17% with recurring major depressive illness would end their own lives.

[12] See Part 1 of Chapter 2: Literature Review for a discussion on this.

prison.[13] While the available data for Scotland indicates that prisoners with MHPs are prevalent throughout the prison system "prisoners with severe and enduring MHPs in prison make up a relatively small proportion of prisoners with MHPs" within the wider population in Scotland.[14] Nevertheless people with "severe and enduring MHPs also constitute a relatively small proportion of the total number of prisoners receiving medication for some form of MHPs".[15] In the 2008 report it was suggested that some Multi Disciplinary Mental Health Teams commented "on the high number of prisoners overall with some form of MHP".[16] In that regard it was suggested that almost all prisoners "exhibited some form of personality disorder" while it was also suggested that about 70% of prisoners had some form of mental health issue.[17] It was reported that at least 315 prisoners were identified as having some form of "diagnosed condition".[18] The 2008 Report concluded that a much larger proportion of people with severe and enduring MHPs are in prison than in the wider community. In that regard it reported, "some prisoners' behaviour suggested that they may have undiagnosed severe and enduring MHPs, and prisoners with personality disorders may be amongst those most likely to be within this group".[19]

3. Scottish Policy on Offenders with MHPs

Unlike Ireland there is a clearer policy in Scotland regarding persons with MHPs in contact with the criminal justice system. The overall policy for forensic mental health in Scotland is set out in "Health, Social Work

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[13] Cited in "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons" (Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008) at page 10.

[14] *Ibid*, at page 11.

[15] *Ibid*.

[16] *Ibid*.

[17] *Ibid*.

[18] *Ibid*. However, this figure excluded prisoners in Polmont (the national holding facility of young offenders in Scotland), as psychiatrists there are generally reluctant to reach a formal diagnosis on young people. An additional eight prisoners were identified as undergoing assessment in a hospital facility at the time the inspection was undertaken. The Polmont facility represents approximately 4.5% of the Scottish prison population.

[19] *Ibid*, at page 12.

and Related Services for Mentally Disordered Offenders in Scotland".[20] This policy has been described as "a multiagency, multi-disciplinary approach to work with "mentally disordered offenders", and encompasses all stages from investigation, through court processes, imprisonment and care in the community".[21] The policy seeks "... to co-ordinate care and support for the benefit of the individual and to ensure public safety".[22] Importantly in the document there is a commitment to providing services where possible in the community as opposed to an institutional setting, so as to maximise "rehabilitation and the individual's chance of an independent life".[23] The 1999 policy document while having "due regard" for public safety, is framed positively placing a premium on community living as opposed to detention in institutional settings. The policy also contains principles of therapeutic jurisprudence (EG rehabilitation) and principles core to the CRPD such as enhancing the possibility of living independently in the community. In realising these principles the policy document provides that health boards and social work departments are required to "work together to develop services for mentally disordered people who come into contact with the criminal justice agencies through joint planning procedures which are already an integral part of the community care process".[24] These service agreements provided for a range of elements including "facilities and services that can be used for mentally disordered people diverted from the criminal justice system".[25]

The 1999 policy effectively sets out the range of services that should be available to "mentally disordered offenders" through the relevant providers within the NHS and local authorities in Scotland. It also explicitly defines the roles of the various partners, and the ways that

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[20] "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland" (Edinburgh: HMSO, The Scottish Office, 1999).

[21] "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons" (Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008) at page 5.

[22] "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland" (Edinburgh: HMSO, The Scottish Office, 1999) at page 1.

[23] *Ibid*.

[24] *Ibid*. The policy document also provided that Procurators Fiscal should be involved in "discussions as to levels of service" (at page 15).

[25] *Ibid*.

they should work together. The policy articulates the policy direction of the Scottish Prison Service, which it required to identify prisoners with MHPs, and identify the responses required to meet their needs. An important component of the Scottish Prison Service policy is to provide support and care for prisoners not meeting the criteria for admission to hospital and who require treatment in prison.[26]

The 1999 Scottish policy document is much more robust than the corresponding policy documents in Ireland.[27] The Henchy Report and the Green and White Papers on Mental Health recommended diversion, community disposal (where appropriate) and the development of links between the criminal justice system and the health system. However, these recommendations while accepted by Government were never implemented in Ireland. Similarly, the current mental health policy "A Vision for Change" while committed to diversion principles failed to date to develop services and forge formal connections between the criminal justice system and the health system in a way that responds to the needs of defendants and offenders with MHPs and ID.

4. Care Programme Approach

As discussed in Chapter 4: England and Wales the CPA was introduced to provide a co-ordinated approach to the assessment, planning and review of care for persons with MHPs. It was suggested that the CPA has the potential to develop diversion at the pre-arrest stage and facilitate access to community based mental health services. The CPA was introduced on a mandatory basis in England and Wales in 1992 and was recommended for use in Scotland in 1996. It is not mandatory in Scotland in general but is mandatory for "restricted patients" since 2002.[28] The Scottish Government endorsed the use of the CPA as it considered many aspects of the programme to be positive such as the formalised communication between agencies and their

[26] *Ibid*, at page 61.

[27] See Chapter 3: Ireland.

[28] Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 183.

multidisciplinary colleagues.[29] The CPA explicitly sets out the roles of the different professionals and seeks to provide clarity to service users and carers.[30] It also seeks to avoid duplication in services and contains a significant risk management component.[31]

However, the CPA was reviewed and new guidance for restricted patients was issued in 2007 following a homicide by a restricted patient who was subject to supervision in the community.[32] There has been criticism of the CPA and it has been suggested that care coordination and communication are inadequate in the delivery of good quality of care in the community of persons with MHPs at risk of committing violent crimes.[33] The Ritchie Inquiry into the care and treatment of Christopher Clunis reported a significant number of missed opportunities and poor communication in his care and treatment, which reflected the failure of the working relationships of a number of different professions.[34] As the CPA was not mandatory and only applied to "restricted patients" its use has been variable.[35] In 2006 the Scottish Government established an expert group to review the use of the CPA in Scotland. It is of note that the review was endorsed by the Scottish Government and became one of the "drivers" for the new Multiagency Public Protection Arrangements (MAPPA, 2005) and the *Management of Offenders etc. (Scotland) Act 2005*.

The Mental Welfare Commission's report in 2006 inquiring into the murder committed by a man conditionally released from a forensic psychiatry service indicated the need for new guidance on the relevant

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[29] *Ibid*.

[30] *Ibid*.

[31] *Ibid*.

[32] "Guidance for Forensic Services" (Edinburgh: Health Policy and Strategy Directorate, Mental Health Division, CEL 13, 2007). For a discussion see Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011).

[33] See Crichton and Sheppard "Psychiatric Inquiries: Learning the Lessons" in Peay (ed) *Inquiries after Homicide* (London: Duckworth, 1996).

[34] Ritchie, Dick and Lingham "The Report of the Inquiry into the Care and Treatment if Christopher Clunis" (London: HMSO, 1994).

[35] Quinn and Crichton 'Case Managing High-Risk Offenders with Mental Disorders in Scotland' in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 187.

law and policy in Scotland.[36] The Report identified a number of problems with the clinical governance in local services and weaknesses with the application of the CPA in respect of patients on conditional release. In particular, it identified that there was an absence of a crisis plan to respond to relapse.[37] In addition the section in the CPA documentation on risk management was not completed.[38] The Hunter Report published in 2006 carried out a study of the CPA across forensic services in Scotland, which revealed that practice varied significantly between different teams, adopting different practices.[39] The Hunter Report identified deficiencies with the documentation of the programme. The verdict was that the use of the CPA was unsatisfactory and despite pockets of good practice that CPA was not implemented fully and key information regarding risk management was not present in forensic centres. Nonetheless the CPA remains the method of regular review of all restricted patients in Scotland with the exception of prisoners held on remand.[40]

The policy of applying the CPA to patients in forensic services is interesting from the perspective of the right to community living, health, habilitation and rehabilitation and recovery.[41] The requirement on forensic mental health services to produce a "care plan" is key for recovery and enhances the potential for community living. In the Irish case *DPP v B* Sheehan J was scathing in his criticism of the lack of a recovery ethos in the care provided to the forensic patient detained in the CMH.[42] In Scotland the CPA requires that the care plan address the patient's needs and clearly sets out the responsibility of the professional in respect of the plan and requires the agreement of the patient who also has a copy of the plan.[43] The voice of the patient is

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[36] "Report of the Inquiry into the Care and Treatment of Mr L and Mr M" (Edinburgh: Mental Welfare Commission, 2006).

[37] *Ibid*, see for example page 19.

[38] *Ibid*, at page 14.

[39] For analysis of the Hunter Report see Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 188.

[40] *Ibid*.

[41] See Part 2 of Chapter 2: Literature Review.

[42] [2011] IECCC1.

[43] "The Care Programme Approach (CPA): A Policy for the Care and Treatment Planning of

given some consideration in that there is a requirement to note any objections to their care plan. However, the questions as to whether the CPA is an administrative or therapeutic process remain with concerns about facilitating recovery and coercion.[44]

5. Scottish Policy of Mental Health Services

The Scottish policy on mental health "Framework for Mental Health Services in Scotland" works with the specific policy on forensic mental health services.[45] In the 1997 policy document prioritises mental health services for persons considered to have an "enduring" or "severe" MHPs. One of the important features of this policy is that no patient is to be discharged from hospital unless the supports in the community are available. Specifically the Framework provided that its implementation would require a number of elements including "that no person should be discharged from NHS long-stay care without an agreed care plan, support and accommodation in place, available and properly resourced".[46]

In 2001 a review group was established by to consider the governance and accountability of State Hospital's Board for Scotland. A consultation document resulted from the review entitled "The Right Place – The Right Time", which created the Forensic Network in 2003.[47] The Forensic Network's role is to oversee the development of services across Scotland and to provide strategic overview and direction for the planning and development of forensic services.[48] The creation of the Forensic Network in Scotland is a significant development, in

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Patients" (The State Hospitals Board for Scotland and NHS Scotland, 2010) at page 2.

[44] See Gould "Service Users Experiences of Recovery Under the 2008 Care Programme Approach" (London: Mental Health Foundation, 2013).

[45] "Framework for Mental Health Services in Scotland" (Edinburgh: Scottish Office 1997).

[46] *Ibid*, at page 3.

[47] "The Right Place - The Right Time: Improving the patient journey for those who need secure mental health care a review of the governance and accountability of the State Hospital Board: proposals for consultation" (Edinburgh: Scottish Executive, 2002, CMA02805). For a discussion see Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 185. The full name of the Forensic Network is Forensic Mental Health Services Managed Care Network.

[48] See the website of the Forensic Network at: http://www.forensicnetwork.scot.nhs.uk/. <Last accessed 10 November 2013>

overseeing the development of services across Scotland and to provide strategic overview and direction for the planning and development of forensic services. As discussed in Chapter 3: Ireland psychiatrists from the CMH (in the absence of other regional or local forensic services) dominate policy on forensic services in Ireland. In contrast the Forensic Network in Scotland takes a "pan-Scotland" approach to its work.[49]

6. Forensic Mental Health Services in Scotland

Ireland like Scotland has considered the modernisation and development of forensic mental health services since the 1960s. However, as will be seen Scotland has developed forensic mental health services to a greater extent than Ireland. The Harper Report in 1968 recommended regional step down services to complement the work of the only Scottish forensic mental health hospital at that time (the State Hospital in Carstairs).[50] More recently the 1999 mental health policy committed to the development of forensic mental health services in Scotland.[51] This followed lobbying from the Royal College of Psychiatry and other interested groups.[52] The 1999 policy document was subsequently adopted by the Scottish Government and continues to guide services for offenders with MHPs in Scotland.[53]

Scotland has seen much change over the past decade in the delivery of forensic mental health services. The creation of the Forensic Network coincided with the introduction of new mental health legislation in Scotland by way of the *Mental Health (Care and Treatment) (Scotland) Act 2003*. This period marked the beginning of a significant reform of

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[49] See the Website of the Forensic Network at: http://www.forensicnetwork.scot.nhs.uk/about. <Last accessed 10 November 2013>

[50] "The Harper Report" (Scottish Home and Health Department, 1969). For a discussion in the development of forensic psychiatry in Scotland see Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at pages 184-185.

[51] "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland" (Edinburgh: HMSO, The Scottish Office, 1999).

[52] Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 184.

[53] *Ibid*, at page 185

forensic mental health services in Scotland".[54] There was recognition that research and education was "patchy" and underdeveloped in respect of forensic mental health services. The Forensic Network produces important policy documents.[55] In 2006, the Scottish Executive issued a new policy on forensic mental health services, which outlined the new structures for the delivery of in-patient forensic mental health services, and established a set of standards for the different aspects of this care.[56] There are essentially three levels of forensic mental health services in Scotland, the national, the regional and the local.[57] Within these levels there are different levels of security – high security, medium security and low security. The 2006 policy provides very clear direction on the different parts of the different levels of security.[58] The 2007 guidance introduced a risk management system using risk management traffic lights translating complex assessments into "concise directions for clinical teams in various scenarios… designed to assist clinicians asked to intervene in urgent high-risk cases when they might not be familiar with the case in hand".[59]

The position is Scotland contrasts sharply with the position in Ireland. Forensic mental health services operate only in Dublin in the CMH; with outreach into one remand centre and one prison both also located in Dublin. This contrasts with the commitment to developing forensic

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[54] "Configuration of Services, Monitoring Patient Flows, Definitions of Levels of Security, NHS and SPS Liaison, Services for Women, Services for Learning Disabilities" (Edinburgh: Scottish Executive, Health Department, Directorate for Service Policy and Planning, HDL, 2006, 48) and "Care Programme Approach, Risk Assessment and Management of Restricted Patients, Clinical Governance" (CEL, 13, 2007).

[55] *Ibid*.

[56] "Configuration of Services, Monitoring Patient Flows, Definitions of Levels of Security, NHS and SPS Liaison, Services for Women, Services for Learning Disabilities" (Edinburgh: Scottish Executive, Health Department, Directorate for Service Policy and Planning, HDL, 2006, 48).

[57] *Ibid*, at page 2.

[58] *Ibid*.

[59] Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at pages 183-184. A green light signals that the current care plan is going to be continued with. An amber light would signal a divergence from an agreed arrangement and would result in "early clinical review" normally the next working day. A red light contingency occurs when the presence of a major risk factor is identified and results in emergency action such as an urgent recall to hospital for conditionally discharged patients.

mental health services in "A Vision for Change".[60] The 2006 Scottish policy on forensic mental health services clearly focuses on public protection. It states the "… purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community".[61] The policy states that the "primary determinant of appropriate level of security is the best estimation of risk posed by an individual to themselves or others".[62] The policy is based on assessing the risk of persons admitted to forensic mental health services with a view to determining, which security level is considered appropriate.

7. Diversion in Scotland

As noted above the literature examining the diversion of defendants and offenders with MHPs in Scotland is underdeveloped. However, there are interesting aspects to the diversion system in Scotland that are novel. One of these novel features is the focus on diversion to social work, which is separate to police and court diversion. Section 27 of the *Social Work (Scotland) Act 1968* requires every local authority to provide a "probation and community service scheme", which includes a wide range of services. Section 27 of the *Social Work (Scotland) Act 1968* also provides the statutory basis for diversion to social work.[63] This process of diversion involves referral of the defendant to social work or to another agency where it is considered that continuing with the criminal proceedings is not necessary. [64] Whyte notes that schemes were introduced in the late 1970s and involved unconditional diversion, which was known as the "waiver method" or conditional diversion where there was acceptable outcome to an agreement made with the Procurator Fiscal, this was known as the "deferred method".[65]

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[60] See Chapter 3: Ireland.

[61] "Configuration of Services, Monitoring Patient Flows, Definitions of Levels of Security, NHS and SPS Liaison, Services for Women, Services for Learning Disabilities" (Edinburgh: Scottish Executive, Health Department, Directorate for Service Policy and Planning, HDL, 2006, 48) at page 4.

[62] *Ibid*.

[63] For a discussion on this see Whyte "Probation in Scotland" in Kalmthout and Durnescu (eds) "Probation Service Systems in Europe" (Amsterdam: CEP/Wolf, 2008).

[64] *Ibid*, section 4.2.

[65] *Ibid*.

While there is little literature on diversion to social work the Procurators Fiscal have "experimented with social work diversion for young adult offenders (aged 16-21), for mentally disordered offenders, for those with drug and alcohol problems, and for reparation and mediation purposes".[66] There is provision for funding for these schemes, originally funded form central Government but now by the Community Services Authority and diversion schemes are available in all local authority areas. According to Whyte the objective of the diversion schemes is to explore the potential for social work services to respond to the defendants and seduce costs in the criminal justice system. However, he notes that their potential while promising remains "underdeveloped".[67]

This process of diversion is disability neutral in that it is not limited to persons with MHPs or ID. The literature on the nature and prevalence of these diversion schemes in Scotland is unfortunately very limited.[68] The types of schemes that tend to operate are at the local level.[69] The available literature does not explicitly examine the use in respect of persons with MHPs or ID. Indeed, there is a dearth of information and guidance in the public domain on diversion to social work at the national and local level.[70] This information gap may explain variations in diversion practice across Scotland.[71] There is "no-over arching policy regime" to guide diversion by Procurators Fiscal, with decision-making happening at the local level.[72] Nonetheless and despite a lack of a coherent policy it is suggested that Procurators Fiscal regard diversion

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[66] *Ibid*.

[67] *Ibid*.

[68] This report is a notable exception Barry and McIvor "Diversion from Prosecution to Social Work and Other Service Agencies: Evaluation of the 100% Funding Pilot Programmes: 1999 - Research Findings" (Edinburgh: Crime and Criminal Justice Research Findings No. 37, 1999).

[69] See Bradford and MacQueen "Diversion from Prosecution to Social Work in Scotland: A Snapshot of Current Patterns and an Examination of Practice in Three CJAs" (Glasgow: Scottish Centre for Crime and Justice Research. Research Report No. 1, 2011) at page 32. This research was commissioned due to a concern in the reduced use of diversion to social work in Scotland. The research reported that despite a decline in diversion in 2005/2006 and 200/2008 this decline did not continue into 2008/2009.

[70] *Ibid*, at page 3.

[71] *Ibid*.

[72] *Ibid*.

as a desirable alternative to prosecution.[73] However, given the informal nature of the diversion process, the successful operation of diversion schemes is dependent upon "informal working relationships" between the Procurators Fiscal and the criminal justice and social work departments across Scotland.[74] There has been little systematic gathering of evidence as to the effectiveness of diversion to social service.[75] This can impede the development and indeed continued support for diversion schemes that may be effective.[76]

While little is known about diversion to social work schemes they are of interest for the purpose of this thesis, as eligibility for diversion is broad. Diversion is particularly aimed at young offenders, first time offenders, offenders who commit minor offences and cases where it is not considered to be in the public interest to prosecute.[77] In effect these diversion schemes are disability neutral and have the potential to divert defendants with MHPs or ID on an equal basis to others. A disability neutral diversion process has potential for reducing coercive requirements around treatment. However, as Bardford and MacQueen's research revealed the use of diversion rested essentially on the confidence of the Procurators Fiscal that the scheme would address the underlying causes of the person's offending behaviour. There is no research that examines the use of diversion to social service from the perspective of defendants and offenders with MHPs or ID. Despite the lack of research it is a reasonable contention that the absence of services and treatment in the community that the Procurators Fiscal considers effective may impact on decisions to divert.

It is of note that the power of the Procurators Fiscal is discretionary.[78] Unlike England and Wales this process is more informal and less guidance is provided on decisions to prosecute. There is no legislation

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[73] *Ibid*.

[74] *Ibid*.

[75] *Ibid*, at page 4.

[76] See Chapter 2: Literature Review, Part 2.

[77] See for example the website of East Lothian Council at http://www.eastlothian.gov.uk/info/1396/criminal_justice_social_work/739/diversion_from_prosecution. <Last accessed 10 November 2013>

[78] They can divert any person charged with a criminal offence from prosecution, where they are of the view that prosecution is not in the public interest

governing this practice in Scotland. It has been suggested that when the defendant has a MHP, recognition that their behaviour is "problematic" is sought.[79] In order to benefit from diversion a link must be established connecting the MHP and the offending behaviour.[80] In addition it should be considered that treatment would reduce the likelihood of offending.[81] The Procurator Fiscal can divert the case and waive the right to prosecute or can decide to defer the decision on prosecution.[82] In circumstances where the decision to defer is taken the subsequent decision to divert will be dependant upon the person's co-operation and "progress with treatment".[83] This informal process of diversion is of interest from the perspective of developing CRPD compliant diversion processes and research exploring the experiences of persons with MHPs and ID would be welcome.

Police officers in Scotland respond to persons with MHPs and ID in a variety of ways and have discretion to deal with persons informally.[84] Unlike Ireland there is greater provision for psychiatric services to police stations in Scotland. Forensic medical examiners are initially summoned to police stations with a view to assessing, persons who are considered to have a MHP.[85] In some areas a forensic medical examiner may call a psychiatrist if they consider that a further examination is necessary and this may lead to a consideration of whether hospitalisation is required or if further follow up is necessary.[86] The doctor also has a role in making recommendations as to diversion. Inpatient treatment can be carried out on a voluntary basis or can be compelled under the 2003 Act.[87]

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[79] See "Community Services for Mentally Disordered Offenders in Scotland" (Forensic Mental Health Services Managed Care Network, Community Services Working Group, 2005) at page 24.

[80] *Ibid*.

[81] *Ibid*.

[82] *Ibid*.

[83] *Ibid*.

[84] See McManus and Thomson *Mental Health and Scots Law in Practice* (Edinburgh: Thomson W Green, 2005) at page 122.

[85] *Ibid*, at page 125.

[86] *Ibid*.

[87] See Appendix 1: Statutory Powers of Diversion Scotland.

While the literature on appropriate adult services in Scotland is not as rich as that in England and Wales a review was published in 2004.[88] The research reported that there were common misconceptions about the role of appropriate adults and a lack of clarity about the operation and management of the appropriate adult schemes.[89] In addition it was reported that there was evidence of "a general under utilisation of schemes across Scotland" despite widespread awareness of appropriate adult schemes.[90] Indeed, the research called into question the use of the initiative as the researchers identified the presence of many persons in custody who should have been provided with an appropriate adult, who were not.[91] However, appropriate adults were not requested to attend police interviews in the police station during the observation period of the study. It is also of note that appropriate adult services across Scotland vary in terms of their design and operation.[92] The suggested reasons for these variations have been identified as differences in local need that have driven their development. Other explanations for variations in practice include different lead agencies, different partnership members, different service delivery organisation and funding systems. Unlike the limited provisions in Ireland the appropriate adult schemes have a broad scope to include persons with MHPs and ID (as they fall under the definition of "mental disorder" under the *Mental Health (Care and Treatment) (Scotland) Act 2003*).[93]

It is also of note that the *Vulnerable Witnesses (Scotland) Act 2004* provides that child defendants under the age of 16 or vulnerable adults have equality of access to special measures compared to other

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[88] See Thomson, Galt and Darjee "An Evaluation of Appropriate Adult Schemes in Scotland" (Edinburgh: The Scottish Government, 2004). In 2002 there were 16 appropriate adult schemes operating in Scotland with 414 appropriate adults.

[89] *Ibid*.

[90] *Ibid*.

[91] *Ibid*.

[92] See "Guidance on Appropriate Adult Services in Scotland" (Edinburgh: The Scottish Government, 2007). It reported that the "examination of psychiatric morbidity in one Police station" identified "high rates of mental disorder, including severe neurotic symptoms, psychotic symptoms and learning disabilities".

[93] *Ibid*, at paragraph 1.1. This includes any "mental illness, personality disorder, learning disability however caused or manifested".

witnesses (with the exception of a screen).[94] This is a more progressive approach compared to that in England and Wales under the *Coroners and Justice Act 2009.* From the perspective of the CRPD the measures contained in the legislation are part of a framework of measures that point towards the UK complying with its obligations under Article 13. Similar special measures as discussed in Chapter 3: Ireland have not been enacted in respect of vulnerable defendants with the fitness to plead provisions seeking to safeguard against any inherent injustice.

8. Statutory Powers of Diversion

Unlike Ireland, mental health services are provided for in most courts in Scotland.[95] The normal interaction is through requests to provide psychiatric reports by Procurators Fiscal, defence lawyers and Sheriffs clerks.[96] There are a number of court liaison schemes in operation in Scotland.[97] However, there is limited research mapping and evaluating these court liaison schemes. The available research nonetheless suggests that court liaison schemes are effective in identifying and diverting persons with psychotic illness.[98] Conversely it has been suggested that few defendants are sent for assessment through these liaison services.[99]

The provisions for the disposal by the criminal courts of persons with MHPs involved in criminal proceedings are contained in Part VI and sections 200 and 230 of the *Criminal Procedure (Scotland) Act 1995*. Part 8 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*

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[94] See Hoyano "Coroners and Justice Act 2009: Special measures directions take two: entrenching unequal access to justice?" (*Criminal Law Review*: 5, 2010, pages 345-367) at page 265.

[95] McManus and Thomson *Mental Health and Scots Law in Practice* (Edinburgh: Thomson W Green, 2005) at page 130.

[96] *Ibid*.

[97] They operate in Greater Glasgow, Forth Valley, and in parts of Ayrshire and Arran and Lanarkshire. See Grant "Towards Implementation if the Mental Health (Care and Treatment) Act 2003" (Edinburgh: Scottish Government, 2004) at page 54.

[98] See for example Orr, Baker and Ramsay "Referrals to the Glasgow sheriff court liaison scheme since the introduction of referral criteria" (*Medical, Science and the Law: 47*(4), 2007, pages 325-329).

[99] Grant "Towards Implementation if the Mental Health (Care and Treatment) Act 2003" (Edinburgh: Scottish Government, 2004) at page 54.

amended the 1995 Act to provide for two new pre-sentence disposals, namely assessment orders and treatment orders.[100] Essentially the 1995 Act and the *Mental Health (Care and Treatment) (Scotland) Act 2003* confer upon the Scottish courts a range of powers that seek to ensure that offenders with MHPs receive the necessary care and treatment. These provisions are broadly similar to legislative provisions operating in England and Wales by way of the *Mental Health Act 1983* and the *Mental Health (Northern Ireland) Order 1986*.[101]

Persons with a mental disorder who are convicted of a criminal offence in Scotland can be dealt with by being placed on an order under the *Criminal Procedure (Scotland) Act 1995*, which requires treatment in hospital or, occasionally, in the community.[102] As the Mental Welfare Commission for Scotland have noted in some cases "… additional restrictions are placed on the individual and any lessening of their security status or suspension of detention has to be approved by Scottish Ministers. An individual may be subject to a number of different orders before final disposal of the case which may be by Compulsion Order or Compulsion Order and Restriction Order".[103] Part 8 of the 2003 Act is entitled "Mentally Disordered Persons: Criminal Proceedings". Part 8 contains a number of provisions for different orders that can be made in respect of persons with MHPs in contact with the criminal justice system.

As will be seen from the outline of the different orders provided for under the *Mental Health (Care and Treatment) (Scotland) Act 2003* the criminal courts in Scotland are in a position to choose from a range of

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[100] Part 8 of the 2003 Act also replaced interim hospital orders and hospital orders with interim compulsion orders and compulsion orders, to provide courts with the power to detain acquitted persons and to make minor changes to the provisions on remanding defendants for inquiry into mental health and on probation with a requirement that the defendant receives treatment for their mental disorder. Part 8 of the 2003 also provides for the transfer of mentally disordered prisoners to hospital. Part 8 of the 2003 Act also amended the 1995 Act by this Part, through paragraph 8 of schedule 4, and repeals are made by schedule 5, to the 2003 Act.

[101] The *Mental Health (Care and Treatment) (Scotland) Act 2003* was enacted in Scotland in 5 October 2005. See "The New Mental Health Act: A guide for people involved in criminal justice proceedings" (Edinburgh: Scottish Executive, 2005) and "The New Mental Health Act What's it all about?: A Short Introduction" (Edinburgh: Scottish Executive, 2005).

[102] "Key findings from our monitoring of mental health and incapacity legislation in Scotland" (Edinburgh: Mental Welfare Commission for Scotland, 2010/2011) at page 28.

[103] *Ibid*

orders that can connect the defendant with MHPs to services. Of course that is contingent on the court forming the view that the defendant may have a MHP. The following is a list of orders that can be made under the 2003 Act: Assessment Order; Treatment Order; Temporary Compulsion Order; Acquitted but detained; Remand on Bail for Enquiry; Committal to Hospital for Enquiry; Interim Compulsion Order; Compulsion Order; Restriction Order; Hospital Direction; Transfer for Treatment Direction; Probation Order with Requirement of Treatment. Many of the orders that can be made under the 2003 Act reflect orders that can be made under the *Mental Health Act 1983*. As there has been a discussion of similar orders in Chapter 4: England and Wales an outline of the orders are contained in an appendix to this thesis.[104]

It is of note that a new Mental Health Tribunal was established to assume some of the powers that are currently exercised by the courts and the Scottish Ministers. For example, the power to make decisions about whether orders should be extended, cancelled, or varied in some way. There are three members on each Tribunal; consisting of a legally qualified person, a doctor with experience in mental health, and a third person with other relevant skills in health or social care in addition to or with experience in providing care for someone with a mental disorder. It is a complicated system, for example with the different timescales for making applications to the Tribunal to cancel or amend an order. The timescales vary in respect of Compulsion Orders either with or without Restriction Orders, Hospital Directions and Transfer for Treatment Directions.[105]

The policy document concerning restricted patients is currently the "Memorandum of Procedure on Restricted Patients".[106] This was

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[104] See Appendix 1: Statutory Powers of Diversion Scotland

[105] If a person is subject to a Compulsion Order (with or without a Restriction Order), a Hospital Direction or a Transfer for Treatment Direction there is a right to appeal to the Tribunal in respect to the level of security that is being imposed. This right of appeal extends to inpatients regardless of whether they are detained in the State Hospital. The level of security is very important for "patients" as the level of security will dictate whether they live in a locked ward, a hospital surrounded by a large fence and the level of liberty that they have to get fresh air in the grounds of the hospital with or without supervision, or whether they can have some time in the community.

[106] "Memorandum of Procedure on Restricted Patients" (Edinburgh: Scottish Executive, May 2010).

published in 2010 and replaced an earlier version of the memorandum that was published by the Scottish Executive in September 2005, which was developed to "accompany the coming into force of the *Mental Health (Care and Treatment) (Scotland) Act 2003 in October 2005*".[107] The Memorandum is designed as an "essential reference document for those who are involved with the management and care of patients subject to a compulsion order with restriction order, a hospital direction or a transfer for treatment direction; that is, patients who are subject to special restrictions". All three categories of patients are referred to as restricted patients. Patients are detained indefinitely if they are subject to a compulsion order with restriction order (CORO). A person subject to a CORO is under the supervision of a government department in the Scottish Government. Scottish Ministers must approve any request for time spent in the community of a person subject to a CORO or indeed any transfer or lower level of security. As of March in 2010 there were 300 restricted patients in Scotland 47 of who are on conditional discharge in the community.[108]

There has been a focus over the past decade on risk management of offenders with MHPs in Scotland. Like NI, England and Wales and Australia this focus is clear from the development of policies developed specifically to address the perceived risk posed by offenders with MHPs. However, it is important to note that the approaches taken in Scotland to "dangerous offenders" is significantly different from the approach discussed in England and Wales.[109] The provisions essentially provide for involuntary admission to hospital or release into the community subject to strict conditions. Scotland, like England and Wales, has provisions for compulsion in the community. These powers as discussed elsewhere in this thesis, give a measure of assurance to the public and politicians when defendants and offenders with MHPs

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[107] *Ibid*, at page 3.

[108] Quinn and Crichton "Case Managing High-Risk Offenders with Mental Disorders in Scotland" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 183 and 186. Of this number 23 patients were held on remand. 37% of the patients were inpatients (94 in total) who were detained in the State Hospital who accounted for 67% of patients held on high security. The two Scottish medium secure units had 23 % of the total restricted inpatient population, which accounted for 52% of the total medium-secure population. The remaining 31% of inpatient-restricted offenders were held in low security settings throughout Scotland.

[109] See Chapter 3: England and Wales.

are released into the community. While there are procedural safeguards around the involuntary detention and treatment the provisions are undoubtedly at odds with the CRPD.

The Mental Welfare Commission for Scotland reports annually on it's monitoring of the *Mental Health (Care and Treatment) (Scotland) Act 2003*. The Commission generally reports that the compulsory admissions of persons to mental health services in Scotland through the courts as being static.[110] However, in its most recent report the Commission stated "[a] surprising finding this year was the increase in some compulsory admissions via the courts. There was a sharp rise in the number of "treatment orders" (hospital orders for people awaiting trial or sentence for a criminal offence)".[111] The Commission did not offer any explanation as to the reasons for the increase in the use of these powers but committed that "[i]f this is still high next year, we will look into this further".[112] It is of note that the Mental Welfare Commission reported, "[m]en are more likely to be subject to long-term civil orders and to criminal procedure orders."[113]

9. Other Community Based Disposals

The courts, in addition to the range of orders that can be made under the 2003 Act, also have a range of other statutory community disposals to choose from. In that regard one of the major developments in Scottish community sentencing has been the enactment of Community Payback Orders, which came into force in 2011.[114] These orders replaced provisions for Community Service Orders, Probation Orders and Supervised Attendance Orders and are provided for by section

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[110] For example in 2010-2011 the Mental Welfare Commission for Scotland reported that the use of CPSA orders continues to be stable with only small variations within order types and that gender differences remained the same with many more men than women being dealt with under CPSA, and the age peaking between 25 and 44. A small number of people in 2010-2011 were placed on community orders either directly or as a result of variation from hospital based orders. See "Key findings from our monitoring of mental health and incapacity legislation in Scotland" (Edinburgh: Mental Welfare Commission for Scotland, 2010/2011) at page 28.

[111] "Annual Monitoring Report: Key findings from our monitoring of the Mental Health Act 2011–12" (Edinburgh: Mental Welfare Commission for Scotland, 2012).

[112] *Ibid*.

[113] "A special report on equality in our monitoring of mental health and incapacity law 2011-12" (Edinburgh: Mental Welfare Commission for Scotland, 2012) at page 1.

[114] The provisions were introduced by the *Criminal Justice and Licensing (Scotland) Act 2010*.

227 of the *Criminal Procedure (Scotland) Act 1995*.[115] These provisions contain a number of requirements, which the court may select in making an order. The orders can be tailored individually to respond to the circumstances of the offender. The approach is based on principles of therapeutic jurisprudence and restorative justice, in seeking to address the underlying problems that result in the offending behaviour and requiring the offender to contribute to the community. It was envisaged in creating these orders that they would be appropriate for persons with MHPs, in particular personality disorders and persons with ID.[116]

Some of the requirements provided for in Community Payback Orders include undertaking unpaid community work that contributes to the community, completion of rigorous supervision and engagement with alcohol, drug or behavioural programmes.[117] Examples of the type of community work involved in these orders include de-icing public paths of snow and ice, building "eco-plant areas for school children", painting community buildings and churches, growing vegetables and dispensing the produce to care homes.[118] Community Payback Orders have a clear therapeutic role and the community work involved has great potential to assist in the recovery of persons with MHPs who have been in contact with the criminal justice system. However, the fledgling analysis of these orders suggests underuse in disposing of persons with MHPs to the community.[119] The underuse in respect of persons with MHPs in the community is disappointing. However, in the current "Mental Health Strategy for Scotland" there has been a commitment to "promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health

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[115] The other court imposed community orders include the Drug Treatment and Testing Order (introduced by the *Crime and Disorder Act 1998*) and the Restriction of Liberty Order (effectively electronic tagging introduced by section 245A of the *Criminal Procedure (Scotland) Act 1995*).

[116] "Mental Health Strategy for Scotland: 2012-2015" (Edinburgh: The Scottish Government, 2012) at page 49.

[117] See Website of the Scottish Government at: http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/CPO. <Last accessed 10 November 2013>

[118] *Ibid*.

[119] See "Mental Health Strategy for Scotland: 2012-2015" (Edinburgh: The Scottish Government, 2012) at page 49.

condition in appropriate cases".[120]

10. Forensic Services and Diversion

An important development in 2007 was the creation of eight Community Justice Authorities (CJAs) across Scotland. These Community Justice Authorities were established with a view to taking a coordinated approach to the planning and delivery of services for offenders. The rationale for these CJAs is based on therapeutic jurisprudence seeking to take a problem solving approach by reducing reoffending in Scotland. As the HM Chief Inspector of Prisons for Scotland thematic inspection Report suggested these CJAs while at an early stage in their development are expected to contribute to policy and practice relating to "mentally disordered offenders".[121] It has been suggested that there is "conflicting evidence about the added value of Community Justice Authorities", however, there has been no independent assessment of its effectiveness.[122] Further research examining the CJAs work in respect of persons with MHPs and ID would be welcome.

There has been much progress in the implementation of the plan on forensic mental health services in Scotland. Implementation has involved investment in constructing services.[123] The State Hospital in

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[120] *Ibid*, at commitment 32.

[121] "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons" (Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008) at page 7. The eight CJAs will be made up from the local authorities in: Glasgow, Aberdeenshire, Aberdeen City, Moray, Highland, Orkney, Shetland, Eilean Siar; Angus, Dundee, Perth and Kinross; Fife, Clackmannanshire, Falkirk, Stirling; Edinburgh, East Lothian, West Lothian, Midlothian, Scottish Borders; Argyll and Bute, East Dunbartonshire, West Dunbartonshire, East Renfrewshire, Renfrewshire, Inverclyde; North and South Lanarkshire; East, North and South Ayrshire, Dumfries and Galloway.

[122] See Angiolini "Reforming Women's Justice" (London: Prison Reform Trust Lecture 2012, 26 November 2012).

[123] See http://www.tsh.scot.nhs.uk/. <Last accessed 10 November 2013> Implementation involved the construction a new hospital on the site of the State Hospital at Carstairs. Phase I of the hospital was completed in 2009/10, with the commissioning of the Skye Centre (for patient therapy and activity) and the Essential Services buildings. Phase 2 construction of the new State Hospital continued during 2010/11 with the wards (hubs and clusters), Family Centre and Reception buildings "taking shape". The new Hospital was reported to become "fully operational" in September 2011. The new hospital has 140 high-secure beds for male patients requiring maximum secure care. There are 12 beds specifically for patients with a "learning disability".

Cairstairs continues to be the national resource for Scotland and NI. There has also been the development of new medium secure forensic mental health services and the redevelopment of low security services and community services throughout Scotland.[124] Most Health Boards in Scotland now have Low Secure Services, Community Forensic Mental Health Teams and Forensic Learning Disabilities Teams.[125] However, there is little research on how the development of these services has impacted on defendants and offenders with MHPs and ID in contact with the criminal justice system. The development of low security and in particular community based services could facilitate diversion that complies with the CRPD.[126] It is of interest that the Scottish policy of forensic mental health services was developed at approximately the same time as the "A Vision for Change" in Ireland. However, comparatively there has been a significant failure in Ireland to develop the forensic mental health services committed to in "A Vision for Change".

11. Intellectual Disability

A key policy document in Scotland relating to defendants and offenders with ID is also the "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland" from 1999.[127] This policy outlines the various different roles and duties of the different agencies working with persons with ID, including where there has been an identification of risk of contact with the criminal justice system.[128] Unlike Ireland specific forensic services have been developed for persons with ID, which have different levels of security.[129] It was

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[124] See the Forensic Network at: http://www.forensicnetwork.scot.nhs.uk/services-in-scotland. <Last accessed 10 November 2013> The Rowanbank Clinic in Glasgow and the Rohallion Clinic in Perth. The other medium secure services are available at the Orchard Clinic in Edinburgh. There has also been the redevelopment of low secure and community services in a number of locations throughout Scotland.

[125] *Ibid*.

[126] See Chapter 2: Literature Review, Part 1.

[127] "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland" Edinburgh: HMSO, The Scottish Office, 1999).

[128] Myers "On the Borderline? People with Learning Disabilities and/or Autistic Spectrum Disorders in Secure, Forensic and Other Specialist Settings" (Edinburgh: Scottish Government, 2004).

[129] *Ibid*.

identified that persons with ID are present in the secure accommodation in the State Hospital, Scottish prisons and a number of forensic or other specialist in-patient settings for persons with ID (and those for persons with MHPs).[130] The 2006 policy document contains specific guidance on services for persons with ID.[131] The document states that there is "a continued need for high secure care at the State Hospital for this client group and regional medium secure and local low secure services need to be developed".[132] The policy also commits to weighting "robust services" towards the community through the development of regional multi-agency risk management groups required in terms of developing the multi-agency risk governance to maintain "joined-up" services.[133] The policy envisages that "generic learning disability services will have a lead role in the provision of local care".[134]

While there is little research evaluating these services there has been some concerns voiced. For example, People First Scotland have queried why the law is applied unequally to persons with ID who it suggests are detained for much longer than others and more likely to suffer "harsh restrictions through Multi-Agency Public Protection Arrangements or Sexual Offences Prevention Orders than people who commit much more serious crimes".[135]

The Scottish approach to responding to defendants and offenders with ID is based essentially on social service provision. The Procurator makes decisions about the prosecution of persons with ID in the same as other decisions about diversion of other offenders. It may be decided not to prosecute or use direct measures such as warnings,

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[130] *Ibid*, at page i.

[131] "Forensic Mental Health Services" (Edinburgh: The Scottish Executive, Scottish Executive 2006).

[132] *Ibid*.

[133] *Ibid*.

[134] *Ibid*. The 2006 policy document endorsed the principle of co-locating medium secure learning disability services with either low secure learning disability services or medium secure mental illness services.

[135] "Citizens' Grand Jury Report: Care, Protection and Human Rights or Danger, Neglect and Human Wrongs?" (People First Scotland, May 2011) at page 6. People First Scotland is an independent self-advocacy organisation run by and for people with learning difficulties.

fiscal fines, compensation offers and diversion (see above). When persons with ID are involved in the criminal justice system they may be dealt with under the *Adults with Incapacity (Scotland) Act 2000* or the *Mental Health (Care and Treatment) (Scotland) Act 2003*.[136]

The available Scottish research suggests an under-identification of persons with "learning disability" or "Autistic Spectrum Disorders" when they come into contact with the criminal justice system.[137] The research identified that this under-identification was as a result of a multiplicity of social disadvantages that resulted in persons falling between services in Scotland.[138] In addition to the appropriate adult scheme another process operates at the court level in Scotland, where a defendant receives support defendants from a person other than their lawyer in court.[139] The role of the support person is similar to an appropriate adult process available at the police station.[140] The role of these support persons is not formalised, nonetheless it is identified that it plays an important role in supporting persons to navigate and participate effectively in court proceedings.

12. Prisoners with Severe and Enduring MHPs in Scotland

Despite the range of diversion provisions, processes and initiatives in Scotland there remains an over representation of persons with significant MHPs in the Scottish prison population. In 2008 the Chief Inspector of Prisons for Scotland published a thematic inspection Report of prisoners with severe and enduring MHPs and made a number of recommendations to address the deficits identified with current practices.[141] The aim of the thematic inspection was to examine

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[136] See Bowden, Douds and Simpson "People with Learning Disabilities and the Criminal Justice System" (Edinburgh: The Scottish Government, 2011) at page 33. See also "Adults with Learning Disabilities and the Criminal Justice System: Their Rights and Our Responsibilities" (Edinburgh: The Scottish Government, 2009).

[137] Myers "On the Borderline? People with Learning Disabilities and/or Autistic Spectrum Disorders in Secure, Forensic and Other Specialist Settings" (Edinburgh: Scottish Government, 2004).

[138] *Ibid*.

[139] See Loucks "No One Knows: Offenders with Learning Difficulties and Learning Disabilities: Review of Prevalence and Associated Needs" (London: Prison Reform Trust, 2007) at page 22.

[140] *Ibid*.

[141] "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons"

the scale of severe and enduring MHPs in prisons in Scotland, the processes involved, the impact of prisoners with MHPs on the prison, the issues prisoners face on release, prison-based and community interventions and the reasons for use of prison for people with severe MHPs.[142]

In the report it was acknowledged that prison "is not the most appropriate environment for a significant number of individuals with severe and enduring MHPs".[143] In that regard it was recommended that alternative environments that can provide "appropriate treatment, intervention and support" should be identified.[144] Despite many different policy initiatives and recognition of the over-representation problem the Inspector concluded that the provisions "for prisoners with severe and enduring MHPs in prison is varied and inconsistent and dependent on the resources available to individual establishments".[145] The Inspector recommended that high priority attached to improving consistency in provision of services across Scotland. Related to this was the Inspector's view that the identification of severe and enduring MHPs at the prison reception stage is not consistent and coherent.[146] In order to address this the Inspector recommended an "early, systematic, exploration of mental health issues" that should be carried out in an environment that supports and enables the disclosure and identification of "severe and enduring MHPs".[147]

The inconsistency in services for prisoners with MHPs in Ireland is an issue that has also been identified in Scotland.[148] The Inspector suggested that some aspects of the treatment, intervention and support available to prisoners depended on the prison that they are sentenced to.[149] This further highlighted the inconsistency of mental

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(Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008).

[142] *Ibid*, at page 2.

[143] *Ibid*, at page 74.

[144] *Ibid.*

[145] *Ibid*.

[146] *Ibid*.

[147] *Ibid*.

[148] See Chapter 3: Ireland.

[149] "Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons" (Edinburgh, The Scottish Government, HM Chief Inspector of Prisons for Scotland, 2008) at page 74.

health services across Scottish prisons. The Inspector considered that minimum standards of treatment, intervention and support should be available to all prisoners with severe and enduring MHPs, regardless of where they were detained.[150] With respect to these standards the Inspector further recommended that staff should have relevant training and be provided with information to ensure that they are equipped to deal with the needs of prisoners with MHPs.[151]

Additionally, the Inspector recommended that prisoners "with severe and enduring MHPs must have access to a regime which meets their needs".[152] Recommendations were not made in respect of care and support in the community, despite an acknowledgement that prison settings were not an appropriate environment for prisoners with MHPs. It was disappointing also that the Report did not engage with the issue of diversion to any great extent and the potential for diversion to address the problems identified in the report.

In relation to training the Inspector concluded that prison staff have an increasing role to play in respect of prisoners with severe and enduring MHPs. However, the inspector considered that prison staff "do not always feel adequately trained or prepared" to undertake this work and this in turn had led to significant pressure and stress.[153] Structured training and support for prison staff was recommended in order to address the current deficits in the Scottish prison system. While the Inspector was positive about the work of Multi Disciplinary Mental Health Teams that operated, concern was expressed that not all cases are brought to meetings. This was concluded to be at odds with the design and purpose of the Multi Disciplinary Mental Health Teams whose meetings are designed to provide an effective forum for discussing prisoners with mental heath problems.[154] In light of these concerns the Inspector recommended that all new cases where severe and enduring MHPs are suspected should be brought to the Multi Disciplinary Mental Health Teams, and should be regularly and

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[150] *Ibid*.

[151] *Ibid*.

[152] *Ibid*.

[153] *Ibid*, at page 175.

[154] *Ibid*.

systematically reviewed at subsequent meetings.[155] In relation to the multidisciplinary approach the Inspector noted that some prisons had the input of non-healthcare staff in assessing prisoners. The inspector recommended that this should happen in all prisons in Scotland.

As with prison practice in Ireland the Inspector acknowledged that segregation units in Scottish prisons were "sometimes used to house prisoners with severe and enduring MHPs".[156] It was recommended that this practice should be discontinued and alternatives to holding prisoners with severe and enduring MHPs for long periods of time should be found. In was identified that there "has been a growing emphasis on prisoners identifying their own needs and participating in their own care".[157] It was of interest that the Inspector considered that in reality few prisoners were given the opportunity to identify their own needs and provide feedback and it was recommended that this issue would also be addressed.[158] In relation to the release of prisoners with MHPs the Inspector identified that there is "no standardised approach to preparation for release for prisoners with severe and enduring MHPs".[159] In order to address the lack of support for prisoners with MHPs it was recommended that a formal, multi agency planning process should be established that would identify the needs of prisoners with severe and enduring MHPs and to ensure that arrangements are put in place for continuity of care.[160]

13. Diversion and Risk Management in Scotland

The MacLean Committee was established in 1999 by the Scottish Office with a view to examining the sentencing of offenders who were convicted of serous violent crimes and sexual offences and the sentencing of offenders with personality disorders.[161] The MacLean

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[155] *Ibid*.

[156] *Ibid*, at page 75.

[157] *Ibid*, at pages 28-29.

[158] *Ibid*, at page 75.

[159] *Ibid*.

[160] *Ibid*.

[161] For a discussion of the Reports recommendations see Darjee and Crichton "The MacLean Committee: Scotland's answer to the 'dangerous people with severe personality disorder' proposals" (*The Psychiatrist*: 26, 2002, pages 6-8).

Committee was charged with examining the same issues as examined by the Home Office in a 1999 publication, but taking a Scottish perspective on the issues involved.[162] The MacLean Committee came to the conclusion that there was a need for special arrangements to respond to offenders considered to be high risk, in particular, offenders that committed violent and sexual offences. The rationale was that offenders who committed such offences were likely to reoffend and special sentencing arrangements would serve to protect the public. Amongst the important recommendations of the Committee was a suggestion that there should be a new Order for Lifelong Restriction (OLR) that could be imposed by a member of the judiciary after a risk assessment was carried out. The Committee also recommended the establishment of a Risk Management Authority (RMA) for Scotland that would have a role in ensuring best practice in risk assessments. The creation of a community specialist services for high-risk offenders was also recommended, in addition to intensive supervision and surveillance.

In addition the Committee made a number of recommendations that related specifically to offenders with MHPs. Such offenders were to be placed on restricted hospital orders. The MacLean Committee considered that offenders, who were deemed high-risk with MHPs and requiring treatment, should be assessed in a secure psychiatric hospital by way of an interim hospital order. It was envisaged that this assessment would involve assessing the risk posed by the offender and whether the required treatment in the hospital for their mental disorder. The Committee was of the view that if the person was assessed as posing risk and requiring treatment for their mental disorder in the hospital then they should be given an OLR with a hospital direction as provided for by section *59A of the Criminal Procedure (Scotland) Act 1995*.[163]

The commitment in Scotland to addressing dangerous offenders is most evident in the creation of the RMA in 2005 by way of the *Criminal Justice (Scotland) Act 2003*. The *Criminal Justice (Scotland) Act 2003*

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[162] "Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development" (London: Home Office, Department of Health, 1999).

[163] This is Scotland's version of a Hybrid Order as provided for in England and Wales, where an order is made that provides for both a prison sentence and a treatment in hospital.

sets out the statutory duties of the RMA.[164] The RMA's statutory obligations essentially focus around the provision of "robust and effective risk assessment and risk management practices are in place to reduce the risk of serious harm posed by violent and sexual offenders".[165] The RMA has specific responsibility to administer and oversee the risk assessment and management processes relating to the sentences that are OLRs. This role extends to the accreditation of risk assessors who carry out these duties on behalf of the High Court, and the approval of Risk Management Plans for offenders subject to sentences that are OLRs.[166]

Following the recommendations of Lady Cosgrove's Review and the Recommendations of the MacLean review the Scottish Parliament introduced the *Criminal Justice (Scotland) Act 2003*, which contained new provisions for the sentencing and treatment of serious violent and sexual offenders who are considered to present a continuing danger to the public.[167] OLRs came fully into force in June in 2006. OLRs are open as a sentencing option where a defendant is considered to be a violent or sexually violent offender who in the opinion of the court has a tendency to committing these serious crimes. The OLRs are imposed in the High Court, as they are a form of life sentence. However, it is important to note that OLRs are very different from a life sentence or a determinate sentence as the sentence is based on the risk assessment of the defendant prior to the imposition of the sentence.[168] The other important difference with OLRs relates to the level of supervision of the

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[164] The RMA is established as an "independent Non-Departmental Public Body", which in theory means that they are independent and impartial in discharging their statutory duties and are accountable to the Scottish Executive in respect of their performance and funding. For further information on the RMA see http://www.rmascotland.gov.uk/. <Last accessed 10 November 2013>

[165] *Ibid*.

[166] It is of note that it is not just psychiatrists that carry out the risk assessments. However, it is not clear from the RMA's documentation the professional backgrounds of the accredited assessors.

[167] See Maclean "Report of the Committee on Serious Violent and Sexual Offenders" (Edinburgh: Scottish Executive, 68, June 2000) and Cosgrove "Reducing the Risk: Improving the Response to Sex Offending" (Edinburgh: The Report of the Expert Panel on Sex Offending, June 2001).

[168] McFadyen "Scottish experience: The Order for Lifelong Restriction" (Dublin: International Society for Reform of Criminal Law Conference, Workshop B4: Dangerous and Persistent Offenders: Preventative Detention, July 2008) at pages 1-2.

defendant after their release.

Essentially OLRs provide for the lifelong supervision of defendants that are considered to be of high-risk violent and sexual offenders. Once enacted the provision of the 2003 Act provided for much more significant level of supervision and control of offenders considered to be risky than was previously permitted under Scottish law. As discussed in Chapter 2: Literature Review there has been a much greater focus in Western Europe and North America on public protection and taking preventative measures to protect the public from what McSherry and Keyzer describes as "dangerous people".[169] Much like the extension of psychiatric control over persons with MHPs through compulsory treatment orders, OLRs arguably now extend greater control over offenders even after they have served a custodial sentence. The RMA consider that OLR are "designed to ensure that offenders, after having served an adequate period in prison to meet the requirements of punishment, do not present an unacceptable risk to public safety once they are released into the community. The period spent in the community will be an integral part of the sentence, which lasts for the remaining period of the offender's life".[170] There have been calls for the RMA to embed human rights standards and principles into their guidelines on OLRs, so that practitioners adopt a human rights based approach in their work and specifically consider the implications of the orders on young persons.[171]

Through its 2006 Guidelines the RMA set out the definitions of low risk, medium risk and high risk and recognised the "inherent flaws" in these definitions.[172] The guidelines were designed to promote consistency in relation to risk assessment and to minimise as much as possible what has been described as the potential "net widening" that inevitably

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[169] See McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011).

[170] See http://www.rmascotland.gov.uk/. <Last accessed 10 November 2013>

[171] Fyee and Gailey 'The Scottish Approach to High-Risk Offenders: Early Answers to Further Questions' in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 216.

[172] For a discussion on this see Fyee and Gailey 'The Scottish Approach to High-Risk Offenders: Early Answers to Further Questions' in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 204-205.

accompanies statutory provisions of this nature.[173] It has been suggested that there are a number of areas where the Risk Assessment Orders could be improved.[174] The OLR is essentially a lifetime sentence of imprisonment or detention. However, it involves a series of stages from maximum security through to, where appropriate, supervised release into the community. As the RMA acknowledges the "… key objective is to ensure better continuity of supervision. Thus supervision in the community may be gradually stepped down if appropriate but equally an offender will swiftly move back up a stage or several stages, including return to custody, if the conditions for release are breached and as a result an assessment is made that the offender presents a serious risk to public safety".[175] Risk Assessment Reports are documents prepared by the RMA accredited Risk Assessor, which informs the High Court's judgement on whether an OLR should be imposed. The RMA published a document in July 2011 entitled "Framework for Risk Assessment, Management and Evaluation: FRAME".[176] The Multi Agency Public Protection Arrangements (MAPPA) established by the *Management of Offenders etc. (Scotland) Act 2005* imposes an obligation on agencies to collaborate.

The terms of reference for the work of the MacLean Committee included a direction to consider offenders with personality disorder. The Committee considered additional provisions for dealing with this category of offenders. The Committee ultimately decided that a third way of responding to offenders with personality disorders was not desirable. The Committee concluded that the appropriate way of responding to offenders with personality disorders was to assess them in the same manner as other high-risk offenders. What is interesting about the approach of the MacLean Committee was that it did not follow the approach taken in England and Wales by the Home Office in

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[173] *Ibid*, at page 205.

[174] See Darjee and Russell "The Assessment and Sentencing of High-Risk Offenders in Scotland: A Forensic Clinical Perspective" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011).

[175] See http://www.rmascotland.gov.uk/. <Last accessed 10 November 2013>

[176] "Framework for Risk Assessment, Management and Evaluation: FRAME" (Paisley: Risk Management Authority, July 2011). This document also stated that the aim of FRAME is to develop a "consistent shared framework that promotes defensible and ethical risk assessment and management practice that is proportionate to risk, legitimate to role, appropriate to the task in hand and is communicated meaningfully" (at page 10).

1999, where preventative detention could be used where there was a diagnosis supporting indeterminate sentences.[177] The approach taken by the MacLean Committee at this time was regarded as avoiding the "ethical concerns raised over the English and Welsh proposals".[178] The Scottish approach relies on the risk assessment of the offender as opposed to their diagnosis. Of course the Scottish proposal was open to ethical concerns particularly if the risk assessment uses the information on a mental disorder to attach greater risk to the assessment of the offender's risk of recidivism. The approach advocated by the MacLean Committee to risk assessment was very much based on the clinical assessments in preference to actuarial assessments, which it considered inflexible, difficult to apply [179]in the court setting and unhelpful from a risk management point of view.

As discussed above there is no requirement under the 2003 Act that the risk assessment for the purposes of OLR needs to be linked to a mental disorder. In that regard and from the perspective of the CRPD it could be argued that this indicates that the provisions are disability neutral. As Tuddenham and Baird acknowledged there has been little criticism in the psychiatry journals of the recommendations regarding risk assessments, compared to the response to the proposals introduced in England and Wales.[180] However, the fact that the law is framed in a disability neutral way to avoid provisions that would directly discriminate against a defendant with a MHPs, does not mean that defendants with MHPs who have committed violent or sexual offences will be indirectly discriminated against in the decision-making as to the imposition of OLRs. There was a suggestion that the arrival of OLRs may result in the increased use of the insanity defence, which is rarely used at present.[181]

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[177] For a discussion on this see Darjee and Crichton "The Maclean Committee: Scotland's answer to the 'dangerous people with severe personality disorder' proposals" (*The Psychiatrist*: 26, 2002, pages 6-8) at page 7.

[178] *Ibid*.

[179] *Ibid*.

[180] Tuddenham and Baird "The Risk Management Authority in Scotland and the forensic psychiatrist as risk assessor" (*Psychiatric Bulletin*: 2007, 31, 164) at page 164.

[181] Darjee and Crichton "The Maclean Committee: Scotland's answer to the 'dangerous people with severe personality disorder' proposals" (The Psychiatrist: 2002, 26) at page 8.

Despite concerns with the OLR system in Scotland it is being proposed as "an alternative to the … counterproductive, economically and ethically questionable alternatives".[182] It is suggested that the system in Scotland needs to be rooted in strong "political intent", supported by the professional groups and other stakeholders and "grounded in standards of collaborative, evidence-based and rights conscious practice".[183] It is also essential that the model is subject to oversight and seeks to make improvements systematically on an on-going basis. However, there are implications of a "rights-based risk management approach" in terms of being "indisputably resource intensive", however, the preventative detention system is also costly and "breaches traditional principles of justice and human rights".[184]

OLRs are effectively about the long-term risk management of offenders who are considered to pose a risk. They are imposed after an accredited assessor who is working in accordance with national standards and guidance has undertaken a comprehensive, structured risk assessment.[185] There are clear difficulties with the Scottish approach in that the assessments are resource intensive and the long-term sustainability of the system is open to question.[186] There are also serious concerns that the expert could be seen as playing a role in "determining … the sentence imposed".[187] There is an additional difficulty in matching "clinical resources for risk management … [to the] effort put into assessments for sentencing, meaning that there is a shortage of appropriate treatment programmes for offenders with complex needs in both the prison and in community.[188]

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[182] Fyee and Gailey 'The Scottish Approach to High-Risk Offenders: Early Answers to Further Questions' in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 216.

[183] *Ibid*.

[184] *Ibid*.

[185] For a discussion on this see Darjee and Russell "The Assessment and Sentencing of High-Risk Offenders in Scotland: A Forensic Clinical Perspective" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011).

[186] *Ibid*, at page 231.

[187] *Ibid*.

[188] *Ibid*.

The Scottish model is certainly being considered an alternative to the indeterminate sentencing approaches in England and Wales and the US and its proponents emphasise that the system is about risk management and not indefinite detention.[189] The process in Scotland is essentially about managing perceived risk in institutional settings and in the community "not just identifying dangerous people and sequestering them for society".[190] The Scotland provisions are considered to respond to risk through a "robust framework" of intervention.[191]

The recent reforms in Scotland reflect the international trend towards preventative detention and indeterminate sentencing.[192] While the *Human Rights Act 1998*, which applies to Scotland places a premium on the balancing of rights and the principle of proportionality it is seems clear that the trend in Scotland is towards managing the risk that offenders with MHPs are considered to pose. It has been commented that Scottish criminal justice policy "… has a tendency to evolve in response to tragic incidents when individual or system error has been identified or suspected".[193] The political element and "perceived public anxiety" regarding the "dangerous offender" seems to have influenced recent law and policy in this area in Scotland.

While the expectation is that the OLR replaces the discretionary life sentence the expectation is that it will be used only "rarely".[194] In was initially suggested that OLRs would be used in a limited way at a rate of around 15 orders per year.[195] This was considered to be an optimistic target as indeterminate sentencing initiatives led to a much greater use than initially anticipated.[196] As of March 2010 less than 50 OLRs were

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[189] *Ibid*, at page 232.

[190] *Ibid*.

[191] *Ibid*.

[192] Fyee and Gailey 'The Scottish Approach to High-Risk Offenders: Early Answers to Further Questions' in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 201.

[193] *Ibid*.

[194] *Ibid*, at page 204.

[195] *Ibid*, at page 205.

[196] *Ibid*.

made, which "was within the initial estimate, and providing a broad indication that the targeting of the order may have been effective".[197] The Scottish Government and the RMA have expressed a commitment to keeping the use of OLRs within target.

The foregoing discussion indicates that Scotland is part of an international trend concentrating on managing risk and responding to perceptions of dangerousness.[198] It is also of note that the development of the current Scottish mental health strategy does not reference the human rights of service users. There is neither reference to the ECHR or the CRPD.[199] However, there was reference to the work of the Scottish Human Rights Commission, which established a framework seeking to embed human rights within mental health services and settings. There was a commitment to work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop human rights based approaches to mental health services.[200] Nonetheless the balance seems to be in favour of managing risk.

14. Mental Health and Defences in Scots Law

In Scotland there are a number of defences that allows persons with MHPs to avoid criminal responsibility or benefit from a reduced sentence regardless of their *prima facie* liability, where it is considered that their mental disorder impacted their conduct. The defence "criminal responsibility of persons with mental disorder" recently enacted by statute in Scotland differs in some important ways from the Irish defence of insanity, not only in name but also in that it does not contain any volitional element. The common law test may have included a volitional element, however, the new legislation does not provide for this arm of the test.[201] The insanity defence, diminished responsibility and insanity as a plea in bar of trial were all common law defences in Scotland. Part 7 of the *Criminal Justice and Licensing*

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[197] *Ibid*.

[198] See Chapter 2: Literature Review, Part 1.

[199] See "Mental Health Strategy for Scotland: 2012-2015" (Edinburgh: The Scottish Government, 2012).

[200] *Ibid*, at page 55.

[201] See *HM Advocate v Kidd* 1960 JC 61.

(Scotland) Act 2010 has now replaced these common law defences with version placed on a statutory footing. The insanity defence is now called "criminal responsibility of persons with mental disorder".

Sections 168 to 171 and the associated minor amendments in Part 7 of the *Criminal Justice and Licensing (Scotland) Act 2010* effectively implement the recommendations of the Scottish Law Commission's Report on insanity and diminished responsibility.[202] The provisions in the 2010 Act reflect the draft Bill in the Commission's Report.[203] Section 168 of the 2010 Act introduced a new statutory defence to replace the common law defence of insanity. It did this by inserting a new section 51A into the *Criminal Procedure (Scotland) Act 1995*. The new section provides for a special defence in respect of persons who lack criminal responsibility as a result of their mental disorder at the time of the commission of the offence. Section 51A(1) sets out the test for the new statutory defence. The elements to the test are twofold. The first element is the defendant has a "mental disorder" at the time of the commission of the offence. The second element is that the "mental disorder" must have a specific effect on the defendant for the defence to be raised. The required effect that this had on the accused is that they were not able "to appreciate the nature or wrongfulness of the conduct".[204]

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[202] See "Discussion Paper on Insanity and Diminished Responsibility" (Scottish Law Commission, Discussion Paper No 122, January 2003); "Report on Insanity and Diminished Responsibility" (Scottish Law Commission, Report 195, July 2004).

[203] See explanatory notes on the *Criminal Justice and Licensing (Scotland) Act 2010*, at paragraph 704. Available at: http://www.legislation.gov.uk/asp/2010/13/notes/division/2/7. <Last accessed 10 November 2013> The only differences sought to reflect the incorporation of the provisions contained within the larger Criminal Justice and Licensing (Scotland) Act and to deal with changes to the Scottish law since the completion of the Law Commission's Report, and to correct some minor errors and omissions.

[204] *Ibid*. The concepts of "nature" and wrongfulness are two different concepts and the defendant needs to establish that they lacked "appreciation in respect of only one of them". It is noteworthy that the concept of appreciation is wider than that of mere knowledge and that failure to appreciate the nature of conduct is not prohibited by the knowledge of the physical aspects of the conduct. In addition the defence may be available to an accused where they knew that their conduct was in breach of the law or moral norms but who had reasons for believing that they were nonetheless right to act in the manner that they did. (See paragraph 706).

15. Imposition of the Insanity Defence / New Replacement Defence

The implications of the CRPD for the new defence have not been explored in the literature in Scotland. This is perhaps unsurprising given the general lack of interest and consideration of the recent law reform in Scotland. As Maher noted the law reform process was "hardly noticed and largely mirrored the lack of scrutiny of these provisions during the parliamentary progress of the Bill".[205] There is nonetheless some interesting case law on the imposition of insanity defence (as in was) in Scotland, which is relevant to the thesis. In *HM Advocate v Harrison* the accused raised a plea of diminished responsibility to a charge of murder.[206] The Crown provided evidence that sought to prove that the accused was insane at the time of the commission of the offence (a homicide). The trial judge in the direction to the jury stated that in this situation the responsibility for establishing the insanity of the defendant rested with the Crown but that the standard of proof was the balance of probabilities. As the Scottish Law Commission noted it is not clear if the Crown can raise the issue of the defendant's insanity in other circumstances.[207]

With the exception of *HM Advocate v Harrison* there was little other authority on who could raise the insanity defence. As a result the Scottish Law Commission examined the issue.[208] The Commission noted that the Crown had a "duty to present all evidence which has a bearing on the accused's state of mind at the time of the offence".[209] It considered that the Crown might find itself in a difficult situation where it could present evidence that pointed to the defendants' "insanity".[210] This reflected the concerns of Haugh J in the Irish case of *People (DPP)*

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[205] Maher "The New Mental Disorder Defences: Some Comments" (*Scots Law Times*: 1, 2013, pages 1-4) at page 1.

[206] High Court of Justiciary, Dundee, October 1967, unreported, (1968) 32 JCL 119.

[207] "Report on Insanity and Diminished Responsibility" (Scottish Law Commission, Report 195, July 2004), at pages 62-64.

[208] "Discussion Paper on Insanity and Diminished Responsibility" (Scottish Law Commission, Discussion Paper No 122, January 2003) at pages 60-64.

[209] "Report on Insanity and Diminished Responsibility" (Scottish Law Commission, Report 195, July 2004), at pages 62.

[210] *Ibid*.

v Redmond.[211] The Commission expressed concern that a prohibition on the state in seeking the insanity defence would result in the defendant being "… convicted for an offence despite his lack of criminal responsibility at the time of the offence".[212] The Commission acknowledged that in "some (probably most) cases" this problem would not emerge, as the Crown would decide not to prosecute the defendant.[213] However, the Commission was concerned that there would be "circumstances where the Crown needed to proceed with a trial but also show that the accused was insane at the time of the offence".[214]

The Commission acknowledged the arguments against the Crown imposing the insanity defence. The Law Commission noted the effect would be that a defendant "who is *ex hypothesi* competent to stand trial, would be compelled into a defence which he does not wish".[215] The Commission also recognised that a defendant "especially" a defendant facing minor charges "may decide that he would rather run the risk of being convicted than use the special defence, which he might regard as stigmatising".[216] A number of submissions received by the Commission suggested that the defence should be imposed in order to address public safety concerns. However, the Commission rejected the rationale essentially on the basis that it would be "wrong as a matter of principle for the Crown to force a defence on an accused person where that person does not wish to avail himself of it".[217] The position of the Law Commission is now reflected in law by way of insertion of Section 51A(4) into the *Crime Procedure (Scotland) Act 1995*, which regulates who can raise the defence and with the relevant standard of proof that is required to successfully raise the defence. Subsection (4) provides that only the person who is charged with the offence(s) can raise the new special defence. Importantly the defence

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[211] See Chapter 3: Ireland.

[212] "Report on Insanity and Diminished Responsibility" (Scottish Law Commission, Report 195, July 2004), at pages 62.

[213] *Ibid*.

[214] *Ibid*.

[215] *Ibid*, page 63. The term *ex hypothesi* is a Latin term meaning according to the hypothesis proposed.

[216] *Ibid*.

[217] *Ibid*.

cannot be raised by the Crown or by the court of its own accord.[218] The approach in Scotland then reflects the position in Ireland articulated by the Supreme Court in *People (DPP) v Redmond* that a decision to invoke the defence rests with the defendant. The principal objection to the defence from the perspective of the CRPD is that it infringes the notion of legal capacity in Article 12. The approach in Scotland and Ireland guards against substitute decision-making and allows the defendant to weigh up their preference for a custodial sentence over remittance to a psychiatric setting. Unfortunately, there was no substantive consideration in the law reform process about addressing the human rights concerns with indefinite detention following a successful invocation of the defence.

16. Abolition of Insanity as a Defence / Diminished Responsibility

The Law Commission considered the abolition of the insanity defence, (as it was then) and the defence of diminished responsibility (as it was then). The Commission considered that abolition of the insanity defence would be a "radical approach".[219] While the Commission identified and evaluated the merits of proposals to abolish and partially abolish the defence it did not attach much weight to these law reform options. The Commission recommended that the defence should be retained as part of the criminal law.[220] The Commission's rationale for retention of the insanity defence (and presumably the reason it did not seriously consider the abolition of the insanity defence) was that it the insanity "defence gives effect to a fundamental principle of the criminal law, namely that where a person suffers from a severe mental disorder it is unfair to hold that person criminally responsible".[221] The Commission also concluded that this was unfair regardless of whether the defendant "could have the *mens rea* for the offence charged and whether or not that person could understand and participate in his trial"

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[218] See explanatory notes on the *Criminal Justice and Licensing (Scotland) Act 2010*, at paragraph 709. Available at: http://www.legislation.gov.uk/asp/2010/13/notes/division/2/7. <Last accessed 10 November 2013>

[219] "Report on Insanity and Diminished Responsibility" (Scottish Law Commission, Report 195, July 2004) at page 12.

[220] *Ibid*, at page 14.

[221] *Ibid*, at page 13.

and abolition of the insanity defence would not give effect to this basic principle of fairness.[222]

In its Report the Scottish Law Commission ultimately concluded that the defence should be retained; stating the "plea of diminished responsibility should be retained as a special instance of a plea in mitigation in cases of murder. Where successful its effect should be that the accused is liable to be convicted of culpable homicide rather than of murder".[223] The Commission noted that in coming to its conclusion none of its respondents to its Discussion Paper supported the abolition of the defence.[224] While the Commission noted "conceptual difficulties" with the term "diminished responsibility" it considered that the plea nonetheless serves "an important practical function".[225] A view shared by the legislature as section 51B of the 2010 Act, which codified the law on diminished responsibility.

While the work of the Law Commission took place during the drafting of the CRPD the discourse on abolition is interesting and reveals a strong commitment to the use of defences in criminal law that seek to mitigate criminal responsibility. It is also of note that the Law Commission considered that abolition of the defence of diminished responsibility requires abolition of the mandatory sentence of murder. As such the implementation of CRPD required disability neutral defences would require significant reform of the criminal law. Such reforms render abolition unlikely.

17. Conclusions

Scottish forensic mental health services have developed significantly at the national, regional and local level. This position contrasts sharply with that in Ireland where forensic mental health services operate only in Dublin in the CMH (with an element of outreach in the Dublin area). The Scottish commitment to developing services was made at approximately the same time as the commitment in Ireland, which

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[222] *Ibid*.

[223] *Ibid*, at page 33.

[224] *Ibid*, at page 32.

[225] *Ibid*.

highlights that delivery could have been achieved if the planning and resourcing had been put in place. The development of these forensic mental health services, while offering an alternative to imprisonment, also mean that persons will be detained in very restrictive settings.

The delivery of mental health services under the CPA is based on risk management approaches that can serve to control and coerce. As such mental health policy places a premium on "public safety". However, the approach to defendants and offenders with MHPs and ID has positive elements. Those positive elements include a commitment to rehabilitation and on ensuring community living as opposed to detention in institutional settings. While forensic mental health services have been developed in Scotland the literature indicates inconsistency in the provision of services across Scottish prisons. The requirement on forensic mental health services to produce a "care plan" is key for recovery and enhances the potential for community living. In the Irish case *DPP v B* Sheehan J was scathing in his criticism of the lack of a recovery ethos in the care provided to the forensic patient detained in the CMH. Care plans should be required for persons detained in the CMH and the patient should be involved in the development of the plan. This has potential to ensure that the right to health, habilitation and rehabilitation and community living are vindicated. The creation of the Forensic Network in 2003 is positive in overseeing the development of services across Scotland and to provide strategic overview and direction for the planning and development of forensic services. In Ireland psychiatrists from CMH, in the absence of regional or local forensic services, dominate policy on forensic services in Ireland. In contrast the Forensic Network in Scotland take a "pan-Scotland" approach to its work, an approach that would be useful in Ireland.

There is a dearth of literature on diversion provisions, processes and initiatives in Scotland. However, while the literature examining diversion is under developed diversion provisions, processes and initiatives themselves are not. One of the novel features of the diversion system in Scotland is the informal process of diversion to social work. This process of diversion is disability neutral in that it is not limited to persons with MHPs or ID. This type of diversion involves community disposal and avoids the court process and has the potential to respond to the needs of defendants with disabilities in a CRPD complaint way. However, it is an informal process with success

dependent upon the confidence of the Procurators Fiscal that the scheme will address the underlying causes of the person's offending behaviour. However, it is regrettable that the literature on diversion to social work does not explicitly examine its use in respect of persons with MHPs or ID. In addition the absence of systematic gathering of evidence as to the effectiveness of diversion to social service mean that it unclear whether it is an effective diversion tool.

Police officers in Scotland respond to persons with MHPs and ID in a variety of ways and have discretion to deal with persons informally. Unlike Ireland there is greater provision for psychiatric services to police stations in Scotland, with forensic medical examiners providing support to police stations. In Scotland there is a developed system for dealing with suspects who have a MHP or ID through the provision of appropriate adults to support the person when being questioned. While problems were identified with the appropriate adult scheme in Scotland the system is much more advanced than the provisions currently available in Ireland.

Unlike Ireland, mental health services are provided for in most courts in Scotland. The normal interaction is through requests to provide psychiatric reports by Procurators Fiscal, defence lawyers and Sheriffs' clerks. In addition there are a number of court liaison schemes in operation in Scotland. However, there is limited research mapping and evaluating these court liaison schemes. In addition courts have a range of statutory powers to respond to both defendants and offenders with MHPs and ID. However, many of the powers can be coercive and involuntary detention and treatment may follow. In addition the courts may order disposal to the community with coercive conditions attaching. Unlike Ireland the courts in Scotland also have powers to make a range of community orders. However, the literature suggests that the newly enacted Community Payback Orders have been underused in respect of offenders with MHPs. This is regrettable as the community disposal and the therapeutic community work involved could serve to realise the person's rights to live and be included in the community and aid with recovery.

Despite the provision of a range of diversion provisions, processes and procedures there is an over-representation of persons with MHPs in the Scottish prison population. It is unfortunate that more research has not been undertaken to examine the effectiveness of diversion and identify

ways of refining, reforming and improving the provisions, processes and initiatives. The concern with public safety is evident from the development of the RMA and the creation of OLRs. Additional research examining the impact of these sentences on defendants with MHPs and ID would be of interest as would research examining, in a broad sense, the impact of risk management on diversion in Scotland.

The recent law reform of the insanity and related defences in Scotland contribute little to the understanding of the implications of Article 12 of the CRPD in this area. However, the position under the new legislation prohibiting the imposition of the insanity defence replacement reflects the position in Ireland articulated by the Supreme Court in *People (DPP) v Redmond*. The fact that the defence can only be imposed upon the defendant is suggested to militate against the principal objections to the defence. This prohibition safeguards against substitute decision-making and allows the defendant to weigh up their preference for a custodial sentence over remittance to a psychiatric setting. Unfortunately, there was no substantive consideration in the law reform process in Scotland about addressing the human rights concerns with indefinite detention following a successful invocation of the defence.

Chapter 6: Northern Ireland

1. Introduction

This chapter considers the law and policy in Northern Ireland (NI) relating to persons with MHPs and ID who come into contact with the criminal justice system. It considers the extensive and on-going reform process of mental health law and policy that began in NI over a decade ago. It also critically considers the attempt to create a single piece of legislation that covers mental health and mental capacity and the implications of the fused approach for defendants and offenders in the criminal justice system. In light of the proposed fused approach this chapter also considers the rational for a fused legislative framework and its implications for diversion. The diversion provisions, processes and initiatives in NI are also considered. These are of particular interest given that the Irish Government (the South) considered the NI model as an example of good template when developing mental health legislation in the early 1990s.[1]

2. Background to Mental Health Law and Policy NI

The current mental health legislation in NI is the *Mental Health (Northern Ireland) Order 1986*. The order gave effect to the Report of a review published in 1981. The Review (also known as the MacDermott Report) was influenced by the provisions in the *Mental Health (Scotland) Act 1984* and the legislation in England and Wales the *Mental Health Act 1983*.[2] Some of the important features of the 1986 Order include the use of guardianship as a less restrictive alternative to detention in hospital and the use of other safeguards around powers of involuntary detention and treatment and the creation of the Mental Health Commission (as it was then).

In research commissioned by the Northern Ireland Human Rights Commission published in 2003 it was acknowledged that there were many areas of concern regarding persons with MHPs in prison. A core concern was of human rights violations by not receiving appropriate treatment in the appropriate therapeutic environment and highlighted

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[1] See Chapter 3: Ireland.

[2] "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007) at page 15.

the potential breaches of Articles 2, 3, 5 and 8 of the ECHR. In relation to diversion the Commission suggested that the failure to divert from prison to health and social services increased the risk of suicide and self-harm.[3] The Commission was of the view that in order to respect the rights of the person with a MHP they should be diverted from the criminal justice system as early as possible.[4] Indeed, McGilloway and Donnelly in 2004 suggested that a "radical rethink" and "informed public debate" was needed in responding to offenders who experienced MHPs in NI.[5] This public debate came in the form of the Bamford Review, which undertook a broad consultation process with stakeholders on a range of mental health law and policy issues and produced a specific Report that considered offenders with MHPs. The Report included detailed recommendations on the development of forensic mental health and learning disability services in NI.[6] The report on forensic mental health services is interlinked with the other reports published as part of the Bamford Review of Mental Health and Learning Disability (NI).[7]

The Report was specifically concerned with the development of services for "mentally disordered offenders" and "others with similar needs" while also considering the issue of public protection.[8] The recommendations stem from two underlying themes, the first being that persons in contact with the criminal justice system have high levels of mental disorder. The Report recognised that services currently available were inadequate in meeting the needs of persons with MHPs

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[3] Davidson, McCallion and Potter "Connecting Mental Health and Human Rights" (Belfast: Northern Ireland Human Rights Commission, 2003) at page 66.

[4] *Ibid*, at page 68.

[5] McGilloway and Donnelly "Mental Illness in the UK Criminal Justice System: A Police Liaison Scheme for Mentally Disordered Offenders in Belfast" (*Journal of Mental Health*: 13(3), 2004, pages 263-275) at page 274.

[6] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006).

[7] See "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007).

[8] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006) at page vii.

and "learning disability" in contact with the criminal justice system.[9] Under this theme the Report was of the view that people subject to the criminal justice system should have access to services equivalent to those "available to the rest of society" and that services should be provided in cooperation with the criminal justice agencies in NI.[10] This approach reflects the human rights norm of providing equivalence of healthcare between persons deprived of their liberty in prison with services available in the community.[11]

The second theme that informed the recommendations was that of public protection. While the Report acknowledged that the "majority of people in our society who suffer from mental disorder pose no increased risk of causing harm to others" it stated that "some people suffer from mental disorder" that is associated with significant risks of causing serious harm to others".[12] According to the Report the interests of offenders and the interests of "the wider society" required provision of evidence-based treatment and care that assists in the reduction of the risks posed by the person. Additionally, it was recommended that the Health and Personal Social Care Services should provide services to identify and assess people suffering from mental disorders considered to pose risks, regardless of whether the person is "currently in hospital, in prison, in police stations or in the community and the HPSS should provide these individuals with appropriate treatment, care and safeguards".[13] A further recommendation involved a joint co-operative approach between the Health and Personal Social Care Services and the criminal justice agencies.

The Report suggested the implementation of its recommendations should lead to important improvements by ensuring persons suffering from mental disorders subject to the criminal justice system or whose mental disorder poses "significant risks of serious harm" will have their

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[9] *Ibid*.

[10] *Ibid*.

[11] See Chapter 2: Literature Review, Part 2.

[12] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006) at page vii.

[13] *Ibid*.

needs more effectively identified through "timely access to assessment, support, treatment and care".[14] Flowing from this implementation of its recommendations would mean prisoners with severe MHPs would avoid lengthy waits in prison before being transferred to hospital for treatment.[15]

Bamford also suggested that the implementation of its recommendations would result in service users receiving appropriate psychotherapeutic treatments and that "mentally disordered people" in police stations would have access to a variety of mental health and learning disability services, which would facilitate diversion.[16] The Report singled out the lack of "evidence-based" treatment for persons suffering from "personality disorder" and "developmental disorders" and suggested that its recommendations would address this lack of adequate provision of services. It also suggested the implementation of its recommendations would result in a least restrictive approach with persons no longer receiving treatment "in conditions of security and restriction" if not required.[17]

As referenced already public protection was central to the recommendations made in Bamford, which considered that implementation of its recommendations would result in the public being better informed about mental disorder and "the relationships between mental disorder and risk" and that there would be effective collaboration between the different services.[18] The main recommendations of the Report on forensic mental health services included the creation of a Regional Forensic Network (that has yet to be realised). It was recommended that the Regional Forensic Network should be established to co-ordinate the planning and delivery of forensic services at regional and local levels in NI.

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[14] *Ibid*.

[15] *Ibid*. Similarly, it envisaged that it would be possible in respect of prisoners awaiting sentence and other persons waiting to be admitted to high security hospital facility for detailed assessment to be done with greater ease, so that properly informed decisions would be made about further placement, treatment and care.

[16] *Ibid*, at page viii.

[17] *Ibid*.

[18] *Ibid*.

In the same way that "A Vision for Change" identified the lack of forensic mental health services in the Republic of Ireland the Bamford Review identified that services were under-developed and noted that funding was required for the development of mental health and ID inpatient services at high security, long stay medium security and low security. In addition the Review identified that there was a need to provide accommodation and day facilities in the community, mental health and learning disability community teams, services for mental health and ID services to the prisons, and to support people in police stations, in courts and in contact with probation. In order to address the lack of services for persons considered to have personality disorders the Bamford Review recommended the development of comprehensive personality disorder services and psychotherapy services.

The Review considered that all of its recommendations (and the other recommendations detailed in its other reports) were necessary and realistic and that the objectives were achievable over the coming 15 years, through a planned and co-ordinated approach that would involve all of the relevant stakeholders working together to meet the needs of persons with MHPs. However, despite the endorsement of the majority of the recommendations of the Bamford Review by the NI Executive and commitment by both the Department of Health Social Services and Public Safety (DHSSPS) and Department of Justice (DOJ) there has been a failure to implement its recommendations.[19] However, a new implementation plan running from 2012-2015 commits to developing the forensic services as recommended by Bamford.[20]

3. The Diversion System and Special Measures in NI

Despite the failure to implement many of the recommendations contained in the Bamford Review, NI does have a range of diversion provisions, processes and initiatives. Many of these initiatives are

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[19] See "Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability" (Belfast: Northern Ireland Executive, June 2008).

[20] See "Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-2015" (Belfast: Department of Health Social Services and Public Protection, Integrated Projects Unit, November 2012) at page 20.

modelled on provisions in place in England and Wales and could play a role if introduced in Ireland to better respond to defendants and offenders with MHPs and ID.

3.1. Diversion and Special Measures at the Police Station

The Code of Practice for the Detention, Treatment and Questioning of Persons by Police is provided for in NI under Article 65 of the *Police and Criminal Evidence (Northern Ireland) Order 1989*.[21] The Code of Practice makes provisions in respect of persons who are "mentally disordered and otherwise mentally vulnerable" who are detained in police stations in NI. Like England and Wales there is provision for "appropriate adults" and other measures aimed at safeguarding persons perceived to be vulnerable on the basis of disability. Forensic Medical Officers are frequently asked to make a determination as to whether an individual is fit to be interviewed.[22] The Bamford Review considered the issue of fitness to be interviewed in police stations and was of the view that the current Code of Practice was insufficient to deal with the concerns around interviewing persons with MHPs or ID.[23] As such it was recommended that the DHSSPS in partnership with the criminal justice agencies should establish a group comprising of relevant stakeholders to produce guidance on assessment of fitness for interview and related matters.[24] However, to date this recommendation remains unimplemented.

The Bamford Review identified a number of concerns in respect of the appropriate adult scheme as it operates in NI. The Review identified that the criteria for "suspected mental disorder" is potentially very broad, not adequately targeting the most vulnerable coming into contact with the police.[25] It was also suggested that in practice there is a failure by police to identify persons in custody who may have a mental

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[21] "Police and Criminal Evidence (Northern Ireland) Order 1989 (Article 60, 60A and 65): Codes of Practice (Belfast: Stationery Office, 2007 Edition).

[22] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006) at page 13.

[23] *Ibid*.

[24] *Ibid*, at page 14.

[25] *Ibid*.

disorder. Bamford considered that this implied that the interests of "mentally disordered people" are not "demonstrably safeguarded".[26] Bamford also identified difficulties in finding people to act as "appropriate adults"; while social workers may undertake the role of "appropriate adult" Trusts in NI have not received adequate resources to facilitate this.[27] The Review also criticised the lack of detailed guidance available for those acting as appropriate adults and the insufficient training available for people undertaking the role.[28]

The Review noted that a range of different persons could act as appropriate adults (EG parents, guardians, relatives or other persons responsible for the care or custody of a suspect).[29] However, in the Bamford Review concerns were expressed in its consultative process that relatives and carers were not best placed to represent the interviewee. As such the Bamford Review recommended that the DHSSPS in partnership with criminal justice agencies should establish a group consisting of representatives of all the relevant stakeholders to review the appropriate adult scheme.[30] In particular, it was recommended that the group should review "the effectiveness, efficiency and practical working of the scheme, including the criteria invoking the use of appropriate adults".[31] To date this review has not taken place and the implementation plan 2012-2015 does not make any provision for implementation of Bamford's recommendations on reform of the appropriate adult scheme.[32] Despite the deficiencies with the appropriate adult scheme in NI, the provisions are more developed than the corresponding provisions in Ireland in seeking to safeguard suspects who have a MHP or ID.[33]

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[26] *Ibid.*

[27] *Ibid.*

[28] *Ibid.*

[29] *Ibid.*

[30] *Ibid.*

[31] *Ibid.*

[32] See "Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-2015" (Belfast: Department of Social Services and Public Protection, Integrated Projects Unit, November 2012).

[33] See Chapter 3: Ireland.

Police stations in NI are not served by developed forensic mental health services or forensic ID services. Medical services are however provided for by Forensic Medical Officers. Forensic Medical Officers are general practitioners who conduct most of the assessments of persons suspected of suffering from a mental disorder.[34] In 1998 a police liaison scheme for "Mentally Disordered Offenders" known as the "MDO Scheme" was established in Musgrave Street Police Station in Belfast. The scheme involves two community mental health nurses who screen custody records and carry out mental health assessments on selected individuals detained in the police station. The nurses also provide health promotion and liaise with the appropriate agencies to arrange treatment and support for persons detained in the police station. The nurses also provide advice to Forensic Medical Officers, courts, legal representatives and others. In addition the nurses provide training to the Police Service for Northern Ireland (PSNI) to assist them in understanding "the nature of mental disorders and the problems experienced by those suffering from mental disorder".[35] The geographical footprint of the MDO Scheme is confined to Belfast.

The data collected from the MDO Scheme reveals the prevalence of MHPs in police stations in Belfast.[36] The MDO Scheme indicated that 16% of the custody records met one or more of the assessment criteria for mental disorder and that 91% of those who underwent assessment were judged to have a MHP.[37] The data indicated that typically persons identified were single, unemployed males in their early 30s who lived alone.[38] Two thirds of the population were reported to have a history of contact with one or more health, social services or criminal justice institutions and 47% had received inpatient care, and almost half had been in prison previously.[39] The most commonly recorded diagnoses

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[34] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006) at page 9.

[35] *Ibid*.

[36] McGilloway and Donnelly "Mental Illness in the UK Criminal Justice System: A Police Liaison Scheme for Mentally Disordered Offenders in Belfast" (*Journal of Mental Health*: 13(3), 2004, pages 263-275).

[37] *Ibid*.

[38] *Ibid*.

[39] *Ibid*.

were of depression (44%); substance misuse (15%); schizophrenia/paranoid psychosis (11%) and anxiety (11%).[40]

There is a lack of research on the effectiveness of the MDO Scheme. However, service users and carers have made positive comments to the Bamford Review about the scheme.[41] The Bamford Review reported that stakeholders generally regarded the MDO Scheme as beneficial, however, it was also considered to be under-resourced.[42] The Bamford Review also reported communication problems between organisations and difficulties in sharing information and that there was uncertainty in "defining fitness for interview and the roles of appropriate adults". Providing services to persons with personality disorder and difficulties in arranging hospital admissions for persons "suffering from temporary disorders" were identified as barriers to the effective operation of the MDO Scheme. [43]

The nurses working on the MDO scheme have identified problems in terms of accessing accommodation for their clients, particularly for clients with "no fixed abode".[44] It was reported that the nurses sometimes liaise with the District Courts (formerly known as the Magistrates' Court) and have agreed that it was best that the person was not released into the community.[45] The result of which was the person might be sent to "Maghaberry Prison for lack of an alternative".[46] The nurses operating the MDO scheme reported that "they sometimes followed up people they knew to be at risk of suicide or self-harm after they returned to the community".[47] A number of

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[40] *Ibid*.

[41] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006) at page 10.

[42] *Ibid*. See also McCall "Forensic Services in Northern Ireland: A Literature Review and Needs Assessment" (Belfast: Eastern Health and Social Services Board, 2005).

[43] *Ibid*.

[44] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 18. This Report was presented to the Houses of Parliament by the Secretary of State for Northern Ireland under Section 49 (2) of the *Justice (Northern Ireland) Act 2002.*

[45] *Ibid*.

[46] *Ibid*.

[47] *Ibid*.

additional issues with the MDO Scheme include the limitation of the service to daylight hours and alternate weekends and "occasionally friction between the nurses and the FMOs".[48]

The 2004 research indicates "mental health illness amongst many detainees went undetected by Custody Sergeants and/or FMOs, but was identified accurately by the CMHNs who achieved considerable success in linking MDO to health and social services".[49] It was on this basis that the scheme was judged to be effective in terms of identifying and linking defendants to existing services.[50] It was also highlighted that the nurses were successful in developing "close and mutually supportive working relationships" with other health and social services professionals and a wide range of personnel across the criminal justice system.[51] It was suggested that the work of the community mental health nurses played a "pioneering role" in developing and facilitating the required liaison between psychiatric services and the criminal justice system.[52] The failure to develop integrated forensic mental health services for NI was identified as a barrier to the long-term effectiveness of the scheme.[53] Nevertheless this model of inter-agency collaboration "developed within a region of the UK often considered more strongly associated with division and civil unrest than partnership, and it is possible that the integrated health and social services in NI contributed positively to the development".[54]

In addition to the success of the MDO Scheme in developing interagency co-operation it is suggested that the scheme has served to promote a better comprehension of the relationship between mental illness, crime and prevention.[55] However, it was noted "initiatives set up in isolation from mainstream services often fail to achieve their long-

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[48] *Ibid*.

[49] *Ibid*, at page 274.

[50] *Ibid*.

[51] *Ibid*.

[52] *Ibid*.

[53] *Ibid*.

[54] *Ibid*.

[55] *Ibid*.

term goals".[56] It was suggested that this was particularly true in respect of nurse-led schemes that tend to be more effective when "fully integrated" with local psychiatric services or staffed by senior psychiatrists. Therefore, it was recommended that a community forensic mental health service in addition to or a reconfiguration of existing services were needed to support the Scheme.[57] In that respect without changes in the provision of general mental health services it was concluded that a "sizeable group" of offenders with MHPs, in particular, violent offenders and offenders engaged in self-harm would not get appropriate health and social care.[58]

The overall positive assessment of the MDO scheme by McGilloway and Donnelly was confirmed in the Inspector's Report in 2010.[59] However, the Report was also critical of the limitation of the service to Belfast, with "no counterpart in other police Districts".[60] The Report indicated that there was uncertainty surrounding the future of the scheme and that it was possible that the Scheme would be absorbed into community psychiatric nursing, which reflected the concerns about the sustainability of the scheme articulated by McGilloway and Donnelly. The Inspector expressed the view that the scheme represents good practice, and recommend that the MDO Scheme should be preserved and rolled out across NI in line with the recommendations in the Bamford Review and expanded to all custody suites.[61]

The Bamford Review recommended that there must be effective co-ordination between criminal justice, health and social services and "equity of access and provision of services for people subject to the criminal justice system".[62] The Bamford Review also acknowledged that mental health and learning disability services such as community

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[56] *Ibid*.

[57] *Ibid*.

[58] *Ibid*.

[59] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 18.

[60] *Ibid*.

[61] *Ibid*.

[62] *Ibid*, at page 11.

mental health teams, crisis resolution services, community forensic teams, learning disability and alcohol and substance misuse services should be developed across NI and asserted that it is "essential that these developing services are coordinated at local and regional levels to provide a full range of mental health and learning disability services for mentally disordered people in police stations".[63] As such it recommended the commissioning of a full range of statutory mental health and learning disability services to meet the needs of persons detained in police stations.[64] In addition it was recommended that providers of statutory, voluntary and community mental health and learning disability services should ensure they provide equity of access and provision of services for people detained in police stations.[65]

In line with the principles developed in other parts of the Bamford Review specific recommendations were made in respect of advocacy services in police stations, which is important from the perspective of Article 13 of the CRPD. The Bamford Review identified a number of different persons who may adopt an advocacy role for service users in police stations.[66] These groups included lawyers, appropriate adults, health, social services staff, probation staff and members of voluntary organisations.[67] However, it identified that none was specifically responsible for acting as advocates for "mentally disordered service users" within police stations.[68] Bamford recommended that the advocacy services attached to community mental health and learning disability services should be extended to include police stations.[69] In that regard it was recommended that research should be commissioned to assess the needs of mentally disordered people and

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[63] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006).

[64] *Ibid*.

[65] *Ibid*. It was also recommended that mental health and learning disability services to people detained in police stations should be provided locally and coordinated regionally and that the DHSSPS should lead this co-ordination in liaison with the Regional Forensic Network.

[66] *Ibid*.

[67] *Ibid*, at page 12.

[68] *Ibid*.

[69] *Ibid*.

their carers in police stations throughout NI.[70] This recommendation has yet to be implemented.

The Bamford Review identified that Medical Officers had difficulties in accessing the medical records of persons detained in police stations; which was problematical when a detainee was uncooperative "violent or emotionally disturbed".[71] It considered that it was desirable for Forensic Medical Officers to have access to health records and concluded that information technology systems being developed in the NHS should in time provide appropriate access to staff providing assessment and healthcare in police stations.[72]

3.2. Diversion and Decisions to Prosecute

In addition to diversion at the investigation stage diversion may also happen at the pre-trial stage. The Public Prosecution Code of Practice for NI sets out a two-prong test with regards to prosecuting criminal offences.[73] The first element is an "evidential test"; which assesses whether the evidence can be adduced in court is sufficient to provide a reasonable prospect of conviction. The second element is the "public interest test"; which considers whether the prosecution is required in the public interest.[74] The Code of Practice recognises a number of situations where it may not be in the public interest to prosecute criminal offences. Amongst the circumstances is "where the defendant was at the time of the offence or trial suffering from significant mental or physical ill-health".[75] The Code of Practice governing prosecutions in NI is currently under review and it is expected that the revised code will place a greater emphasis on the prosecution of persons with

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[70] *Ibid*. Bamford stipulated that this research should include recommendations that would lead to the establishment of systems to monitor on-going need and the impact of services on need.

[71] *Ibid*.

[72] *Ibid*. Given this may take a number of years it was recommended that service providers should develop information systems that enable Forensic Medical Officers and staff working in mental health and learning disability services to gain appropriate access to the health records of persons detained in police stations.

[73] "Code for Prosecutors: Including a Code of Ethics" (Belfast: Public Prosecution Service for Northern Ireland (PPS), 2008 Edition) at page 8.

[74] *Ibid*.

[75] *Ibid*, at page 13.

MHPs.[76] As noted in Chapter 3: Ireland, the DPP in Ireland does not provide a publicly available prosecution policy and it is unclear how the presence of a MHP or ID is factored into decisions to prosecute.

3.3. Diversion from the Courts

An essential component of a diversion system is a process that facilitates the identification of persons eligible to access diversion.[77] In that regard the Bamford Review identified a need to develop the range of services available in the criminal courts in NI including services to assess the needs of persons "suspected or confirmed as suffering from mental disorder".[78] It also identified a need for services to "offer appropriate support, treatment and care to service users" and provide appropriate information and support to carers in addition to the need for service.[79] As discussed above the MDO Scheme operates only in Belfast, with no similar service available to other courts throughout NI.

Bamford pointed out that there is no formal psychiatric liaison service in the courts in NI.[80] Neither was there a duty psychiatrist service providing assessments of offenders, which it considered necessary. It was reported that the courts in NI rarely request psychiatric and psychological reports. The figure provided in the Bamford Review was that the court requested reports between 0-5 times in any given year.[81] Solicitors generally commission psychiatric and psychological reports on behalf of clients (a similar situation to that in Ireland).[82] The Bamford Review expressed a number of concerns with the reports, as they were prepared in a limited way.[83] It was concerned that reports

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[76] "Consultation Paper: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC13, 2012) at page 6.

[77] See Chapter 2: Literature Review, Part 1.

[78] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006).

[79] *Ibid.*

[80] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006) at page 21.

[81] *Ibid.*

[82] *Ibid.*

[83] *Ibid.*

commissioned by the defence did not include information as the risks associated with diagnosed mental disorder.[84] It was also pointed out that in many cases the author of court reports made recommendations as to the management of the offender but they assumed no responsibility for delivering the recommended services.[85] Concern was also expressed about the variable quality of the reports.[86] Article 22 of the *Criminal Justice (Northern Ireland) Order 1996* states that in any case where the offender, is or appears to be, mentally disordered, the court shall obtain and consider a medical report before passing a custodial sentence other than a sentence fixed by law. Bamford suggested that it is not clear whether the current systems effectively identify persons suffering from mental disorder.[87]

Unsurprisingly there are a number of statutory provisions aimed at facilitating diversion in NI. Part III of the 1986 Order contains a number of provisions relating to persons with MHPs involved in criminal proceedings or who have been convicted and sentenced.[88] The provisions that are particularly relevant include Article 42, which provides the courts with the power to remand persons to hospital for treatment. Article 42 confers on courts a power to remand a person to hospital for a report on the defendant's mental condition. Article 43 permits the court to remand a defendant to hospital for treatment. Article 44 permits a court to order hospital admission or guardianship for persons convicted of criminal offences and Article 45 provides for interim hospital orders to be made. Part III of the 1986 Order also contains provisions for transfer direction orders that enable prisoners with MHPs to be transferred from prison for treatment.[89] Part III also contains restriction orders, which are imposed for the purposes of public protection.

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[84] *Ibid*.

[85] *Ibid*.

[86] *Ibid*.

[87] *Ibid*. Article 22(5) of the *Criminal Justice (Northern Ireland) Order 1996* requires that the report be prepared by a medical practitioner approved for the purposes of Part II of the *Mental Health (Northern Ireland) Order 1986*.

[88] See "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007) at pages 17-19.

[89] See Articles 53 and 54.

If a person with a MHP is suffering from a mental disorder within the meaning of the *Mental Health Order 1986* and is made subject to a hospital order with restrictions, the Secretary of State has a number of responsibilities in respect of the offender. The Secretary of State can refer the person's case to the Mental Health Review Tribunal, who can review the restriction orders and exercise powers of discharge or vary the order. They are also empowered to grant a leave of absence, in addition to exercising powers of recall. It has been suggested that a hospital order can be regarded as a criminal sanction "even though it is carried out within the health service".[90] However, once an offender becomes a "mental patient" within the Health Service they can be released by the tribunal.[91]

The Bamford Review acknowledged that certain potentially useful disposals available to the criminal courts are "substantially underused".[92] In particular, the Review singled out the underuse of probation orders, which are discussed below in greater detail. It has been suggested that hospital orders were "most frequently" used, however, they were "still very sparingly used".[93] Article 44 of the *Mental Health (Northern Ireland) Order 1986* permits the Court to detain a person who has been convicted of an offence in hospital. An additional power to bring someone into guardianship is rarely used as an alternative to prison.[94]

The Bamford Review discussed the procedures for making different mental health disposals. It stated that disposals such as hospital orders involve the co-ordination of a number of different elements.[95] Those

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[90] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 27.

[91] *Ibid*.

[92] "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007), at page 22.

[93] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 25. The use of Hospital Orders has remained in single figures for most recent years, while total court disposals have been running at the level of around 25,000 annually.

[94] *Ibid*.

[95] "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007), at page 22.

elements involved ensuring that the necessary written or oral evidence (from two appropriately qualified medical practitioners) was provided, ensuring that the receiving Trust has been given an opportunity to make representation to court and that a suitable place is available in hospital for the person. The Bamford Review stated that in practice there were regular difficulties due to the delay or absence of one or more of these necessary elements. Concern was expressed that on a number of occasions individuals have continued to be treated in hospital as if they remained the subject of a Restriction Order, yet the court had dealt with the legal case and terminated the Restriction Order.[96] This situation raises concerns from the perspective of Article 5 of the ECHR; however there has been no litigation on this point. A need to review policies and procedures relating to escorting service users between court and mental health and learning disability facilities, including the use of video link facilities was also identified.[97] It recommended that the DHSSPS establish a group with the Court Service and other relevant stakeholders to review and develop procedures and protocols relating to "mentally disordered offenders" to ensure efficient and effective procedures.[98] However, as of yet this recommendation remains unimplemented.

3.4. Probation and Offenders with MHPs in NI

The Bamford Review in its Report made a number of recommendations relating to probation services in NI.[99] As already discussed they recommended that strategies should be developed to ensure effective joint working between the Probation Board for Northern Ireland (PBNI) and the full range of mental health and learning disability services regarding assessment, treatment and care of "mentally disordered people" who are undergoing assessment by Probation or are subject to a Probation Order.[100] It was also recommended that the Regional Forensic Network (yet to be created) should co-ordinate the

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[96] *Ibid*, at page 24.

[97] *Ibid*.

[98] *Ibid*, at page 25.

[99] "The Bamford Review of Mental Health and Learning Disability: Northern Ireland Forensic Services" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), October 2006).

[100] *Ibid*.

development of services at the interfaces between PBNI with community forensic mental health and learning disability services; prison forensic services; and inpatient secure services.[101] In addition it was recommended that the DHSSPS should, in partnership with PBNI coordinate the development of services at the interfaces between its work and other mental health services.

Parole Commissioners play an important role in respect of extended custodial sentences and indeterminate sentences and their focus is on safeguarding the public.[102] Commissioners are expected to make independent, impartial and informed decisions as to whether an offender who is serving a public protection sentence should be released. This decision on whether to release (in theory at any rate) is based on the level of risk posed by the offender to the general public. If a panel of Commissioners are to release an offender they "must be satisfied that the offender no longer poses a significant risk of serious harm to the public".[103] To satisfy the Commissioners the offender must demonstrate to the Parole Commissioners that they no longer pose such a threat. In that regard offenders are required to undertake a sentence plan that focuses on their "rehabilitations" and reduction of the risk that they are considered to pose. The Offender Management Unit in the NI prisons has introduced an approach that seeks to address the risks posed by offenders through an integrated team of professionals across the probation, prison and psychology disciplines.

Each offender has an individual and targeted sentence plan that includes programmes, interventions, courses and whatever else is considered necessary to reduce the risks identified through the Pre Sentence Report stage and also through additional assessments completed throughout the prisoners' period of detention. It is the assessment of the prisoner's "success" at adhering to this plan and reducing their risk that will be considered by the Parole Commissioners. It has been suggested that the introduction of these new sentences and the measures outlined above that underscore that offenders will be provided with the "motivation to confront and address

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[101] *Ibid*.

[102] "Public Protection Sentences" (*Writ*: January-March 2010, pages 8-9) at page 8.

[103] *Ibid*.

their behaviour whilst in custody".[104] It has also been suggested that this public protection approach will creates a prison environment in NI that supports efforts to "rehabilitate" offenders and reintegrate them into society.[105] However, there are significant theoretical and practical problems with this approach, which is based on a medical model that requires co-operation from the prisoners in terms of engaging with treatment.[106] From a practical perspective release from prison is contingent upon the availability of resources and access to supports and services, which inevitably will be available in line with allocated budgets. The failure to provide this resource will as a consequence detrimentally impact the person and result longer periods of deprivation of liberty.

4. Special Measures at Trial in Northern Ireland

In NI the *Criminal Evidence (Northern Ireland) Order 1999* created a statutory framework that sought to provide procedural protection for certain witnesses that were considered to be vulnerable.[107] The eligibility for access to these special measures has been expanded beyond witnesses considered to be vulnerable.[108] Although special measures were originally devised to offer protection to "vulnerable" witnesses, recent statutory provision has been made in NI to recognise the needs of "vulnerable" accused persons. Article 21A has been inserted into the *Criminal Evidence Order (Northern Ireland) 1999* by way of section 19 of the *Justice Act (Northern Ireland) 2011*. Article 21A provides that a defendant over the age of 18 can give evidence by live television link if he or she has a mental disorder or an ID impacts on their ability to give their evidence or participate in the proceedings.[109] The rationale for these provisions is that the accommodation is

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[104] *Ibid*, at page 9.

[105] *Ibid*.

[106] See Chapter 2: Literature Review, Part 2.

[107] Those though to be vulnerable and in need of special measures included persons with MHPs, ID, person with physical impairments and persons of certain age groups. The equivalent legislation in England and Wales is the Youth Justice and Criminal Evidence Act 1999.

[108] For a discussion on special measures see "Report: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC16, 2013) at chapter 5.

[109] Mental disorder is defined in accordance with the definition in the *Mental Health (Northern Ireland) Order 1986*.

required on grounds of ensuring justice, an approach that resonates with Article 13 of the CRPD. Section 12 of the *Justice Act (Northern Ireland) 2011*, inserted Article 21BA into the *Criminal Evidence (Northern Ireland) Order 1999*, allows specified accused persons to give evidence to the court by way of an intermediary, where the support is considered necessary to ensure the defendant has a fair trial. The Law Commission for NI in its recent Consultation Paper and Report in "Unfitness to Plead" considered the extent to which special measures could be used to support a person to stand trial as opposed to being determined not fit to plead.[110] The Commission in its Report made numerous references to the requirements of the ECHR and the case law of the ECtHR as it related to the topic of fitness to plead. The Commission considered that it was "obvious that there will always be a group of individuals who are deemed to be unfit to plead, under the *Pritchard* test or any test which may replace it, regardless of the use of special measures, because of the severity of the degree of learning disability or mental illness which the accused person is living with".[111] A view that is challenged by the CRPD, in particular, in light of the centrality of supported decision-making and reasonable accommodation. The Commission nonetheless acknowledged that "intermediaries" could play an important role in assisting persons who might be considered lacking fitness to plead to stand trial.[112] As such the Commission considered that intermediaries provided for under the *Criminal Evidence (Northern Ireland) Order 1999* could play a role in supporting defendants where questions were raised over their fitness should the narrow definition be expanded.[113]

5. Diversion and ID

The literature exploring the experiences of persons with ID in the NI criminal justice system is limited. There is no available data on the number of persons with ID interacting with any of the policing

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[110] "Report: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC16, 2013) at page 84.

[111] *Ibid*.

[112] *Ibid*, at page 85.

[113] *Ibid*. In particular, if the role of the intermediary was given a "statutory responsibility to explain the trial process to the accused or to assist him or her make decisions about taking certain actions during the trial, for example, deciding whether to plead guilty or not".

organisations or processed through the courts in NI.[114] In line with the international literature it was reported that persons with ID in NI were considered more likely to be victims of crime.[115] It has been acknowledged that the deinstitutionalisation process in NI and the increased presence of persons with ID in the community has resulted in an increased risk of persons with ID being victims of crime or involved in crime.[116] Persons with ID are entitled to benefit from diversion from prosecution in line with the policy discussed above. However, there is no specific guidance issued by the Public Prosecution Service on diverting persons with ID. ID comes under the general guidance on factoring into the decision to prosecute whether the defendant was "suffering from significant mental or physical ill-health".[117] The MDO Scheme operating in Belfast responds to the needs of suspects with MHPs and there is no corresponding diversion scheme operating in respect of persons with ID.

As in England and Wales and Scotland the appropriate adult scheme (discussed above) is an important element that seeks to protect the rights of suspects with ID. In addition to the critique of the scheme in the Bamford Review, respondents to a recent survey suggested that parents and carers who often act as appropriate adults may not be the "most capable to support the person with learning disability".[118] The reasoning for this is that parents and carers may not know police protocols, may be unaware of the rights of suspects and "may be emotionally distressed themselves … and consequently, may be unfit to support them fully".[119] It has also been suggested that there is a need for a greater choice of persons to act as an "appropriate adult".[120] The

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[114] "Views and Experiences of People with Learning Disability in relation to Policing Arrangements in Northern Ireland" (Belfast: Police Ombudsman for Northern Ireland and Northern Ireland Policing Board, Final Report, 2011) at page 12.

[115] *Ibid*, at page 5.

[116] *Ibid*, at page 6.

[117] "Code for Prosecutors: Including a Code of Ethics" (Belfast: Public Prosecution Service for Northern Ireland (PPS), 2008 Edition) at page 13.

[118] "Views and Experiences of People with Learning Disability in relation to Policing Arrangements in Northern Ireland" (Belfast: Police Ombudsman for Northern Ireland and Northern Ireland Policing Board, Final Report, 2011) at page 66.

[119] *Ibid*.

[120] *Ibid*.

need for greater awareness of ID amongst police officers in NI has been recognised and it was recommended that this should be addressed through additional training.[121] In relation to the appropriate adult scheme in NI it was identified that there was a need for further training for the police, solicitors and appropriate adults.[122] The lack of visibility of persons with ID in NI's prisons is illustrated by Louck's research, which identified that it was unlikely when a person with "learning difficulty" or "learning disability" arrived in prison that there would be information on their disability and support needs.[123] There is a lack of awareness about the support that ought to be provided to prisoners with ID.[124] In prison it was also identified that there was a failure to refer persons with ID to supports and that the types of supports and services varied widely in prisons across NI.[125] It was noted that prisoners with ID were at risk of discrimination in prison through exclusion from "activities or opportunities, primarily from participation in core offending behaviour programmes".[126]

There is a need to develop greater diversion for defendants and offenders with ID in NI, particularly as "most aspects of the prison regimes" have not been adapted to accommodate their needs.[127] It is envisaged that the development of forensic mental health services for persons with ID and community services as recommended by Bamford will facilitate greater diversion through the creation of a range of options for disposal from prison. However, the services recommended in the Bamford Review have yet to be created. The current implementation plan does commit to the development of a plan for forensic learning disability services (subject to available resources).[128]

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[121] *Ibid*, at page 12.

[122] *Ibid*.

[123] See Loucks "No one Knows Offenders: Views of Prison Staff Northern Ireland"(London: Prison Reform Trust, 2007) at page 21.

[124] *Ibid*.

[125] *Ibid*.

[126] *Ibid*.

[127] *Ibid*.

[128] "Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-2015" (Belfast: Department of Social Services and Public Protection, Integrated Projects Unit, November 2012) at page 55.

6. Indeterminate Sentences in NI

NI in line with trends in other jurisdictions has moved towards indeterminate sentencing practice. The *Criminal Justice (Northern Ireland) Order 2008* extended the provision for indeterminate sentencing in NI. There are two main categories of life sentence prisoners. Indeterminate sentenced prisoners include offenders who received mandatory and discretionary life sentences, and indeterminate custodial sentences.[129] The difference between mandatory and discretionary life sentences, and indeterminate custodial sentences is dependant upon the offence committed and the relevant legislation under which the offender was sentenced. However, both categories of sentence mean that the prisoners do not know when they will be released from prison. The provisions under the *Criminal Justice (Northern Ireland) Order 2008* were introduced as a response to the public protection / dangerousness and risk concerns in NI. The measures introduced echo the provisions introduced in England and Wales in 2003. However, it is suggested that the NI provisions have "successfully avoided the major difficulties that had accompanied the introduction of similar sentences in England and Wales".[130] The legislation in England and Wales resulted in "huge net-widening and the population of indeterminate sentence prisoners doubled to over 11,000".[131] It is suggested that the NI Order "applied a range of measures which helped ensure much better targeting" of the new indeterminate sentences.[132]

Chapter 3 of the 2008 Order makes provision for indeterminate sentences for "dangerous offenders" and provisions for custodial sentences for certain violent and sex crimes in section 14. Section 15 provides for the assessment of dangerousness of offenders, section 15(1)(b) allows this where the offenders is considered to pose a "significant risk to members of the public of serious harm occasioned by the commission by the offender of further such offences". Section 15(2) allows the court in making the assessment referred to "take into

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[129] "The Management of Life and Indeterminate Sentence Prisoners in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, July 2012) at page 3.

[130] *Ibid*, at page 4.

[131] *Ibid*.

[132] *Ibid*.

account all such information as is available to it about the nature and circumstances of the offence "and any information about any pattern of behaviour of which the offence forms part and any other information about the offender". While it could be said that the 2008 Order is disability neutral it is clear that persons with a diagnosis of a mental disorder are particularly vulnerable to the imposition of an indeterminate sentence following an assessment of the risks they pose and their perceived dangerousness.

The prison population in NI has increased gradually in recent years.[133] Additional capacity has been created at Magilligan Prison, and there are plans to develop the prison estate in NI to cater for the increase in prisoner numbers that will result from the expansion of indeterminate sentences.[134] While there has been little research in NI on the impact of indeterminate sentencing, concern had been expressed about the impact on persons with MHPs. It is envisioned that this increase in the prison population in NI will not

> "[S]pread evenly across all types of prisoners. The prisoners who will find themselves stacking up in prison on grounds of assessed dangerousness will tend to be those with severe personality disorders. The population of prisoners who have special needs and who are particularly hard to manage could therefore double even if the overall prison population rises by only 10%".[135]

The increased length of detention for offenders with MHPs as a result being assessed as posing a risk to the public is clearly at odds with human rights law.[136] Given the vulnerability to discrimination in the length of prison sentences bolsters the argument for diversion as evidenced by the comments of the Criminal Justice Inspection Report.

> "[I]t could be argued that if someone is to be given a disproportionate term of imprisonment on account of mental problems which are not their fault, society owes it to them to

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[133] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 32.

[134] *Ibid*.

[135] *Ibid*.

[136] See Chapter 2: Literature Review, Part 2.

offer them a better environment than that of Maghaberry Prison in which to spend their days".[137]

The Report goes on to discuss where to detain persons who are assessed as being dangerous and held on indeterminate sentences. It was considered that transfer of such prisoners from high security settings to hospital settings would not always be appropriate, due to the "intractable" nature of mental disorders and also because it "would represent a poor use of scarce medical resources".[138] This led the Inspector to the "only conclusion" which is "that these personality disordered offenders will have to remain in prison, and the best we can do for them is to promote a high standard of 'healthy prison' regime for them and for all prisoners, with excellent care and plenty of purposeful activity".[139] This statement further evidences the implications of indeterminate sentencing practices, in effectively warehousing persons with MHPs. It could also be suggested as an example of the trans-institutionalisation process that has occurred in western countries over the past number of decades.[140]

The 2008 Order also provides for extended custodial sentences.[141] These sentences involve the custodial term and a period on licence, which is the extension period. Extended custodial sentences are available where the offender has been convicted of one of the "specified offences" in Schedule 2 of the 2008 Order and has been assessed as posing a risk of serious harm to the public. At the mid point of the custodial period the offender is assessed by the Parole Commissioners, in order to determine whether the serious risk that they are considered to pose, has reduced to the extent that it is no longer necessary for the protection of the public from serious harm to keep the offender confined. If the offender is released by the Parole Commissioners then they serve the remainder of their sentence on "licence", which involves supervision in the community by the Probation

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[137] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 32.

[138] *Ibid*.

[139] *Ibid*.

[140] See Chapter 2: Literature Review, Part 2.

[141] For a discussion on extended custodial sentences see "Public Protection Sentences" (*Writ*: January-March 2010, pages 8-9) at page 8.

Board. If the decision is not to release the offender then they remain in custody and are reconsidered for release within two years, or earlier if directed by the Parole Commissioners. Under the 2008 Order offenders released on "licence" can be recalled to custody if they breach the conditions attaching to their licence.[142]

7. Prisoners with MHPs in NI

Given the limited diversion provisions, processes and initiatives in NI and the criticism of the current arrangements, it is unsurprising that significant issues with prisoners with MHPs have been identified.[143] As with other jurisdictions the evidence suggests that NI's prisons contain a large number of prisoners with MHPs. In its 2009 Report on the UK the CPT made a number of recommendations that were aimed at improving the provision of mental health services to prisoners and persons detained in police custody in NI. In particular, the CPT recommended immediate steps "to ensure that detained persons with mental health disorders, held in police stations, are provided with appropriate care and treatment, until they are transferred to a mental

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[142] Offenders who receive an indeterminate sentence under the 2008 Order remain in custody for an undefined period and until the Parole Commissioners decide they can safely be released into the community. At the sentencing stage, the judge imposes a tariff that represents the minimum custodial period to be served and must be at least two years. An offender will not be entitled to a review until this tariff is met and release is contingent upon the view of the Parole Commissioners. The review processes for extended custodial sentences also apply to offenders subject to indeterminate sentences. Offenders who served an indeterminate sentence fall under the jurisdiction of the Probation Board and remain on "licence" for at least 10 years from their release date, which provides much scope for monitoring and control of persons with MHPs in the community.

[143] There are three prisons in NI and a centre that deals with young offenders. The Centre for young offenders is called Hydebank Wood YOC, it houses young aged between men between 18 and 23, as well as a small number of under-18s which cannot be taken into the Juvenile Justice Centre called Woodlands. One of the prisons known as Ash House: Hydebank Wood Women's Prison is a low security prison and has places for 60 female prisoners. Maghaberry Prison is a high security prison with places for 850 prisoners; the other men's prison is Magilligan Prison a medium security prison has places for 500 prisoners. There has been a lack of consideration of women with MHPs in Northern, a situation that has been recognised by a number of recent reports. However, it has been recommended that alternative disposal options for women should be developed such as step down and supported accommodation. See for example "Prisoners and Mental Health" (Belfast: Research and Library Service Research Paper, Northern Ireland Assembly, 2011), "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) and "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007).

health facility".[144] The CPT noted the lack of mental health professionals working in the prisons and recommended additional recruitment.[145] It requested additional detailed information relating to "initiatives being taken to improve the care afforded to prisoners suffering from a mental disorder".[146]

It has been suggested that the prevalence of offenders with MHPs in NI's prisons is increasing.[147] A total of 700 out of 850 prisoners in Maghaberry Prison were reported to be on medication, mainly tranquillisers, and approximately 7% of the entire prison population (approximately 100 prisoners) are considered to have a serious mental illness.[148] Other research indicates that 25% of persons committed to the prison system were in contact with mental health services in the community.[149] There is also an increasing older prison population in NI. The available statistics indicate that persons aged over 60 are now the fastest growing age group in prison, and the increasing number of people with dementia is anticipated to become an increasing issue within prisons.[150]

In 2012 it was reported that there were 34 offender/patients detained in hospital settings, 27 in NI and 7 that were transferred elsewhere in the UK.[151] Of this number 19 persons were detained under a hospital order, 12 in accordance with a transfer direction order, 8 on remand

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[144] See "Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 18 November to 1 December 2008" (Strasbourg: Council of Europe, 30, 2009) at page 65.

[145] *Ibid*, at page 73.

[146] *Ibid*.

[147] "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) at page 31.

[148] *Ibid*.

[149] "Northern Ireland Prison Service evidence to the NI Assembly Committee for Justice" (Belfast: 9 June 2011) citied in "Consultation on Proposals to Extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and Implications for Mental Health Powers" (Belfast: Department of Justice, July 2012) at page 17.

[150] "Prisoners and Mental Health" (Belfast: Northern Ireland Assembly, Research and Library Service Paper, 46/11, 9 March 2011).

[151] "Consultation on Proposals to Extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and Implications for Mental Health Powers" (Belfast: Department of Justice, July 2012) at page 18.

and 3 life sentence prisoners. It was reported that 19 offender/patients were in the community under conditional discharge from a hospital order.[152] 5 persons in 2012 were subject to Supervision and Treatment Orders.

A Review was undertaken (as part of the Hillsborough Agreement) of the Northern Ireland Prison Service.[153] The inspection team reviewed the conditions of detention management and the oversight of all prisons in NI. The final Report considered a range of issues including mental health of the prison population and how prisoners could engage with community groups and avoid reoffending. It made a number of recommendations that are relevant to responding to the needs of offenders with MHPs. They included strengthening and clarifying the current governance structure for the delivery of healthcare in prisons, in the context of links between criminal justice and healthcare more generally.[154] It was also recommended that a joint healthcare and criminal justice strategy, covering all health and social care trusts should be created and that a joint board should oversee the commissioning processes within and outside prisons in order to ensure that services exist to support diversion from custody and continuity of care in the community.[155] It was also recommended that the establishment of clear pathways for primary healthcare and mental healthcare should be implemented as a matter of urgency.[156]

Despite the deficiencies with the provision of health care in prisons there is a policy commitment to ensuring equivalence in accessing mental services for prisoners. However, a number of reports have identified inadequate services for prisoners with MHPs.[157] A recent

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[152] *Ibid*.

[153] "Review of the Northern Ireland Prison Service: Conditions, management and oversight of all prisons" (Prison Review Team, Final Report, October 2011).

[154] *Ibid*.

[155] *Ibid*.

[156] *Ibid*.

[157] See "Prisoners and Mental Health" (Belfast: Research and Library Service Research Paper, Northern Ireland Assembly, 2011), "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010) and Davidson, McCallion and Potter "Connecting Mental Health and Human Rights" (Belfast: Northern Ireland Human Rights Commission, 2003).

report recommended a formal review of health services in NI's prisons.[158] In addition to inadequate services in prison shortcomings have also been identified with continuity of care for prisoners leaving prison. A particular problem was that prisoners are often removed from the lists of GPs and psychiatrists after they were imprisoned, which restricts access to community mental health services.[159]

8. Future Directions

Whilst there are some initiatives in NI, the situation in the prisons represents a pressing need to develop services to facilitate diversion. In particular, it has been acknowledged that there is a need to develop community mental health and social services in order to ensure that diversion happens as early as possible.[160] In addition to the existing the diversion processes at police stations and courts it was recommended that more schemes should be developed at both venues.[161] Other jurisdiction considered the creation mental health courts as part of their response to defendants and offenders with MHPs. However, the creation of a mental health court for NI was not endorsed.[162] The preferred approach was that the MDO Scheme be extended to all custody suites and that pre-trial hearings with a judge specialising in mental health should be created.[163] It remains to be seen whether this will be realised and whether the deficiencies in prisons across NI will be resolved.

A lot of the discourse in NI about the development of forensic mental health services has focused on the creation of a high secure service such as the one in Carstairs in Scotland or the CMH in Dublin.[164] The lack of this facility results in the "most dangerous mentally disordered

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[158] See "Not a Marginal Issue: Mental Health and the Criminal Justice System in Northern Ireland" (Belfast: Criminal Justice Inspection Northern Ireland, March 2010).

[159] "Prisoners and Mental Health" (Belfast: Research and Library Service Research Paper, Northern Ireland Assembly, 2011) at page 29.

[160] See "Prisoners and Mental Health" (Belfast: Research and Library Service Research Paper, Northern Ireland Assembly, 2011) at page 29.

[161] *Ibid*, at page 2.

[162] *Ibid*.

[163] *Ibid*.

[164] *Ibid*, at page 29.

offenders" being transferred to Carstairs in Scotland or remaining in prison in NI for the duration of their sentence. There are human rights implications flowing from the situation such as impeding recovery and restricting the right to health.[165] From the perspective of the CRPD the transfer of patients to Carstairs restricts the persons contact with family and their community and creates further difficulties of reintegration and community living when released. It remains to be seen whether the creation of a high secure service will be considered economically viable in NI. It has also been recommended that there is a need for low secure step down facilities, which includes hostel accommodation.[166]

9. Fused Capacity and Mental Health Legislation

On the whole the approach to responding to defendants and offenders with MHPs and ID in NI replicates the approach in other common law jurisdictions. The mental health legislation in NI while out-dated, reflects the legislation in place in other parts of the UK in particular England and Wales. However, the Bamford Review has resulted in proposals for a radical approach to reforming mental health law and guardianship law in NI. Most jurisdictions have separate legislative frameworks containing mental health legislation and separate guardianship laws. However, in NI the *Mental Capacity (Health Welfare and Finance) Bill* proposes to merge both.

The legislation if enacted will give effect to Bamford's recommendation of a single, comprehensive legislative framework for mental health and capacity law. The Bill once published and finally enacted will "revoke the 1986 Order and introduce provisions that will put in place a system of substitute decision making arrangements for all persons over the age of 16 who lack the mental capacity to make decisions for themselves in the areas of health, welfare, and finance".[167] It is now envisaged that the legislation "will build on legislative reform in other jurisdictions" more specifically will draw upon the *Mental Capacity Act*

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[165] See Chapter 2: Literature Review.

[166] See "Prisoners and Mental Health" (Belfast: Research and Library Service Research Paper, Northern Ireland Assembly, 2011) at page 29.

[167] "Consultation on Proposals to Extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and Implications for Mental Health Powers" (Belfast: Department of Justice, July 2012).

2005. However, the delay in introducing new legislation has permitted the development and engagement of stakeholders on the process. The Bill has been described as "one of the most important pieces of social legislation to be enacted in NI".[168] In that regard the DHSSPS has sought to develop the legislation "within a comprehensive project management structure".[169]

The Bamford Review recommended that the principles to guide the new legislative framework should be autonomy, benefit, least harm and justice. The DOJ had reported that these principles are largely replicated in the Bill. In the DOJ consultation document a particular emphasis was placed on acting in the best interests of the person subject to the forthcoming legislation, which would have to take into account the person's "past and present wishes and feelings".[170] However, the proposals for the new legislation in NI published in 2009 "do not explain the interface between the new law and the criminal law and the criminal justice system and so it is difficult to anticipate the likely policy position on offenders who retain decision-making capacity but who benefit from mental health treatment".[171] In recognition of this in 2012 the DOJ published a Consultation Paper on proposals to extend the new mental capacity legislation to the criminal justice system.[172] A report of the responses was subsequently produced in

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[168] *Ibid*, at page 9.

[169] *Ibid*. This management structure has involved all Departments, including the Department of Justice, with a direct interest in the legislation and also involved a number of different bodies that have been involved with the Bamford Review. These bodies consist of legal professional, medical professionals, carer representative bodies, voluntary organisations and service users. The Department of Justice considered that this approach has allowed the DHSSPS to develop a "broad consensus of agreement". The Department of Justice has also established both a "Steering Group and external Reference Group to assist it in informing the criminal justice and mental capacity/health policy development process". The DHSSPS is also represented on both groups the Steering Group and Reference Group and there are on-going and planned meetings during and after the current (2012) consultation exercise.

[170] *Ibid*, at page 13. It is planned to codify the common law defence of necessity that would protect a person from liability if they acted on behalf of a person if they believed that they lacked capacity.

[171] McCallion and O'Hare "A New Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland: An Analysis of the Current Proposals" (*Journal of Mental Health Law*: 2010, 84) at page 85.

[172] "Consultation on Proposals to Extend Mental Capacity Legislation to the Criminal Justice System in Northern Ireland and Implications for Mental Health Powers" (Belfast: Department of Justice, July 2012).

2013.[173]

Bamford considered that people who have decision-making capacity should be free to make their own decisions and if those decisions were not wise decisions and culminated in the commission of a criminal offence then the person should be required to take responsibility for the decisions.[174] In that regard it was considered that the principles based approach would not excuse people who have decision-making capacity from the consequences of their poor decisions. The Bamford Review also concluded that this approach could not impose compulsion or restriction on persons who have decision-making capacity, even when they are considered to pose a risk of serious harm to the public. It has been noted "the principle of fusing incapacity and mental health legislation is supported by a broad Mental Health and Learning Disability Alliance of user, carer, voluntary sector and professional organisations in both mental health and disability leaning sectors in NI".[175]

The DOJ indicated that a specific code of practice would be developed for criminal justice system practitioners, providing guidance on the new legislation and existing common law duties.[176] There was also a commitment to the retention of existing statutory powers (discussed above) relating to for cases involving persons with MHPs. In relation to the existing power to remove a person to a place of safety a commitment was reaffirmed to expand the options and avoid the use of

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[173] See "Consultation on proposals to extend mental capacity legislation to the criminal justice system in Northern Ireland: Report on Responses and Way Forward" (Belfast: Department of Justice, 2013).

[174] "A Comprehensive Legal Framework for Mental Health and Learning Disability" (Belfast: The Bamford Review of Mental Health and Learning Disability (Northern Ireland), August 2007).

[175] McCallion and O'Hare "A New Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland: An Analysis of the Current Proposals" (*Journal of Mental Health Law*: 2010, 84) at page 85. See Delivering the Bamford Vision: The Response of Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability" (Belfast: Northern Ireland Executive, June 2008) and "Legislative Framework for Mental Capacity and Mental Health Legislation In Northern Ireland: A Policy Consultation Document" (Belfast: Department of Health, Social Services and Public Safety, January 2009).

[176] "Consultation on proposals to extend mental capacity legislation to the criminal justice system in Northern Ireland: Report on Responses and Way Forward" (Belfast: Department of Justice, 2013) at page 3.

police stations for this purpose.[177] The DOJ also indicated that the current choices available to the courts in disposal would be retained in the new Bill, but that "capacity would be one of the issues to be taken into account".[178] The DOJ also committed to additional community based sentencing options and the creation of powers for either the courts or a tribunal to transfer a detention order into a community order.[179] The DOJ indicated that where a person was considered to lack capacity the person could be transferred or detained in hospital for treatment. However, where the person had capacity their consent to treatment would be required. From the perspective of diversion there was a clear commitment to increasing "opportunities for diversion away from the formal criminal justice process will be developed across police, court and prison stages".[180] In the absence of the legislation it is difficult to assess the implications of the fused approach from the perspective of diversion. Nonetheless there is a clear commitment to the retention of statutory powers that facilitate diversion and to develop the community based sanctions.

9.1. Difference Between Mental Health Laws and Guardianship Laws

Given that the approach proposed to guardianship legislation and mental health laws is a divergent approach this section considers the case for the merger. Guardianship laws respond to persons who are considered to have problems making decisions or perhaps more accurately are considered to have impaired decision-making. Mental health laws on the other hand specifically respond to persons who are considered to have MHPs and who are considered to pose a risk to themselves and others. Another key difference between guardianship laws and mental health laws manifest in respect of the powers relating to emergency intervention. While mental health laws in many jurisdictions empower police officers and other public officials to enter the home of persons suspected of posing risk to themselves or others, and force them to attend a medical setting for assessment for detention and treatment guardianship laws generally do not have corresponding

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[177] *Ibid*.

[178] *Ibid*, at page 4.

[179] *Ibid*.

[180] *Ibid*.

coercive provisions.[181] A more informal process is engaged in respect of emergency situations arising for persons who lack capacity and are being dealt with under guardianship. The less coercive guardianship approach is explained in that a person lacking mental capacity is more likely to comply than resist intervention, as opposed to persons being subject to mental health legislation.

9.2. Arguments for and Against the Fusion of Mental Health and Guardianship Laws

Dawson and Szmukler argue for the fusion of mental health and guardianship laws as they consider that law should respond to a question of lack of capacity in the same manner, regardless of the reason for the perceived lack of capacity.[182] They also argue that the criteria of a lack of capacity should be met in order for intervention to occur.[183] Another suggested benefit of a fused approach is that it would address the discriminatory approach of having a separate legislative substitute decision-making framework for persons with MHPs. When a person is considered to have lost the capacity to make decisions under the fused approach, the substitute decision-making power would shift from a public official to a family member or a trusted person (provided that these natural supports are present) or to a guardian as a last resort.[184] It is suggested that this would be a positive development in promoting "the dignity and autonomy of the person who loses capacity because of mental illness, as in many instances the substitute decision-maker would be a close and trusted person rather than an unfamiliar doctor at a psychiatric hospital".[185]

Separate mental health laws and guardianship laws serve to institutionalise the notion that mental illness requires coercion and

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[181] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010), at page 86.

[182] Dawson and Szmukler "Why Distinguish "Mental" and "Physical" Illness in Involuntary Treatment?" in Freeman and Goodenough (eds) *Law, Mind and Brain* (Farnham: Ashgate, 2009) at pages 174 – 175.

[183] *Ibid*.

[184] *Ibid*.

[185] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 87.

control. In that regard even though mental illness and social control are theoretically and practically different the separate approach results the intertwining of both concepts. Campbell does not argue against the use of preventative detention rather he argues for an equal application of the rules.[186] Richardson has suggested that the discrimination persons with MHPs have experienced could be avoided if "mental health care could be provided according to the same principles, including respect for patient, autonomy, as those which cover all other forms of health care".[187] The presence of separate mental health laws to guardianship laws serves to single persons with MHPs out and that basing the legislation on different sets of principles means that "mental disorder will be regarded as more threatening and its pariah-status will thus be reinforced".[188]

One of the main arguments in support of separate laws is that mental health laws represent special measures that promote the best interests of persons with MHPs. As such mental health laws are not discriminatory and "do not infringe the equal protection and non-discrimination provisions in domestic and international human rights charters."[189] In that regard "special measures" are necessary to respond to persons with MHPs, as "mental illness is different to most other forms of disability because it is sometimes accompanied by a lack of awareness of impaired functioning".[190] Therefore, this difference justifies separate mental health laws, which after all seek to help persons by acting in their "best interests" in involuntarily detaining and treating them. Peay points out "in the tussle between autonomy and coercion, a short period of coercion may be a precursor to a long period of autonomy".[191] The other argument that has been identified opposing fused legal capacity and mental health legislation is that the safeguards that have been developed over many decades and

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[186] Campbell "Mental Health Law: Institutionalised Discrimination" (*Australian and New Zealand Journal of Psychiatry*: 28, 1994, page 554) at page 556.

[187] Richardson "Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions" (*Modern Law Review:* 2002, 65, 450).

[188] *Ibid*, at page 459.

[189] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 90.

[190] *Ibid*.

[191] Peay (ed) *Seminal Issues in Mental Health Law* (Aldershot: Ashgate, 2005) at page 199.

generations of mental health law could be undermined if legal capacity laws as opposed to mental health laws were used to involuntarily detain and impose treatment on persons with MHPs.[192]

The fusion approach is very problematical in the guardianship paradigm as it may result in vesting what has been the power of the states to impose detention and coercive treatment to a single person (EG the guardian) who will normally either be a family member or trusted person or where such a person does not exist a third party appointed under guardianship laws, to exercise the functions of a guardian. Vesting power in a guardian raises fundamentally important issues with regards to the "liberty and bodily integrity" and there is a need for independence and transparency in the decision-making processes around involuntary detention and forced treatment, which is the hallmark of modern robust mental health legislation.[193] The same level of safeguards is not provided for under guardianship legislation. It also suggested "guardianship laws lack the necessary process provisions to respond effectively to the circumstances in which some people with a mental illness come to the attention of police and ambulance services".[194] Mental health laws generally have detailed provisions to deal with emergency situations where a person with a MHP is experiencing a crisis, while guardianship laws tend not to have corresponding provisions. It is also identified that a problem with fusing mental health law and guardianship laws is that guardianship laws are generally triggered when some one is considered to lack capacity. This it is suggested "may not be an effective means of providing assistance in some cases involving people with a mental illness".[195] If there is a debate as to the capacity of the person to make decisions for themselves as is often argued in respect of persons with MHPs, the provisions under guardianship laws to resolve disputes as to the persons capacity "may be too slow and awkward to permit timely clinical intervention in many cases".[196]

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[192] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 91.

[193] *Ibid*.

[194] *Ibid*.

[195] *Ibid*.

[196] *Ibid*.

The other main argument opposing a fused approach is that persons acting as a guardian are required under the legislative framework to act in the best interests of the person and also to consider the persons own views. It is foreseeable that this is problematical, as the guardian may be pressurised by clinical mental health professionals to make decisions on the person's behalf that are at odds with the persons "will and preferences" and the paradigm shift required by Article 12 of the CRPD.[197] The guardian who is often a family member or family friend will make decisions in the person's best interests based on clinical advice. It is suggested that this is "a recipe for conflict" with the "on-going relationship between a friend or relative who accepts appointment as a guardian and the represented person may be irrevocably damaged in these circumstances".[198]

The main arguments put forward opposing the fusion of mental health laws and legal capacity laws are based on more practical concerns on how guardianship law can accommodate the needs of persons with MHPs rather than on any substantive ideological opposition to the rationale for fusing the legislative frameworks. Those practical oppositions are less defensible as the CRPD requires a radical overhaul of guardianship laws. At a conceptual level the fusion debate is a dead one in light of the statements of the OHCHR and those of the Committee on the Rights of Persons with Disabilities that Article 14 of the CRPD requires the abolition of mental health laws.[199] However, given that State Parties to the CRPD have not begun the process of decommissioning mental health laws and guardianship laws (based on mental capacity and substitute-decision making) the notion of fusion may have some currency. That currency may have most value if the fused law are based on supported decision-making, that complies with Article 12 of the CRPD. The positive elements of non-coercive guardianship law, which may be more susceptible to supported decision-making, could filter less coercive and restrictive approaches into provisions relating to persons with MHPs. The law reform required by Article 12 provides a unique opportunity to critically review mental health laws and guardianship laws. A guardianship system that

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[197] See Chapter 2: Literature Review, Part 2.

[198] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010), at page 92.

[199] See Chapter 2: Literature Review, Part 2.

embraces supported decision-making system (even incrementally) may ensure that the rights of persons with MHPs could be bolstered in a fused legislative regime.[200]

Despite the strong arguments in favour of fusing mental health and legal capacity laws there has been a failure to achieve the goal in jurisdictions where there was an opportunity to fuse legislative regimes.[201] It has been suggested that the failure to implement the fusion proposal in England and Wales indicates that it will only succeed "if consensus can be reached among a coalition of consumers, clinicians, carers and human rights lawyers who are able to persuade the broader community that the suggestion is fair and workable. That consensus may not be easily given the struggles that invariably accompany attempts to rewrite mental health laws".[202] The fusion of mental health laws and legal capacity laws might go some way towards addressing the requirements of Article 14 of the CRPD provided that the "paradigm shift" in thinking and recognition of "universal legal capacity" is embedded and involuntary detention and forced treatment are not a part of the legislative framework. The suggestion that permitting "the concurrent operation of mental health and guardianship laws, so that either statutory regime may be used to authorise involuntary detention and treatment (in hospital or in the community) of persons with a mental illness … unable to consent to their own treatment" will be insufficient to address the requirements of the CRPD.[203]

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[200] In relation to the concerns with under developed emergency provisions to respond to the needs of a person with a MHP there is potential to address these through determining a persons "will and preferences" in advance of a crisis and advance planning through advance directives. The concern expressed in relation to the need to have a lack of capacity as a trigger for guardianship laws and how this would not apply to persons with mental health laws becomes redundant under supported decision-making as the notion that a person ever lacks capacity is promoted by Article 12 of the CRPD.

[201] Daw "Mental Health Act 2007: The Defeat of the Ideal" (*Journal of Mental Health Law*: 2007, 131).

[202] Rees "The Fusion Proposal: A Next Step" in McSherry and Weller (eds) *Rethinking Rights-Based Mental Health Laws* (Oxford: Hart Publishing, 2010) at page 92.

[203] *Ibid*.

10. Unfitness to Plead Reform in NI

The insanity defence in NI is governed by the *Criminal Justice Act (Northern Ireland) 1966*. The Law Commission for NI is examining reform of this area of law as part of its second programme of law reform.[204] It will be interesting to see the approach adopted by the Commission as the DOJ's reference of the issue to the Commission specifically requests an examination of the "legal defence and its appropriateness in light of changes in mental health and capacity legislation and modern psychiatric thinking".[205] The approach of the Commission will no doubt be informed by its recent work on "unfitness to plead".[206] The approach of the Commission to the issue of unfitness to plead is relevant here as it is based on reforming the law to reflect the conception of mental capacity as provided for in guardianship legislation.

Unfitness to plead is currently governed by a mixture of common law and statute in NI. However, the substantive law setting out the criteria for unfitness to plead is governed by common law and has no statutory basis.[207] Part III of the *Mental Health (Northern Ireland) Order 1986* sets out the procedural process around a person's fitness to plead and determines whether they have carried out the act or made the omission that is subject to the criminal offence. The Commission discussed the judgments in *R v Moyle*[208] and *R v Diamond*[209] and concluded that the *Pritchard* test is "problematic if it is being applied to individuals who are experiencing mental illness with a delusional aspect".[210]

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[204] See "Northern Ireland Law Commission's Second Programme of Law Reform (2011-2015)" (Belfast: Law Commission, 2011).

[205] *Ibid.*

[206] "Consultation Paper: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC13, 2012). The consultation period on unfitness to plead ended on 19 October 2012 and the report was published in 2013 see "Report: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC16, 2013).

[207] "Consultation Paper: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC13, 2012), at page 20.

[208] [2008] EWCA Crim 3059.

[209] [2008] EWCA Crim 923.

[210] "Consultation Paper: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC13, 2012) at page 33.

The Law Commission for England and Wales in its recent work considered whether a mental capacity test set out in the *Mental Capacity Act 2005* should be used to replace the current test for fitness to stand trial as developed in the common law. It is noteworthy that the Law Commission for NI was specifically requested by the DOJ under the terms of the reference of the project to consider replacing the *Pritchard* test with a test "based on mental capacity".[211] The Law Commission in its Consultation Paper referenced a number of sources that advocated for a mental capacity approach to assessing fitness to plead.[212] As discussed in Chapter 4: England and Wales the Law Commission for England and Wales provisionally recommended that the mental capacity test contained in the *Mental Capacity Act 2005* should replace the *Pritchard* test. Its rationale was that *Pritchard* was overly focused on the intellect of the accused person. This was considered unfair as persons with MHPs were deemed fit to stand trial, with no consideration of their decision-making ability, which raised concern about the right to a fair trial under Article 6 of the ECHR. This approach is problematic from the perspective of the CRPD in serving to restrict the legal capacity of the defendant considered to have reduced mental capacity.

In its Consultation Paper the Law Commission formed the view that in criminal proceedings it is impossible to take the civil law approach that applies the mental capacity test to each decision that a defendant has to make.[213] In particular, the Commission considered that the approach would not be feasible to apply to all of the decisions that would need to be made in the context of a trial. It was also identified that it would be difficult to determine how the trial should proceed if the functional approach was taken and it was decided that the defendant had capacity to make some decisions but not others. The Commission considered that if the mental capacity approach were to be applied to the issues of fitness to plead it would be necessary to modify the approach for criminal proceedings. The NI Commission concurred with the Law Commission for England and Wales that it

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[211] *Ibid*, at page 33.

[212] Scott-Moncrieff and Vassall-Adams "Yawning Gap" (*Counsel*: 2006, 14) at peg 15 and Brookbanks and Mackay

[213] "Consultation Paper: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC13, 2012) at page 40.

would be necessary to identify a number of key decisions that an accused person is required to make.[214] The mental capacity test would then have to be applied to decision "not as a single determinations, but as part of a whole".[215] Therefore, if an accused person was assessed as being able to make one or more of the identified decisions they would be deemed fit to plead, conversely, if they were assessed as unable to make one or more of the decisions they would be considered unfit to plead.[216]

The Commission in its Report ultimately decided that the *Pritchard* test ought to be modified so that the language used in the test reflected the language of the *Mental Capacity Act 2005*.[217] As such the Commission requires that the accused person ought to be assessed to determine that because of "an impairment or disturbance in the functioning of his or her mind or brain to be unable to understand the charges brought against" them or follow the course of the proceedings and make decisions that they would be required to make in relation to the trial.[218] This test is based on a functional approach. The defendant would be "required to make the identified decisions during the trial and will have to be able to understand the information relevant to the decision, retain that information, use or weigh the information as part of the decision-making process and communicate any decision".[219] The Commission while recognising that a determination of unfitness to plead on the basis of "ill-health or disability", may result in "unequal treatment between those who are deemed to be unsuited to the trial process and those who are so suited".[220] Nonetheless the Commission considered

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[214] *Ibid*, at page 41.

[215] *Ibid*.

[216] The Law Commission for NI provisionally decided that the "disaggregated" approach was neither workable or undesirable and opted for an assessment of decision-making that would be required during the course of the trial and called for submissions on its provisional recommendation.

[217] "Report: Unfitness to Plead" (Belfast: Northern Ireland Law Commission, NILC16, 2013) at page 51.

[218] *Ibid*, at pages 51-52. The Commission identified the following areas where a defendant would have to make decisions in relation to their trial "deciding whether to plead guilty or not, exercising the right to challenge jurors, instructing solicitors and counsel and giving evidence in his or her own defence" (at page 52).

[219] *Ibid*.

[220] *Ibid*, at page 86.

that the unequal treatment could be strongly defended.

The other recommendation of note relates to current demarcation in the law on "unfitness to plead" in the lower Court and the Crown Court, which the Commission considered ought to be bridged. The Commission acknowledged that while its recommendation would impact practice and procedure, it considered that the number of unfitness cases would be small as the numbers in the Crown Court in NI are small and as such it would be "surprising if the numbers were significantly large".[221] There is potential for unintended consequences and that a test for fitness based on an assessment of mental capacity could see significant numbers of persons being determined unfit for trial. That would be positive if the net result is diversion and connection to supports and services in the community. However, the approach is problematical from the perspective of the CRPD and the implications for the recognition of universal legal capacity (Article 12).

11. Conclusions

In line with the experience in other jurisdictions the prevalence of defendants and offenders with MHPs in the criminal justice system presents significant challenges. There is a recognition that the mental health legislation is outmoded and in need of reform in NI in order to facilitate diversion. However, the Bamford Review acknowledged that the courts in NI substantially underuse these potentially useful disposal options. In particular, there is an underuse of probation orders. Despite the criticisms of diversion in NI when compared to Ireland the diversion provisions, processes and initiatives are much more developed and have great potential for future development and expansion. The Bamford Review and "A Vision for Change" represent ambitious plans for the development and modernisation of mental health services both north and south of the border. Unfortunately both plans have faced significant barriers in implementation of their core recommendations. There may be potential to develop North South cooperation to propel implementation in both jurisdictions. When the Regional Forensic Network is eventually established in NI it should create links with the National Forensic Mental Health Service based in Dublin.

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[221] *Ibid*, at page 93.

The MDO Scheme has operated in Belfast for many years and there is evidence to show that it operates effectively. There is potential to connect new forensic and community mental health services to police stations throughout Ireland as a way of facilitating diversion and connecting persons to services in the community. Such an approach would realise the rights of persons with MHPs and ID, living in the community. There is no liaison service to support the work of the courts in NI in diverting defendants and offenders with MHPs and ID. The lack of a liaison services has resulted in a very passive role for the courts in NI, in requesting few psychiatric and psychological reports. The result is that defence solicitors commission the majority of reports, provided that they have the skills to identify that their client may have a MHP or ID.

The literature in NI reveals an absence of provision of services or supports for persons with personality disorder. The Bamford Review recommended the development of forensic mental health services and for persons with ID. It was envisaged that these services would facilitate diversion. While there has been some development the failure to develop the range of services has restricted the development of diversion. The increasing prison population and the vulnerability of offenders with MHPs to indeterminate sentencing is of particular concern.

The literature exploring the experiences of persons with ID in the NI criminal justice system is limited. There is no available data on the number of persons with ID interacting with any of the policing organisations or processed through the courts. However, persons with ID are entitled to benefit from diversion from prosecution in line with the policy discussed above. There is a range of procedural accommodations for defendants with ID such as the appropriate adult scheme. However, there is a need to develop greater diversion for defendants and offenders with ID in NI. It is envisaged that the development for forensic mental health services for persons with ID and community services as recommended by Bamford will facilitate greater diversion through the creation of a range of options for disposal from prison.

NI is attempting an ambitious, wide ranging reform of mental health services and corresponding law and policy. Part of that law reform

process is the development of a single legislative framework to encompass mental health and mental capacity provisions. Kerzner identified it is a difficult prospect to reform capacity law and mental health law simultaneously, particularly as the reform of mental health law can be very contentious.[222] It is unclear how this fused approach will impact upon diversion. However, it is promising that the consultation documents on the fused legislation are committed to community disposal and enhancing the potential for diversion at different points in the criminal justice system. The underdevelopment of diversion in NI corresponds with a failure to provide sufficient investment in mental health services in NI. In particular, a lack of provision for adequate staffing in prison was identified as a significant issue. Resources will have to be committed to realise the commitments to diversion.

The approach advocated by Bamford and now the NI Executive in pursuing a fused legislative framework is human rights based. The Bamford Review finished its work as drafters of the CRPD concluded theirs. Unfortunately, this overlap did not provide Bamford with the opportunity to examine its recommendations through the prism of the Convention to any great degree. The approach based on a mental capacity / functional approach will need to be reconsidered if the new legislative framework is to comply with Article 12 and Article 14 of the CRPD. The NI Law Commission's recommendations on unfitness to plead are also inconsistent with Article 12 of the CRPD. It is conceivable that the proposed application of the test of mental capacity to offenders with MHPs will result in restricting their legal capacity and decision-making. The trend in embedding the mental capacity approach to criminal law is evident in NI. This is at odds with the CRPD and provides further evidence that the CRPD is not impacting the law reform process at the national level. This is also evidenced in that there was not even a single reference to the CRPD and the implications of Article 12 for the law on fitness to plead in the Law Commission's work.

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[222] See "The Canadian Perspective on Legal Capacity Law and Supported-Decision Making" (Dublin: Looking Globally, Legislating Locally: The Irish Legal Capacity Bill, Amnesty International, 3 April, 2012).

The reluctant acceptance of the NI Executive that the single legislative framework will need to meet the needs of persons in the criminal justice system is of note. While the rights based approach in the legislation is essentially positive, seeking to augment decision-making, it is at odds with the other provisions relating to offenders with MHPs most notably provisions on indeterminate sentences that invariably impact offenders with MHPs. These "disability neutral" provisions demonstrate how the criminal law is *prima facie* non-discriminatory but can have very real indirectly discriminatory effects on offenders with MHPs.

Although the law reform process in NI has been painstakingly slow in developing modern mental health services and coming forward with new legislation as envisioned in Bamford, the process is a meaningful one. There is a huge investment in the process not only amongst the relevant Government Departments and agencies but also amongst service users, legal professionals, and medical professionals. The conclusion of the Bamford Review in 2007 has given the DHSSPS and the DOJ an opportunity to take ownership over the development of the legislation and the development of services. This sense of ownership perhaps in the long run will result in implementation of the Bamford recommendations.

Chapter 7: Australia

1. Introduction

As discussed in the introduction to this thesis Australia was selected as a comparator jurisdiction as there has been a significant amount of research and policy formation on persons with MHPs and ID involved in the criminal justice system.[1] The purpose of this chapter is to examine innovative diversion provisions, processes and initiatives and their potential application in Ireland. In particular, this chapter critically discusses the trend across Australia of developing mental health courts in response to the over-representation of persons with MHPs in the Australian criminal justice system. Australian law and policy on responding to offenders with MHPs and ID has been heavily influenced by therapeutic jurisprudence and this philosophy is embedded with the diversion programmes that have been developed in Australia since the 1990s.

2. Background: Diversion in Australia

In Australia there is evidence that persons with MHPs are over-represented in the prison population.[2] Studies that examined the prevalence of MHPs amongst prisoners in different parts of Australia reported that prisoners have a much higher prevalence of MHPs when compared to the general population.[3] While there is a much richer literature exploring the prevalence of persons with ID and MHPs in the criminal justice system in Australia the available data nevertheless paints an incomplete picture.[4] In determining whether there was an over-representation of persons with MHPs and ID in prison the New South Wales Law Reform Commission (NSWLRC) in its work on diversion sought to specify the prevalence against a baseline of

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[1] There is a significant amount of literature on diversion of juveniles and Aboriginal and Torres Strait Island persons with MHPs and ID from the criminal justice system. This literature falls outside the scope of this thesis and is not considered in this chapter.

[2] See Wallace, Mullen, Burgess, Palmer, Ruschena and Browne "Serious Criminal Offending and Mental Disorder: Case linkage study" (*British Journal of Psychiatry*: 172, 1998, pages 477-484).

[3] For example see Butler, Allnutt, Cain, Owens and Muller "Mental disorder in the New South Wales prisoner population" (*Australian and New Zealand Journal of Psychiatry*: 2005, 39, 2005, pages 407-413) and Butler, Andrews, Allnutt, Sakashita, Smith and Basson "Mental disorders in Australian prisoners: A comparison with a community sample" (*The Australian and New Zealand Journal of Psychiatry*: 2006, 40, 2006, pages 272-276).

[4] See "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 47.

prevalence in the community, concluding that there was an over-representation.[5]

In Australia the federal criminal justice system in the different States and Territories have taken different approaches to defendants and offenders with MHPs and ID. Under the federal system the six States and two Territories have different mental health and criminal justice systems. These different systems have led to separate approaches and have resulted in "a great deal of discrepancy in options for offenders with mental illnesses".[6] As Richardson and McSherry note, "health courts and diversion programs for offenders with mental illnesses are a relatively recent innovation in Australia" with the first scheme introduced in 1999.[7] The "Hobart Mental Health Diversion List" commenced in the Magistrates Court of Tasmania in 2007 as a pilot programme.[8] Victoria and Western Australia have also introduced a court-based model of diversion. Queensland, Tasmania, South Australia and Victoria also use mental health courts. The Queensland Mental Health Court differs in its design to the courts used in the other jurisdictions. Some of the diversion programmes in Australia facilitate diversion prior to conviction while others do not.[9] There is provision in Australia for judges and magistrates to make hospital orders as an alternative to a sentencing a person to a term of imprisonment.[10] Mental health courts and other diversion initiatives will be discussed in greater detail below.

Australia has developed numerous programmes that seek to divert offenders with MHPs from the criminal justice system through pre-offending interventions, pre-arrest and arrest interventions, court-linked

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[5] *Ibid*, at page 50. However, the Commission identified significant gaps in the available data.

[6] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257).

[7] *Ibid*, at at page 250. The first court was the Magistrates Court Diversion Program, which was established in South Australia in 1999, this will be discussed in greater detail below.

[8] *Ibid*.

[9] See Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) and Richardson "Mental Health Courts and Diversion Programs for Offenders with Mental Illnesses: The Australian Context" (Vienna: Paper presented at the 8th Annual International Association of Forensic Mental Health Services Conference, 2008).

[10] These orders are similar to the provisions in England and Wales and NI and Scotland.

interventions and corrections-based interventions.[11] Pre-offending interventions are generally community based and involve police, clinical and social support services and communities working together with a view to facilitating access to supports for persons with mental problems and ID, sometimes prior to the commission of an offence where an elevated risk of contact with the criminal justice system is identified.[12] Pre-arrest and arrest interventions are also used by police, and emergency services and mental health services with a view to ameliorating responses to mental health crises. These initiatives also involve non-crisis situations and include use of police cautions/warning, discretionary powers to prosecute, police bail and referrals to supports and services.[13] Court-linked interventions involve situations where a person has been charged with a criminal offence and are facing court proceedings. These interventions seek to inform the court about the offenders' MHP and take a problem solving approach that reduces the offending and improves the well being of the defendant.[14] Corrections-based interventions occur after a person has been convicted and sentenced for an offence. These measures typically involve prison-based transition programmes and community corrections. The objective of these types of programmes is to address the risk factors for future offending.[15] Therefore, unlike Ireland it is clear that there are many different methods and processes available in responding to persons with MHPs and ID embroiled in the criminal justice system at different points in the criminal justice system.

Effective diversion of persons with MHPs and ID from the criminal justice system requires the identification of persons meeting the eligibility criteria for diversion, as such assessment services are an essential part of the diversion framework.[16] Due to the variety of different models for court assessment and support provisions it is

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[11] See "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Melbourne: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010).

[12] *Ibid*.

[13] *Ibid*.

[14] *Ibid*.

[15] *Ibid*.

[16] See Chapter 2: Literature Review, Part 1.

difficult to describe these models in a concise or coherent way.[17] This is made increasingly complicated as processes change as they seek to respond to external and internal demands.[18] The NSWLRC divided the different approaches to assessment and court support offered to defendants in Australia into 3 categories.[19] The first, described as "assessment and advice" involves court support personnel (normally mental health professionals) undertaking clinical assessments with a view to determining whether a person has some sort of impairment. This is very much based on a medical model approach to defendants with professionals assessing and then reporting back to the court using these assessments to inform the court about the support and ability of the person to "make effective and well-informed decisions regarding the best outcome for the individual".[20]

The second category identified by the NSWLRC is case management.[21] The case management model in Australia seeks to address the complex needs of persons with MHPs and ID, through "coordinated, multi-disciplinary team-based approach to assessment and referral of clients to services".[22] Case management involves linking persons to a range of support services (EG drug and alcohol treatment, accommodation and health services). Case management and support operates normally on an on-going basis. The assessment also extends to evaluating the persons individual impairment and personal circumstances, in addition to "their progress or engagement in requisite services".[23] The third model identified by the NSWLRC is the court intervention model, which it considered to be the model that involves the "closest collaboration between the criminal justice system and court support staff".[24] The court intervention model is essentially a mental health court that takes a

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[17] *Ibid*.

[18] "Court-based Mental Health Diversion Programs" (Australian Institute of Criminology, Research in Practice Tipsheet, 20 2011) at page 2.

[19] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 176.

[20] *Ibid*.

[21] *Ibid*.

[22] *Ibid*.

[23] This feedback assists the court to making decisions relating to the defendant.

[24] See "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012).

problem solving approach that includes a dedicated judge and dedicated court intervention team. As discussed below most Australian states offer court support services in the different forms outlined above.

3. Diversion: The Australian Context

In comparison to Ireland there are a significant number of diversion provisions, processes and initiatives in operation. However, there is a clear desire by policy makers to extend programmes, particularly through the use of the mental health court model. The Australian Senate Select Committee on Mental Health produced a Report in 2006 that made a number of recommendations on mental health and the criminal justice system.[25] It is interesting that the Committee recommended that there should be "a significant expansion of mental health courts and diversion programs, focused on keeping people with mental illness out of prison and supporting them with health, housing and employment services that will reduce offending behaviour and assist with recovery."[26] The other recommendations contained in the Committee's final report included placing responsibility for the decision to release forensic patients with mental health courts or mental health tribunals within each State and Territory in Australia.[27]

In addition the Report recommended that Australian "State and Territory governments aim as far as possible for the treatment of all people with mental illness in the justice system to take place in forensic facilities that are physically and operationally separate from prisons, and incorporate this aim into infrastructure planning".[28] Importantly the Committee also recommended that the Australian State and Territory governments review their funding for prescription medicines and medical care. This was recommended to achieve an equivalence of care between care received in the community and in the prison and to eliminate "anomalies and differences in quality of care".[29] The

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[25] "A National Approach to Mental Health from Crisis to Community: Final Report" (The Australian Senate Select Committee on Mental Health, 2006).

[26] *Ibid*, at page 20.

[27] *Ibid*.

[28] *Ibid*. In that regard it was suggested that the Thomas Embling Hospital in Victoria be used as a model for such facilities to be used by the Territories and States.

[29] *Ibid*.

Committee recommended "… governments establish protocols for mental health assessments for prisoners on entry into the criminal justice system" and that the states set up "separate dedicated forensic mental health facilities for women with a number of beds that reflects the prevalence of women with mental illness in prisons".[30] In addition the Committee made a number of recommendations in identifying best practice models of forensic mental health care. In that regard it was recommended that the State and Territory governments take "into account best practice models, substantially increase the provision of step-down supported accommodation programs to facilitate reintegration into the community following release from incarceration and forensic facilities."[31]

However, Richardson and McSherry have commented the rationale underlying the recommendation to establish more mental health courts was not set out in the Senate's Report.[32] This is of concern as "the information available within Australia about mental health courts and diversion programs is … scant".[33] The expansion of problem-solving courts, including mental health courts has been a trend in North America and in other common law jurisdictions over the past two decades.[34] However, there is no definite consensus as to whether problem-solving courts such as mental health courts actually achieve their goals.[35] Richardson and McSherry have identified "a presumption that mental health courts reduce the prison population and recidivism by diverting the offender to appropriate treatment".[36] In that regard the "authority of the judge and structure of the court can be used to promote change, healing and well-being by encouraging the person to engage with treatment".[37] The appeal of mental health courts in

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[30] *Ibid*, at page 21.

[31] *Ibid*.

[32] See Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 252.

[33] *Ibid*, at page 253.

[34] See Chapter 2: Literature Review, Part 1.

[35] See Freiberg "Problem-oriented courts: An update" (*Journal of Judicial Administration*: 14, 2005, pages 196-219).

[36] *Ibid*.

[37] *Ibid*.

Australia is that they facilitate a collaborative approach between mental health providers, the courts and providers of other social services.[38] This approach ensures that mental health providers are more accountable to the court for the provision of services.[39] However, it is worth noting that this collaborative approach can be achieved by other means also.[40]

In NSW there has been much focus on improving diversion. Government policy in NSW seeks to employ the use of diversion programmes as a priority action under its policy "NSW 2021: A Plan to Make NSW Number One".[41] The NSWLRC in its review of diversion endorsed diversion, highlighting the positive therapeutic benefits diversion yielded. Drawing on the available literature on diversion the NSWLRC was very much influenced by the therapeutic jurisprudence philosophy of addressing the needs of "people with cognitive and mental health impairments in the criminal justices system" and the rewards associated in terms of reductions in offending.[42] In addition the NSWLRC recognised the vulnerability of persons with MHPs and ID in the criminal justice system and endorsed diversion as addressing the impact on their "welfare and well-being" brought about as a result of imprisonment.[43]

The NSWLRC considered that a person's impairment "may result in reduced culpability" following from which it was suggested that the application of "traditional criminal law processes and penalties" were potentially "unfair or inappropriate".[44] The NSWLRC endorsed diversion also on the premise of intersectionality, namely that such persons "face multiple social disadvantages that make them more likely

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[38] Blagg "Problem-oriented Courts: A Research Paper Prepared for the Law Reform Commission of Western Australia" (Perth: Government of Western Australia, 96, 2008).

[39] *Ibid*.

[40] See Chapter 2: Literature Review, Part 1.

[41] See "NSW 2021: A Plan to Make NSW Number One" (Sydney: NSW Government, 2011). This is a 10 year plan to rebuild the NSW economy, reinstate quality services, renew infrastructure, restore accountability to government, and strengthen local environment and communities.

[42] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 29.

[43] *Ibid*.

[44] *Ibid*, at page 28.

to offend" resulting in embroilment in a "cycle of offending and incarceration".[45] The NSWLRC considered that diversion could play a role in to breaking this cycle and that traditional criminal justice mechanisms were unlikely to be as successful, given that diversion facilitates rehabilitation and prevents future offending through a problem-solving approach.[46]

The NSWLRC used human rights arguments to bolster their support for diversion.[47] For example, it was of the opinion that the CRPD and the MI principles necessitate diversion.[48] It also noted that Article 5 of the CRPD, which provides for a general right of equality and freedom from discrimination, including a guarantee that parties to the Convention will take all appropriate steps to ensure the provision of reasonable accommodation to achieve equality was relevant.[49] The NSWLRC considered that Article 13 of the CRPD, which provides for a right to effective access to justice (for PWDs on an equal basis with others), is relevant as is Article 14 (right to liberty and security of person and the right not to be arbitrarily or unlawfully deprived of liberty.[50] Interestingly, it considered that the obligation to reasonably accommodate is aligned with "the implementation and use of diversionary schemes".[51] However, the NSWLRC's analysis fell short in not discussing the divergences and conflicts between the traditional understanding of human rights law as applied in the field of mental health and the evolving understanding discussed of Articles 12, 14 and 17.[52]

Richardson and McSherry have suggested that in Australia there "is the possibility that diversion programs may have a negative impact on the lives of offenders with mental illnesses".[53] Diversion programmes in

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[45] *Ibid*.

[46] *Ibid*.

[47] *Ibid*, at pages 32-33.

[48] See Chapter 2: Literature Review, Part 2.

[49] *Ibid*, at page 33.

[50] *Ibid*. See Chapter 2: Literature Review, Part 2 for a discussion of the CRPD and diversion.

[51] *Ibid*.

[52] *Ibid*.

[53] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental

increase involvement of a defendant with the criminal justice system, as participation in the programme extends the length of contact.[54] This will be evident from the discussion below of the different programmes operating throughout Australia. Participation in all of the court-based programmes requires a lengthy period of supervision by the court and regardless of a person's compliance with programme they generally have to return to the court for disposal of the offences they were originally charged with. A number of user and survivor groups oppose specialised programmes for offenders with MHPs. The World Network of Users and Survivors of Psychiatry has suggested in their review of the Standard Minimum Rules (SMR) that the "The SMR should prohibit the diversion of people with psychosocial disabilities into medical supervision and control at any stage of detention or proceedings under the criminal law – trials, sentences and parole should be handled on an equal basis with others, as criminal rather than medical matters."[55] Roberts and Indermaur have similarly made the point that marking persons with MHPs for specialised programmes may be discriminatory and could serve to widen the net of involvement of participants in the criminal justice system.[56]

Richardson and McSherry raise the important issue of examining why persons with MHPs in contact with the criminal justice system have not engaged with mental health services.[57] It is not clear whether barriers prevent access to treatment or whether "the stigma in accessing treatment" prevented people from seeking treatment, or whether the available services were services that the person did not want.[58] It has also been suggested that while "the perception may be that the aim of

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Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 254.

[54] Roberts and Indermaur "Timely Intervention or Trapping Minnows? The Potential for a Range of Net-widening Effects in Australian Drug Diversion Initiatives" (*Psychiatry*: 13(2), 2006, pages 220-231) at page 220. See also Chapter 2: Literature Review, Part 1 and Part 2.

[55] "WNUSP Submission on Revision of the SMR" (World Network of Users and Survivors of Psychiatry, 14 March 2011) at page 3.

[56] Roberts and Indermaur "Timely Intervention or Trapping Minnows? The Potential for a Range of Net-widening Effects in Australian Drug Diversion Initiatives" (*Psychiatry*: 13(2), 2006, 220-231) at page 220.

[57] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 255.

[58] *Ibid*.

a mental health court is to enable offenders with mental illnesses to receive treatment which they have not been able to access and are not already involved in the mental health system, this is not always the case".[59] In this regard the evaluation of the South Australian Diversion Program indicated very few clients were not involved with health and welfare services at the time they were referred to the programme.[60] The research indicated that 95.1% of the participants accepted onto the programme were already involved with service agencies.[61] It has been argued that this suggests that participants had to be referred to other agencies as part of their treatment plan and this may not be possible in all jurisdictions due to resources and the lack of choice around services.[62] In the case of the available services in South Australia and the high level of contact of service users with the criminal justice system this raises important questions about "what was going wrong".[63]

Questions have also being raised in relation to the effectiveness of mental health court programmes such as those in South Australia and Tasmania, as they run for short periods of six months or less (see below).[64] In that regard it has been suggested that expectations of what programmes can achieve need to be realistic and the provision of "after care is very important".[65] In that regard many of the mental health court programmes in the US run for much longer periods, such as the San Francisco Behavioral Health Court, where participation can be required for a number of years.[66] However, this poses significant human rights issues not least concern about the exercise of control and forced treatment in the community. Other criticisms of problem-solving mental health courts are important to note also. One

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[59] *Ibid*.

[60] Hunter and McRostie "Magistrates Court Diversion Program: Overview of Key Data" (Adelaide: Office of Crime Statistics, Information Bulletin, No. 20, July 2001) at page 10.

[61] *Ibid*.

[62] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 255.

[63] *Ibid*.

[64] *Ibid*.

[65] *Ibid*.

[66] See http://www.sfsuperiorcourt.org/divisions/collaborative/behavioral. <Last accessed 10 November 2013>

commentator suggested that mental health courts serve to supervise offenders with MHPs in a cost inefficient manner and that the role would be better carried out by a probation body.[67] Other commentators have suggested that a more mainstream approach to responding to offenders with MHPs would be preferential than a specialised approach.[68] In that regard it has been suggested that all courts should be provided with the power to impose alternatives to custodial sentences and to connect offenders to relevant services.[69]

4. Diversion: Policy Coherence in Australia

From the foregoing discussion diversion of persons with MHPs and ID is an established policy gaol in Australia. This is further evidenced by the National Justice Mental Health Initiative, which was established with a view to improving the identification, treatment and coordination of services to people with MHPs who come into contact with the criminal justice system in Australia. In 2008 a working group of representatives from each State and Territory was established to commence a project on diversion. Each working group representative collected and summarised the key reports released in their jurisdiction from January 2003 to March 2008.[70] The purpose of this audit was to bring together the latest research and policy developments in justice mental health to allow policymakers, practitioners and researchers to draw on the material more easily.[71] The Audit also identified priority areas in the justice and mental health arenas that require further work.

The second stage of the project involved the completion of a needs analysis of policymakers and identified gaps in availability of material relating to mental illness in the criminal justice system in Australia. The Justice Mental Health Initiative is currently working with Auseinet to consider how to make justice mental health research more accessible

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[67] Bozza "Benevolent Behavior Modification: Understanding the Nature and Limitations of Problem-solving Courts" (*Widener Law Journal*: 17(1), 2007, pages 97-143).

[68] See Chapter 2: Literature Review, Part 1 for a critical discussion of mental health courts.

[69] See Bamberger "Specialized Courts: Not a Cure-all" (*Fordham Urban Law Journal*: 30, 2003, pages 1091-1103).

[70] The material was then collated into one document for public release.

[71] "Justice Mental Health Audit 2003-2008" (National Justice Mental Health Initiative, National Justice Chief Executive Officers' Group, December 2008).

to policymakers, practitioners and researchers. The third stage of the project sought to develop guidelines for best practice diversion and support for persons with MHPs in contact with the criminal justice system. The Victorian Government DOJ developed a set of guidelines in 2010 entitled "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice".[72] These guidelines developed by the National Justice CEOs Group and aim to provide policymakers and diversion programme developers with guidance on an evidence-based approach in establishing diversion and support programmes.[73] While these guidelines do not present a consensus policy statement for all Australian jurisdictions they are very useful in taking evidence-based approaches to responding to offenders with MHPs in the criminal justice system and ensures that criminal justice policy in this area does not stagnate.

Richardson and McSherry have been critical of the lack of an evidence-based approach to the development of diversion programmes and processes in Australia.[74] They have stated that the "political reality is that problem-solving courts such as mental health courts and similar diversion programs are here to stay. Such measures are popular with the judiciary, governments and the public, perhaps because there is a feeling that "something" must be done to alleviate the problem of over-representation in prisons of offenders with mental illnesses".[75] The lack of an evidence-based approach to mental health courts has been noted elsewhere.[76] It has also been suggested that mental health courts have grown in popularity as a response to offenders with MHPs as the criminal justice system has failed to effectively deal with social problems.[77] However, despite a significant amount of enthusiasm for

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[72] "Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice" (Victoria: National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice, 2010).

[73] These guidelines were developed using a broad consultative approach with significant input from NGOs, government all other stakeholders from all over Australia (States and Territories).

[74] See Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257).

[75] *Ibid*, at page 253.

[76] See Redlich, Steadman, Monahan, Clark Robbins, and Petrila "Patterns of Practice in Mental Health Courts: A national survey"(*Law and Human Behavior:* 30, 2006, 347-362).

[77] Schneider and Heerema *Mental Health Courts: Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007), Blagg "Problem-oriented Courts: A Research Paper Prepared for the Law Reform

the potential of problem-solving mental health courts and other diversion programmes empirical research is required to validate and rationalise the development of similar programmes.[78]

It has been noted that while the evaluation of mental health courts and diversion programmes is crucial, evaluations for some programmes are carried out as an "afterthought".[79] Evaluations are not always planned as part of the establishment of a mental health court or diversion programme, and when carried out they are not done on an on-going basis.[80] It has been suggested that evaluations are not carried out on an "intensive" basis (EG longitudinal studies of outcomes), a failure that can eventually weaken their operation and expansion and ultimately could undermine the continuation of the programme.[81] The importance of systematic evaluations is essential as diversion programmes involve considerable expenditure of public monies, and this expenditure needs evidence to justify and support long-term funding.[82] However, even where evaluations in Australia have been carried out, they have tended either to focus on a cost-benefit analysis or on a review of programmes processes.[83] It has been suggested that process evaluations have been more common in Australia than outcome evaluations, which is unfortunate as outcome evaluations can identify whether a programme is meeting its objective(s).[84] Other problems with the evaluation of mental health courts and diversion programmes in Australia include difficulties in comparing

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Commission of Western Australia" (Perth: Government of Western Australia, 96, 2008) and Indermaur and Roberts "Drug Courts in Australia: The First generation" (*Current Issues in Criminal Justice*: 15, 2003, 136-154).

[78] Roberts and Indermaur "Key Challenges in Evaluating Therapeutic Jurisprudence Initiatives" (*Journal of Judicial Administration*: 17(1), 2007, pages 60-70).

[79] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 253.

[80] *Ibid*.

[81] *Ibid*.

[82] See Blagg "Court Intervention Programs: Consultation Paper" (Perth: Law Reform Commission of Western Australia, 96, 2008).

[83] Payne "Specialty courts in Australia: Report to the Criminology Research Council" (Canberra: Australian Institute of Criminology, 2005) at page 107.

[84] Ryder, Kraszlan, Lien, Allen, Chiplin and Petsos "The Western Australian Court Diversion Service: Client Profile and Predictors of Program Completion, Sentencing and Re-offending" (*Psychiatry*: 8(1), 2001, pages 65-75) at page 66.

programmes.[85] Much of the problems in this regard come from the esoteric nature of programmes, in addition to the complications in evaluating recidivism, and the inability to identify a randomly selected control group to match a comparable control group.[86]

5. Diversion: The Prominence of Therapeutic Jurisprudence in Australia

There is a "growing philosophical change around the role of the court system as playing a direct role in addressing social issues" in Australia.[87] For example, in *Lauritsen v The Queen*[88] Malcolm CJ of the Supreme Court of Western Australia referred to the rationale for diversion in the following way:

> "Although the Court must take cognisance of the offender's mental illness in assessing the appropriate punishment, when imprisonment is required the Court is required to impose a sentence on the mentally ill offender as if the person concerned were an ordinary offender. Prison is not necessarily appropriate to the proper treatment and rehabilitation of such persons, nor is that form of punishment always a proper reflection of the different class of offenders to which such persons belong. There is scant evidence that special measures can properly be taken within the prison system to deal with such persons without an unnecessary drain on resources. The consequence is that there is a risk of further degeneration by the offender and there is a risk to the other inmates and staff."

This statement acknowledges that the criminal justice system is not an appropriate environment for persons with MHPs to receive services and treatment and the risk that a MHP will deteriorate in the prison environment. This approach is rooted in therapeutic jurisprudence.

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[85] Payne "Specialty courts in Australia: Report to the Criminology Research Council" (Canberra: Australian Institute of Criminology, 2005) at pages 109-110.

[86] *Ibid*, at page 110.

[87] See Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 252.

[88] [2000] WSCA 203 at paragraph 78.

Until the late 1990s therapeutic jurisprudence was unknown in Australia.[89] It has been suggested that the influence of therapeutic jurisprudence is evidenced in different diversion court initiatives throughout Australia.[90] However, there have been challenges to the development of therapeutic jurisprudence in Australia. Namely it has been primarily associated with problem-solving courts and has not been embedded further in judging and in legal practice, with judges considering that they are already engaged in therapeutic jurisprudence practices when further therapeutic jurisprudence practice is suggested.[91] Legal culture in Australia has been resistant to adopting therapeutic jurisprudence practices with members of the judiciary and the legal profession considering that wellbeing is the realm of health professionals' not legal professionals.[92] It has been suggested that the development of therapeutic jurisprudence has been hampered in Australia as a result of Government bureaucracy, and in some cases a resistance to the therapeutic jurisprudence rationale and the changes required to the criminal justice system.[93]

Therapeutic jurisprudence requires members of the judiciary that are more active in relation to case management and it has been suggested in Australia that this leads to difficulties as judges may be seen as "encroaching on the areas best left to the executive, that unlike the judiciary (it is believed), has the necessary expertise".[94] While therapeutic jurisprudence has clearly extended into specialist courts in Australia it has not been embedded within "mainstream legal education, legal practice and judging".[95] However, it is worth noting that therapeutic jurisprudence has been added to the national

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[89] For a discussion of the origins of therapeutic jurisprudence in Australia see King, Freiberg, Bagtagol and Hymas *Non-Adversarial Justice* (Sydney: Federation Press, 2009) at pages 34-38. See also See also Gutman "The Reality of Non-Adversarial Justice: Principles and Practice" (*Deakin Law Review*: 14(1), 2009, pages 29-51).

[90] *Ibid*, at page 36.

[91] *Ibid*, at page 37.

[92] *Ibid*.

[93] *Ibid*.

[94] *Ibid*, at page 38.

[95] *Ibid*.

curriculum for the National Judicial College of Australia.[96] The NSWLRC highlighted the need for appropriate training on mental illness for judges. It recommended that judicial officers involved with special lists should receive special training and have aptitude for work involving a problem-solving approach to defendants and offenders with MHPs.[97] The NSWLRC also recommended that defence lawyers and prosecutors should understand the approach of essentially therapeutic methods of working and be assigned to the list on a permanent basis.[98]

It is considered that therapeutic jurisprudence can "limit the negative side effects of the law and promote justice system outcomes such as conflict prevention and resolution, respect for the law and offender rehabilitation" in Australia.[99] The development of problem-solving or "problem orientated" courts across the common law world including Australia have been suggested as representing a failure of "social services and traditional court systems to cope with major social problems and of the creativity of governments and courts in developing innovative solutions to some of the seemingly intractable problems".[100] It is clear from examining the literature and the discussion in this chapter that non-adversarial initiatives have grown significantly in recent years in Australia.

While there has been much support for "problem-orientated courts" in Australia it has been acknowledged that the "paradigm raises some profound questions about the nature and operation of the court process itself".[101] Concern has been expressed in relation to the changing role of judges who need to "act as judge, mentor, supervisor,

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[96] "Report: A Curriculum for Professional Development for Australian Judicial Officers" National Judicial College of Australia, 2007) at pages 26-27.

[97] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at recommendation 12.4.

[98] *Ibid*, at recommendation 12.5.

[99] King, Freiberg, Bagtagol and Hymas *Non-Adversarial Justice* (Sydney: Federation Press, 2009) at page 38. It is also considered that therapeutic approaches enhance the opportunity for behavioural sciences to contribute to improving legal processes and outcomes.

[100] *Ibid*, at page 14.

[101] *Ibid*, at page 167.

and service broker" and this challenges some of the core "judicial values such as impartiality, fairness, certainty and the separation of powers between the executive and judiciary".[102] This new system of operating involves a collaborative approach that involves team meetings and case conferencing (EG judges, prosecutors, defence lawyers, clinicians). This poses significant questions as to whether this system disadvantages defendants and offenders with MHPs and ID. In Australia this has not been adequately considered. As discussed already therapeutic jurisprudence is very much endorsed by the NSWLRC in its recent work on diversion. While the NSWLRC identified a number of disadvantages associated with diversion it was committed to the philosophy and benefits that are to be had by taking a problem-solving approach to defendants and offenders with MHPs and ID.

Steele has been critical of the therapeutic jurisprudence approach of mental health courts and in a submission she called on the NSWLRC to take a more critical view of therapeutic jurisprudence.[103] She opposed the use of special court lists and mental health courts in NSW on a number of different grounds.[104] It was argued that the structural division of the forensic mental health system and other issues were discriminatory.[105] As such she recommended that the forensic mental health system should be "dismantled rather than merely fine-tuned".[106] In her submission to the NSWLRC she specifically outlined how diversion could be at odds with the evolving understanding of the State obligations under the CRPD. It is of note then that the NSWLRC while referencing her submission throughout its final report on diversion in 2012 failed to engage in this debate opting instead to suggest that diversion was consistent with Articles 5 and 13 of the CRPD. This supports the suggestion that the CRPD and some of the more challenging interpretations of Articles 12, 14 and 17 are unlikely to yield any substantive law reform in the short to medium term,

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[102] *Ibid*.

[103] Steele "Submission to the New South Wales Law Reform Commission: People with Cognitive and Mental Health Impairments" (Sydney: New South Wales Law Reform Commission, 2011) at page 2.

[104] *Ibid*.

[105] *Ibid*, page 17.

[106] *Ibid*, page 21.

particularly in the field of criminal justice policy.[107]

6. Pre-Court Diversion in Australia

The literature on pre-court diversion reveals that it is underdeveloped when compared to the processes for diversion at the court stage. The NSWLRC in their examination of pre-court diversion considered the police in Australia have a central role in facilitating diversion earlier in the process. Particularly through use of the NSW mental health legislation, which provides police officers with the power to forcibly bring a person to a mental health facility for assessment and treatment under specified certain circumstances.[108] The NSWLRC's work on pre-court diversion is promising as a way of diverting persons with MHPs and ID from the criminal justice system. The use of diversion before the court stage has many benefits, including the avoidance of further stigma that attaches to a criminal conviction.[109] It was also argued that appropriate use of pre-court diversion had the potential to better comply with the States obligations under the CRPD (EG the right to community living, avoiding involuntary detention in mental health facilities, forced treatment and the right to habilitation and rehabilitation). The NSWLRC considered that effective pre-court diversion would involve early intervention, effective use of warnings and cautions and maximising the use of police and prosecution practice and policy.[110]

The NSWLRC recommended the creation of a statutory scheme for pre-court diversion, considering that such a scheme would improve understanding of policy and procedure.[111] It formed the view that this statutory system would ensure far greater numbers of persons with MHPs would be diverted from the criminal justice system. The NSWLRC believed this would bring about the clarity needed for police to exercise their discretion in pursuing criminal charges against

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[107] See Chapter 2: Literature Review, Part 2.

[108] See section 22 of the *Mental Health Act 2007* (NSW).

[109] See Chapter 2: Literature Review, Part 1.

[110] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) see chapter 8.

[111] *Ibid*, see chapter 230.

offenders with MHPs and ID. It considered that a statutory scheme would save significant costs and reduce reoffending. The benefits of this statutory system if implemented in the way recommended are clear over court-based diversion programmes. It recommended that the scheme would establish a clear power for the police to discontinue proceedings when appropriate. This would resolve some of the problems with processes in court that result in participants having criminal convictions recorded against them despite complying with the onerous terms and conditions of these programmes.

However, while there are many positive elements to the NSWLRC's work on pre-court diversion the approach was heavily influenced by the desire to protect the public and to respond to the perceived dangerousness of persons with MHPs in particular. This is illustrated by the NSWLRC's view on the use of police powers to respond to persons with MHPs under NSW mental health legislation. It considered that the non-admission of persons with MHPs to mental health facilities was a problem. As such it recommended that where a person referred to a mental health facility under section 22 of the *Mental Health Act 2007* (NSW) was not admitted, the police should be entitled to refer the decision to the Mental Health Review Tribunal for review.[112] This approach engages many of the criticisms of diversion from a human rights perspective in facilitating forced treatment. In particular it places a premium upon forced treatment as an integral part of effective pre-court diversion. However, a clear deficit of the NSWLRC's recommendations on pre-court diversion is their limitations in respect of persons with ID. In that regard the NSWLRC noted that its recommendations on pre-court diversion were unlikely to benefit persons with ID as "the problem is primarily related to service provision, it is not a problem that can be resolved by legal reform".[113]

7. Problem-solving Initiatives

In this section there is an outline of the different initiatives and processes that have been developed (or recommended) in the different Australian jurisdictions. The available literature on the effectiveness of these different initiatives is discussed. There is no

[112] *Ibid*, at recommendation 8.1.

[113] *Ibid*, at page 218.

universally accepted standard or definition of diversion.[114] This is reflected across the Australia where "laws, practices and programs governing these activities vary widely between jurisdictions".[115]

7.1. Diversion in Victoria

In 2008 the Victoria Government issued a ministerial statement entitled the "Attorney-General's Justice Statement 2" outlining the Victorian government's imminent plans for the justice system.[116] Included was a commitment to the consideration of new ways of addressing the needs of offenders with MHPs. The Assessment and Referral Court List (ARC) is a specialist court list that was subsequently developed by the DOJ and the Magistrates' Court of Victoria. The list is placed on a statutory basis by way of the *Magistrates' Court Amendment (Assessment and Referral Court List) Act 2010*. ARC was introduced to "meet the needs of accused persons who have a mental illness and/or a cognitive impairment."[117] The List is located at Melbourne Magistrates' Court and works collaboratively with the Court Integrated Services Program (CISP), which provides case management to persons who participate in the court list. The case management in Victoria may involve referral for psychological assessment or referral to welfare, health, mental health, disability, housing services or drug and alcohol treatment. The rationale for the list fits with the therapeutic jurisprudence philosophy underlying mental health courts in North America.[118] ARC's objectives include reducing "the risk of harm to the community by addressing the underlying factors that contribute to offending behaviour" and to

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[114] See Chapter 2: Literature Review, Part 1.

[115] King, Freiberg, Bagtagol and Hymas *Non-Adversarial Justice* (Sydney: Federation Press, 2009) at page 170.

[116] "Attorney-General's Justice Statement 2" (Victoria: Department of Justice, October 2008).

[117] The website for the Assessment and Referral Court List is available at: http://www.magistratescourt.vic.gov.au/home/court+support+services/magistrates+-+assessment+and+referral+court+list. <Last accessed 10 November 2013>

[118] See Schneider and Heerema *Mental Health Courts: Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007). The mission statement of the list reads as follows "the ARC List operates on a Problem-Solving Court model, which provides an informal approach where the Magistrate hears the matter(s) and reviews the participant's progress on the program from the Bar Table, along with ARC List staff and the participant". See the website for the Assessment and Referral Court List at: http://www.magistratescourt.vic.gov.au/home/court+support+services/magistrates+-+assessment+and+referral+court+list. <Last accessed 10 November 2013>

"improve the health and wellbeing of accused persons with a mental impairment by facilitating access to appropriate treatment and other support services".[119] The other aims of the list are to increase public confidence in the criminal justice system by ameliorating court processes and "increasing options available to courts in responding to accused persons with a mental impairment, cognitive impairment or neurological conditions" and to "reduce the number of offenders with a mental impairment and other conditions received into the prison system".[120]

There are numerous eligibility criteria that govern which defendants can participate in this court-based programme. For example, there is a requirement that the defendant is not charged a violent criminal offence, serious violence or serious sexual offence as defined by section 6B(1) of the *Sentencing Act 1991*. Other eligibility requirements include: a "mental illness", "intellectual disability", "acquired brain injury", "autism spectrum disorder", "neurological impairment, including but not limited to dementia".[121] In addition the eligibility requirements demand that the defendant consents to participate and has one or more of the above that "causes a substantially reduced capacity in at least one of the areas of self-care, self-management, social interaction or communication" and that the accused would "benefit from a problem-solving court process and an individual support plan".[122]

There is quite a flexible approach with referrals to ARC. Referrals are accepted from the accused, "significant others", community service organisations and a range of actors in the criminal justice system such as magistrates, police, prosecutors, legal representatives and other court based support services. After a referral is requested CISP staff carry out an initial assessment of the defendant.[123] In terms of Article

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[119] *Ibid*.

[120] *Ibid*.

[121] *Ibid*.

[122] *Ibid*.

[123] If the referral is not accepted, the charges against the defendant will be referred back to the ordinary court lists. Where the Court Integrated Services Program (CISP) consider it appropriate they continue to provide "necessary support to the accused or, where connected with services, referred back to those relevant treatment and support services".

12 of the CRPD it is interesting that the CISP staff at this point will "commence addressing support needs" of the defendant at this stage, although it would be preferable if the issue of support was addressed earlier in the process.[124] The participant in the list appears before the List Magistrate on a regular basis to discuss their progress. At the end of their participation in the list the participant will be sentenced within the list if they plead guilty. If the defendant pleads not guilty the case is returned to ordinary criminal court for a "contested hearing". Under the Victoria system participants become involved with the List for between three to twelve months, "with most being discharged from the List within six months".[125]

The successful functioning of the List is very much dependant upon the Mental Health Court Liaison Service (MHCLS).[126] The MHCLS is a court-based assessment and advice service that is provided by "Forensicare, the Victorian Institute of Forensic Mental Health". This service is well-established having being set up at the Melbourne Magistrates' Court in November 1994. There has been an increasing demand on the service and positions were subsequently created at a number of different Magistrates' Courts.[127] The MHCLS's role is to provide court assessment and advice services to magistrates in respect of defendants who may have a mental illness when they appear before the Magistrates' Courts. The MHCLS essentially seeks to undertake mental health assessments with a view to determining the presence or absence of serious mental illness and inform the court of the assessment. The role of the Service also includes the provision of advice and consultation about mental health issues to members of the legal profession and other relevant professionals and community agencies.

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[124] The List staff liase with the Assessment and Referral Court List in order to determine the next available court date and a List clinical advisor will undertake a comprehensive clinical assessment of the defendant. The List magistrate at the next available List sitting, the will decide whether to accept the participant onto the List. If the referral is accepted the List clinical advisor develops a "draft individual support plan" in collaboration with the participant and the CISP staff for approval of the Magistrate.

[125] See the website for the Assessment and Referral Court List at: http://www.magistratescourt.vic.gov.au/home/court+support+services/magistrates+-+assessment+and+referral+court+list. <Last accessed 10 November 2013>

[126] See the website for the Mental Health Court Liaison Service at: http://www.magistratescourt.vic.gov.au/home/court+support+services/magistrates+-+mental+health+court+liaison+service. <Last accessed 10 November 2013>

[127] *Ibid*.

The Service also assists the defendant with accessing appropriate treatment. This involves facilitating liaison with "Area Mental Health Services" in circumstances where a defendant is assessed as having a serious mental illness. The Service also facilitates liaison with the Police, nurses and Forensic Medical Officers in order to ensure that the mental health needs of the defendant held in police custody are met.

There has not been much literature produced on the effectiveness of the ARC initiative. However, there is a sense that ARC has the potential to curb the "revolving door" phenomenon that motivated the creation of this diversion programme in the first instance.[128]

7.2. Diversion in Queensland

Queensland has made provision for a mental health court. However, the model in Queensland is very different to our understanding of a problem solving mental health court, in that its mandate is to examine questions of criminal responsibility and fitness to stand trial as opposed to adopting a therapeutic jurisprudence approach that seeks to divert and facilitate rehabilitation.[129] It has been suggested that the main work of the court is informing the court on the fitness of defendants to plead.[130] In Queensland the Mental Health Court is a Superior Court that consists of a president of the court and other Supreme Court judges, who are assisted by two psychiatrists.[131] The role of the psychiatrist involves assisting the court to understand the clinical

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[128] See Zafirakis "Curbing the "Revolving Door" Phenomenon with Mentally Impaired Offenders: Applying a Therapeutic Jurisprudence Lens" (*Journal of Judicial Administration*: 20, 2010, page 81).

[129] For a discussion of the Queensland court see "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at pages 323-325. See also Schneider and Heerema *Mental Health Courts: Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007) and R Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) and Richardson "Mental Health Courts and Diversion Programs for Offenders with Mental Illnesses: The Australian Context" (Vienna: Paper presented at the 8th Annual International Association of Forensic Mental Health Services Conference, 2008).

[130] See "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012).

[131] The website of the Queensland Mental Health Court is available at: http://www.health.qld.gov.au/forensicmentalhealth/community/mhcourt.asp. <Last accessed 10 November 2013>

evidence that is available[132]. The court also has a role around the use of the insanity defence and the defence of diminished responsibility. The Court makes decisions as to whether a defendant is of "unsound mind at the time of the offence". If the Court determines that this is the case the Court can then decide that the person may be placed on a forensic order. Alternatively the Court can order that the proceedings relating to the offence be discontinued. If the Court determines that the defendant is not of "unsound mind and is fit for trial" they can order the proceedings for the offence to continue in the criminal justice system.

Where the Court determines that the defendant is "fit for trial" but there is a dispute of facts, this allows the Court to order proceedings relating to the offence continue in the criminal justice system. In circumstances where the Court determines that the defendant is "temporarily unfit for trial" the Queensland Mental Health Court can decide to place the defendant on a forensic order or order that the proceedings relating to the offence be suspended. It is also open to the Court to place the defendant under the regular review of fitness by the Mental Health Review Tribunal. If the Queensland Mental Health Court considers that the defendant is "permanently unfit for trial" it can order the person to be placed in a forensic order or order that the proceedings relating to the offence be discontinued.[133] The Court when considering a murder case can grant a defence of diminished responsibility.

In addition to this unique Mental Health Court model the Brisbane Magistrates Court in Queensland operates the "Special Circumstances Court Diversion Program". This is a special list open to persons who are considered to have "impaired decision making capacity". The list is also open to persons who have a "disability attributable to a psychiatric impairment".[134] The Special Circumstances Court takes a problem-solving approach that seeks to connect defendants "to available treatment, rehabilitation and support services with the focus on

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[132] The Mental Health Court is usually open to the public but can be closed in special cases or when the person charged under the age of 18.

[133] This is contrary to the review requirements under the ECHR.

[134] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 323.

reduction of their criminal offending behaviour".[135] This programme is open to defendants who are facing charges for offences that can be tried summarily, however, offences that involve violence, sexual offences or other serious offences are excluded.[136] According to the practice direction for the programme if the defendant is eligible for bail the Magistrate can grant bail and adjourns the case to the Special Circumstances Court.[137] The programme uses conditional bail and the threat of sentencing as tools to ensure compliance with the treatment requirements of participation in the programme. As with many diversionary initiatives of this nature participation in the programme is voluntary.[138] However, as expected participation requires the defendant to plead guilty or indicate that it is their intention to plead guilty. Upon completion of the programme the defendant will be sentenced regardless of successful completion of the programme.[139]

It is important to note that the Special Circumstances Court was initially called the "Homeless Persons Court Diversion Program". This programme was subject to a review 17 months after it began operating.[140] This review reported that a number of people who participated in the programme had been referred to service providers and that they complied with the terms of their referrals and were making progress in addressing the problems underlying their offending behaviour and that the initiative had yielded a reduction in offending.[141] A follow up study was carried out and published in 2011.[142] A different study reported that mental illness or ID was

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[135] See "Practice Direction No 25 of 2010: Special Circumstances Diversion Court Program" (Magistrates Courts, 2010).

[136] *Ibid*.

[137] *Ibid*.

[138] See Chapter 2: Literature Review, Part 1.

[139] "Practice Direction No 25 of 2010: Special Circumstances Diversion Court Program" (Magistrates Courts, 2010).

[140] See "Homeless Persons Court Diversion Program Pilot Evaluation" (Creative Sparks Pty Ltd, November 2007). The methodology of the review was with key stakeholders who were interviewed about the outcomes of the programme.

[141] *Ibid*, at page 49.

[142] See Walsh "A Special Court for Special Cases" (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland, 2011). The methodology for this study involved data collection of 185 over a 6-month period.

declared in court in relation to 53 people in the sample of the study.[143] It included interviews with 20 defendants and 12 professionals who worked with the court. While the sample was limited the review identified the following advantages to the court. The court had the "to contextualise defendants' offending behaviour" and respond to their needs.[144] In addition the court was considered capable of building good supportive relationships with defendants.[145] However, the research also reported a number of other issues such as concerns about confidentiality and privacy; lack of resources for the sector in general and for community service providers working with defendants referred to them.[146] Furthermore, it was reported that sentencing alternatives were inadequate in equating with the philosophy of the court.[147] The evidence from this research suggests that this programme seems to be delivering on the objective of the programme to connect defendants to services and supports in the community that are considered appropriate. However, the research did not show whether the programme yielded a reduction in reoffending. Walsh reported that some defendants when interviewed suggested that the programme had the potential to reduce offending.[148] As such it as recommended that longitudinal studies were required to measure the impact in addressing recidivism.[149] This longitudinal study is necessary as the court has evolved to focus specifically on offenders with MHPs and data on the effectiveness of the court is necessary to inform the courts work.

7.3. Diversion in South Australia

The "Magistrates Court Diversion Program" has been operating in South Australia since 1999 making it the first mental health court to be

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[143] *Ibid*, at page 16.

[144] *Ibid*, at page 43.

[145] *Ibid*.

[146] *Ibid*, at page 44.

[147] *Ibid*.

[148] *Ibid*, at page 40.

[149] *Ibid*, at page 64.

established in Australia.[150] Interestingly this programme was developed as a response (at the time) to a growth in the numbers of defendants using the defence of mental illness for minor offences, which was expensive and resource intensive.[151] This diversion programme commenced initially as a pilot project and since 2001 has received continued Government funding following an independent evaluation. The Office and Crime Statistics and Research undertook the independent evaluation, which provided evidence that the programme was successful in meetings its objectives.[152] In particular, the evaluation concluded that the programme was being implemented as designed and that a high percentage of persons accepted as participants in the programme successfully completed it.[153]

The court sits on a weekly basis in the Adelaide Magistrates Court, monthly in four different suburban locations, and also on a bi-monthly basis in four rural locations in South Australia. The eligibility requirements for participation in the "Magistrates Court Diversion Program" are that the defendant is charged with a minor or summary offence(s) that are to be heard in the Magistrates Court of South Australia. The defendant is required to have impaired intellectual or mental functioning as a result of mental illness, ID, a personality disorder, acquired brain injury, or a neurological disorder including dementia. So the programme adopts a broad approach in terms of who is eligible to participate. Participation in the programme is encouraged, as participants will normally receive a reduced sentence for participation in and completion of the programme than they would have received had they not participated.[154] The objectives of this

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[150] For information on the Magistrates Court Diversion Program see: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013>

[151] See Burvill, Dusmohamed, Hunter and McRostie "The Management of Mentally Impaired Offenders Within the South Australian Criminal Justice System" (*International Journal of Law and Psychiatry*: 26(1), 2003, pages 13-31) and "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 325. Law reform has subsequently been enacted to curb the increased use of the defence for minor crimes.

[152] Hunter and McRostie "Magistrates Court Diversion Program: Overview of Key Data" (Adelaide: Office of Crime Statistics, Information Bulletin, No. 20, July 2001).

[153] *Ibid*.

[154] Dusmohamed and Burvill "Development of a Specialist Sentencing Court in South Australia" (*Canberra Bulletin of Public Administration*: 2003, 106).

diversion programme are rooted in a therapeutic jurisprudence approach to offenders with MHPs and other impairments. The programme seeks to thwart future offending through the provision of access to early assessment and interventions aimed at addressing the defendants mental health or disability needs and to "[p]rovide assistance to the court in the identification and management of people with a mental impairment in the court system".[155]

The other aims and objectives of the programme include provision of greater options within the Magistrates Court other than pleading the "mental impairment defence" under section 269 of the *Criminal Law Consolidation Act (1935)*. In addition to these therapeutic jurisprudential rationales this diversion programme seeks to achieve "broader outcomes" through "the development of best practice techniques in dealing with mentally impaired persons, specialised court based personnel with in-depth knowledge of court processes, mental impairment, service providers and treatment regimes who can advise on the management of people with an impairment".[156] The other "broader outcomes" include simplifying and streamlining the "… processes for dealing with people with a mental health and/or disability issue who come before the court" and improving the interface between the health and justice systems in a way that leads "to shared outcomes for persons with a mental impairment and increased understanding of each sector and their systems".[157] The other "broader outcomes" include collection of data that allows for the identification of trends and projections, and the impact on demand for services and to provide encouragement and opportunities "for support services to respond pro-actively to issues impacting on their clients involved in the justice system" [158]

Interestingly, one of the "broader outcomes" identified was a the generation of greater understanding amongst not only service providers but also the general public of the needs of defendants with a MHPs or an ID, who have committed a criminal offence, and of the

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[155] *Ibid*.

[156] See: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013>

[157] *Ibid*.

[158] *Ibid*.

issues impacting on their behaviour leading to the offence. This approach is very much in keeping with Article 8 (awareness-raising) of the CRPD and is an interesting component of this programme.[159] In particular, 8(1)(b) requires State Parties to the Convention to combat stereotypes prejudices of PWDs. The State is required to take a proactive role in combating the portrayal of PWDs, and in particular persons with MHPs, as dangerous and violent. This will be essential if diversion programmes are effective and persons with MHPs who come into context with the criminal justice system are to be connected to the services and supports that they want and require. The approach also facilitates greater compliance with ensuring access to justice in line with Article 13 of the CRPD.

As one would expect the Magistrates Court Diversion Program operates on a voluntary basis. The referral process ensures the decision by the defendant to participate is fully informed.[160] Of course this is subject to the caveat that the voluntariness of the participation is questionable given the lack of options, EG serve a prison sentence of participate in and comply with the programme.[161] Interestingly, there is no "formal requirement" for the defendant to plead guilty to any offence in order to be accepted onto the programme. However, the Court does require to be informed as to whether "the objective facts are not under dispute nor likely to be contested".[162] It is common practice for the prosecutor to indicate the likely outcome if the defendant should successfully complete the programme.[163] Under the programme the legal proceedings against participants are adjourned for approximately 6 months. However, the length of participation in the programme is be determined on a case by case basis as the circumstances are considered likely to vary in complexity and the goal of the programme is to allow sufficient time for the person to receive

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[159] For a further discussion on this see Chapter 2: Literature Review, Part 2.

[160] The court procedures, treatment and justice options are fully explained to the applicant prior to proceeding with an assessment.

[161] See Chapter 2: Literature Review, Part 1.

[162] See the website for the "Magistrates Court Diversion Program" at: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013>

[163] Dusmohamed and Burvill "Development of a Specialist Sentencing Court in South Australia" (*Canberra Bulletin of Public Administration*: 2003, 106, 41-44).

the treatment it is considered that they need.[164] The purpose of this is to provide the programme staff with the time to connect the participant to the relevant services in the community and monitor their progress. This process facilitates the participant to be connected to community based service providers. The "progress" made by the participant is reported back to the court and the Magistrate, police and defence lawyers and the information can then be used in dealing with the case further. Although, this does raise questions regarding confidentiality, and the defendants right to privacy. Under the Programme the Magistrate reviews the individual every two months with a view to "reinforce and reward compliance with treatment regimes and lifestyle changes and to take alternative action if the interventions are not working or if the individual is not complying with the interventions".[165]

At the final hearing the Magistrate makes a determination taking into account the participant's involvement in the programme.[166] The prosecution was initially invested with the responsibility of deciding as to whether charges against the offender should be withdrawn. In the programmes first year approximately two thirds of the participants that completed the programme left with a criminal record.[167] The role of the prosecutor was amended by way of the *Statutes Amendment (Intervention Programs and Sentencing Procedures) Act 2005*, which introduced section 19C into the *Criminal Law (Sentencing) Act 1988*. Section 19C confers Magistrates on the diversion programme with the discretionary power to dismiss charges where the prosecution does not withdraw them. The Magistrate can now dismiss the charges against the participant or convict without penalty. However, this depends on

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[164] *Ibid*.

[165] See the website for the "Magistrates Court Diversion Program" at: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013> There are generally 2 reviews carried out and at the second review the Magistrate will decide when the participant will be required to return to Court to finalise the proceedings. The final hearing is generally held approximately two months after the second review. While the Magistrate can excuse the defendant from appearing in court for their reviews all participants are required to appear for a final determination at the end of the adjournment period.

[166] See the website for the "Magistrates Court Diversion Program" at: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013>

[167] Dusmohamed and Burvill "Development of a Specialist Sentencing Court in South Australia" (*Canberra Bulletin of Public Administration*: 2003, 106).

the nature and circumstances of the offences.[168] Another important aspect of the South Australia programme is that no sanctions are imposed if a participant does not comply with their treatment plan. However, they will be required to attend court if they are not in compliance "where the Magistrate will encourage the person to engage with the treatment programs and try to motivate him or her to stay with the Diversion Program".[169]

There seems to be a joined up approach to this diversion programme, as representatives from the criminal justice system and the Department of Health in South Australia provide input into the programme policy and development through their participation in the Steering Committee.[170] The convening of the "Service Providers Operations Group" is further evidence of a collaborative approach.[171] This group includes court personnel, police, lawyers and a range of service providers from the health and disability sector. The group meets quarterly to share information and problem solve issues arise. In addition an information management system has been developed that assists the staff of the programme to manage participants as they progress through the programme. The information management system also compiles data for programme "evaluation and performance monitoring".[172] The Intervention Programs Manager is responsible for the programme and co-ordinates the implementation of different court orders.[173] The programme operates weekly in the

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[168] It is important to note that poor performance in the programme failure to make adequate progress will not be relevant to the sentencing process and section 10(6) *Criminal Law (Sentencing Act) 1988* will apply.

[169] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 250-251.

[170] The Deputy Chief Magistrate chairs the Steering Committee.

[171] See the website for the "Magistrates Court Diversion Program" at: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013>

[172] *Ibid*.

[173] The rest of the programme staff are organised into two teams the Clinical Advising Team and the Clinical Liaison Team. There are 4 clinical advisors in the Clinical Advising Team, who are psychologists with expertise in forensic and general psychological assessment. A coordinating psychologist supervises the operations of the team. The clinical advisors undertake assessments of persons that are referred to the programme and compile reports and "expert advice to the Court regarding an individual's suitability for the program and their needs". These clinical advisors also develop intervention plans for the individual participants.

Adelaide court and monthly and bi-monthly in other locations in South Australia.

There is a flexible referral process for participation in this programme. Referrals to the programme are either made by the defendant or from any "interested third party".[174] Interested third parties can include a "police officer, solicitor, case manager, guardian, Magistrate, Police Prosecutor, service provider or any other party with a genuine interest their welfare".[175] In order to participle in the programme there is a requirement of a causal link between the impairment and the offending. In that regard a preliminary report is prepared for the Magistrate containing recommendations as to the eligibility of the applicant for admission onto the programme. From a legal capacity perspective it is of interest that in circumstances where a defendant has a guardian then the guardian is required to consent to assessment and participation in the Magistrates Court Diversion Program. If consent is not given the person will then be referred back to the ordinary court process. This raises certain difficulties from the perspective of Article 12 of the CRPD but it appears it does not pose problems for the perspective of practice and procedure of this programme in South Australia.[176]

A review of this programme published in 2004 provided data that suggested the programme achieved its objective of "reducing offending amongst individuals with a mental impairment".[177] The evaluation found that a high proportion of defendants who participated in the programme "were not apprehended for offending in the 12 months following program completion and that the number of incidents charged against these individuals was considerably lower

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These plans then form the framework for the involvement of the Clinical Liaison Team. There are 5 clinical liaison officers in the Clinical Liaison Team who report to a clinical team leader. These officers generally come from a social work background. The clinical liaison officers have responsibility for connecting individuals to services they need and seek to sustain a good working relationships with service providers so as to guarantee that they understand the aims of the programme and facilitate access to the services they provide.

[174] See: http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html. <Last accessed 10 November 2013>

[175] *Ibid*.

[176] For a further discussion on this see Chapter 2: Literature Review, Part 2.

[177] See Skezyplec, Wundersitz and McRostie "Magistrates Court Diversion Program: An Analysis of Post-Program Offending" (Adelaide: Office and Crime Statistics and Research, March 2004).

than before they commenced the program is a positive indicator the program may be having some positive effect".[178] The study supported this conclusion with reference to a small group of 15 participants. The samples of 15 participants were persons who were considered "high risk" offenders prior to joining the programme.[179] Twelve of this sample either did not offend at all after the programme or were detected for fewer crimes than in the equivalent period before their participation in the programme.[180] These findings combined with the earlier study evaluating the programme, indicate that this programme is effective in delivering on its goals.

However, it is important to note that the study did indicate that "a small group who not only continued to offend after the program involvement but who were apprehended for more serious incidents".[181] The study also identified the need for further research to identify interventions that might be more appropriate for this small group of offenders. However, Richardson and McSherry are critical of the lack of research on diversionary programmes.[182] They noted that since this study no supplementary evaluations have been carried out on the programme "… although limited information regarding participant demographics, mental impairment type, offence type, and sentencing outcomes are published each year in the Court Administration Authority of South Australia Annual Report".[183]

As referred to above there have been concerns about this programme in relation to the convictions imposed on defendants participating in the programme. Burvill et al note that in the first year of its operation approximately two thirds of defendants who participated in the programme had a final disposal that resulted in a criminal record being recorded against them.[184] However, law reform provided subsequently

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[178] *Ibid*, at page 14.

[179] *Ibid*.

[180] *Ibid*.

[181] *Ibid*, at page 15.

[182] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 254.

[183] *Ibid*.

[184] See Burvill, Dusmohamed, Hunter and McRostie "The Management of Mentally Impaired

enacted provided that Magistrates could dismiss charges regardless of whether the prosecution decided to withdraw charges for the offence(s).[185] However, dispute this law reform the number of defendants with a final disposal resulting in a criminal record actually increased.[186] In 2009-2010 only 22.4% of participants were diverted from a traditional sentencing option.[187] Schneider and Heerema, while acknowledging that this programme is similar to the mental health court programmes in operation in North America in terms of adopting a problem-solving approach, were critical of the numbers of persons leaving the programme with a criminal record.[188] In fact they considered that the approach was "antithetical to the court's primary purpose, which is to decriminalize the mentally disordered population entering the criminal justice system".[189]

7.4. Western Australia

Western Australia is an interesting jurisdiction in that it has a specific diversion programme operating in relation to offenders with ID since 2003. In addition Western Australia has recently commenced another mental health programme aimed at diverting offenders. The Intellectual Disability Diversion Program (IDDP) operating since 2003 is a special court that operates at the Perth Magistrate's Court.[190] The IDDP is again very much based on therapeutic jurisprudence principles and seeks to take a problem-solving approach in relation to defendants with an ID.[191] Persons with an ID who are eligible for services from the

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Offenders Within the South Australian Criminal Justice System" (*International Journal of Law and Psychiatry*: 26(1), 2003, pages 13-31).

[185] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 251.

[186] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 326.

[187] *Ibid*.

[188] Schneider and Heerema *Mental Health Courts: Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007) at page 108.

[189] *Ibid*.

[190] For a discussion on this see "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at pages 328-331.

[191] See "Court Intervention Programs" (Perth: Law Reform Commission of Western Australia, Consultation Paper No 96, 2008) at pages 105-107.

Disability Service Commission are eligible to participate in this programme.[192] The scope of the programme is limited to offences that are disposed of in the Magistrates Court. The matter must be one that can be dealt with in the Magistrate's Court and the defendant has to enter a guilty plea and consent to participation.[193]

After a person is determined to be eligible for participation in the programme an IDDP coordinator develops a plan for the person that seeks to address the behaviour that has resulted in contact with the criminal justice system.[194] The defendant is released on bail if they agree to comply with the terms of the programme.[195] Participation on the programme as with other problem-solving court models requires regular contact with the court, which monitors the participant approximately every two months.[196] The programme is normally finalised after 6 months, however, if participants are not malleable to the terms and conditions attaching to participation they can be returned to court "for encouragement" or indeed returned to the general court list.[197] Malleable and compliant defendants benefit from "a discount on the sentence they would have received had they not participated in the program".[198]

An evaluation of this programme carried out in 2004, on the whole was encouraging in terms of its findings on the effectiveness of the programme in meeting its objectives.[199] The economic savings yielded

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[192] Zappelli and Mellor "Evaluation of the IDDP Project" (TNS Social Research, 2004) at page 26.

[193] See "Court Intervention Programs" (Perth: Law Reform Commission of Western Australia, Consultation Paper No 96, 2008) at pages 105-107.

[194] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 330.

[195] *Ibid*.

[196] *Ibid*. The coordinator facilitates the monitoring and control function of the court through the provision of a report relating to the defendant's participation in the programme.

[197] *Ibid*.

[198] "Court Intervention Programs" (Perth: Law Reform Commission of Western Australia, Consultation Paper No 96, 2008) at page 107.

[199] See Zappelli and Mellor "Evaluation of the IDDP Project" (TNS Social Research, 2004) at page 14. The methodology of this evaluation included an analysis of the Department of Justice data on the referrals, waiting periods, sentence conclusions and training evaluation forms, in addition to interviews with key stakeholders.

from the programme were not clear.[200] However, the evaluation found anecdotal positive evidence that the rate of imprisonment of persons with an ID had been reduced, although it was too early to establish this on a very firm basis.[201] The evaluation also suggested that participation on the IDDP reduced recidivism amongst its participants.[202] While this evaluation has limited use (as it was conducted a mere one year after the IDDP was commenced), the evaluation established that all of the stakeholders considered that the programme delivered a better and more appropriate response to persons with an ID by connecting them to services and supporting persons to modify behaviour that brought them into contact with the criminal justice system.[203] The evaluation also reported that participants with ID and their families (or carers) held the opinion that the programme delivered better social welfare outcomes, as a result of facilitating services and better understanding of the consequences of not compiling with the programme.[204]

The research indicates that there is a problem with the visibility of persons with ID in the criminal justice system.[205] As such this programme in Western Australia is of interest in specifically seeks to respond to the needs of defendants and offenders with ID. It is disappointing then that the Western Australia Law Reform Commission concluded that the Disability Services Commission eligibility criteria in conjunction with the funding available significantly limited the type of offenders that could be accepted onto the programme.[206] As such an opportunity to address the invisibility of offenders with "moderate" or "borderline" ID in the criminal justice system has been missed.[207] In addition persons with acquired brain injuries, or persons with borderline range IQ are currently not eligible to benefit from the

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[200] *Ibid*, at pages 54-58.

[201] *Ibid*, at page 51.

[202] *Ibid*, at page 51.

[203] *Ibid*, at page 53.

[204] *Ibid*, at page 58.

[205] See Chapter 2: Literature Review, Part 1.

[206] "Court Intervention Programs" (Perth: Law Reform Commission of Western Australia, Consultation Paper No 96, 2008) at page 106.

[207] See Chapter 2: Literature, Part 1.

programme.[208]

Following on from a review of the *Criminal Law (Mentally Impaired Defendants) Act 1996* in 2003, a recommended that a taskforce should be created to develop a plan for the establishment of a mental health court for Western Australia (within a 12-month timeframe) was made.[209] Subsequently in 2009 the Commission recommended the establishment as soon as possible of a programme aimed at addressing the needs of defendants with "mental impairment".[210] In its Report the Commission recommended that this initiative ought to operate on a voluntary basis and that participants would not be required to enter a guilty plea unlike other initiatives in other jurisdictions in Australia.[211] The Commission recommended that mental illness (including personality disorders) as the eligibility criteria for admission on to this programme. The Commission considered that an expanded version of the IDDP would deal with persons whose "primary diagnosis" was an ID or other cognitive impairment.[212]

The Western Australian government revealed in 2012 that it would introduce a "Mental Health Court Diversion Program" at Perth Magistrates' Court and Children's Court.[213] The Mental Health Court Diversion Program has been allocated $5 million (Australian dollars) over two years for the period 2012-2013 from the State Budget for services in adult courts.[214] The programme will be led by a full-time Magistrate whose work will be supported by a team of professionals who will provide the crucial "assessments, individualised treatment and liaison to community mental health services".[215] As with other similar

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[208] "Court Intervention Programs" (Perth: Law Reform Commission of Western Australia, Consultation Paper No 96, 2008) at page 106.

[209] See Holman "The Way Forward: Recommendations of the Review of The Criminal Law [Mentally Impaired Defendants] Act 1996" (Government of Western Australia, 2003) at page15.

[210] See "Court Intervention Programs" (Perth: Law Reform Commission of Western Australia, Consultation Paper No 96, 2008) at page 84.

[211] *Ibid*.

[212] *Ibid*.

[213] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 329.

[214] See "State Budget 2012-13: Supporting our Community – Mental health court diversion program first for WA" (Perth: Media Statement, 19 May 2012).

[215] *Ibid*.

programmes this initiative seeks to reduce re-offending by people with "moderate or severe mental illness and divert them away from prison".[216] It is important to note that the Attorney General for Western Australia noted that while there were a number of different diversion options existing within the courts in Western Australia, it was essential to have this type of programme to support diversion.[217] The literature on the effective of the IDDP is limited and as the delivery of the new initiative is on going there is as yet no evidence on the effectiveness of this programme. It will be interesting to see the synergies between these different programmes. Any future evaluations of these programmes might usefully consider the utility and desirability of separating out ID from mental illness in diversion programmes and whether this causes difficulties where offenders have a dual diagnosis.

7.5. Tasmania

Tasmania operates a court-based diversion programme called the "Mental Health Diversion List (MHDL) Program".[218] This programme has dedicated Magistrates in the Hobart and Launceston registries of the Tasmanian Magistrates Court. The approach of this programme is also rooted in therapeutic jurisprudence principles. According to the court website it "has decided to change its way of dealing with people with mental health issues by providing separate lists or sittings for them with dedicated Magistrates and teams that focus on treatment and support."[219] This programme also operates on a voluntary basis and seeks to provide participants with an opportunity to "address their mental health and/or disability needs associated with their offending behaviour."

This programme is more limited in its work than comparable programmes in other Australian jurisdictions (EG South Australia) in that it sits for one afternoon on a Thursday on a monthly basis. The

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[216] *Ibid*.

[217] *Ibid*.

[218] This programme has dedicated Magistrates in the Hobart and Launceston registries of the Tasmanian Magistrates Court.

[219] See the Court website at: http://www.magistratescourt.tas.gov.au/divisions/criminal__and__general/mental_health_diversion. <Last accessed 10 November 2013>

programme operating in The eligibility requirements for participation in this programme are that the applicant is an adult who is charged with either summary offences or indictable offences that can be tried summarily.[220] The person also has to have impaired intellectual or mental functioning as a result of a "mental illness" in order to be eligible to participate in the programme. The definition of mental illness is contained in section 4 of the *Mental Health Act 1996 (Tas)* and offenders with an ID do not come under this definition and as such are ineligible to participate in the programme unless they have a diagnosis of mental illness. Defendants who are minors, charged with sexual offences or who are accused of inflicting actual bodily harm are excluded from participating in this programme, unless the Magistrate considers that the harm caused was only minor. As with the Programme in South Australia the defendant is not required to give a formal guilty plea in advance of participating on the programme. However, the Court must be of the opinion that the offences are not under dispute and are likely to be contested.

As with South Australia this programme requires that informed consent is given, as such the programme and all of its procedures are fully explained to the person seeking to be accepted into the programme. Once a defendant gives their consent to participating in the programme, the Forensic Mental Health Court Liaison Officer carries out an assessment.[221] The purpose of the assessment is to establish whether the person meets the eligibility requirements and that the programme can meet their needs. Once this is established the eligible person will appear before the Diversion List Magistrate who will make a decision as to whether they will be accepted onto the programme.[222] After a defendant is accepted onto the programme they will receive a full assessment and will be supported to access treatment and services in the community. The Forensic Mental Health Court Liaison Officer facilitates this through the creation of a detailed treatment plan. A steering committee supervises the continued development of the programme and seeks to resolves strategic issues regarding the

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[220] "Information and Guidance: Mental Health Diversion List" (Hobart Magistrates Court).

[221] "Mental Health Diversion List: Procedural Manuel" (Hobart Magistrates Court, 2010, version 1.2).

[222] Where a magistrate decides that the person is not eligible to participate in the programme they will send the applicant back to the ordinary list.

programmes operations when they arise.

Unlike other programmes (EG the South Australia programme) there is no general timeframe for participation in the programme. The length of participation operates on a case-by-case basis and the length of participation is determined on the basis of what is considered to be the mental health needs of the defendant.[223] The case pending against the participant is adjourned during the term of participation. Compliance and control of participants is achieved through the provisions of the *Bail Act 1994 (Tas)*. The bail legislation is used to grant bail with conditions attached with a view to allowing the participant to access the services and treatment that they require. The Diversion List team meets on a monthly basis where the Forensic Mental Health Court Liaison Officers, defence lawyers, and the Diversion List prosecutor discuss the participation of the offender on the programme. The Diversion List team and the participant then appear before the Diversion List Magistrate at regular periods for the court for a review.[224] At these reviews the Forensic Mental Health Court Liaison Officer provides an oral report to the Magistrate outlining the progress of the participant. As with practice in many other mental health courts the Magistrate will encourage the participant to sustain progress where the report is positive. The review can also involve modifications to the participant's treatment plan or modification of supervision arrangements or decide on the completion of the programme.[225]

As with other programmes (EG the South Australia programme) failure to comply with the terms and conditions of the programme will not result in the imposition of any formal sanctions. Failure to adhere to the treatment plan may result in the court issuing of "verbal sanctions" from the court or a modification of the participant's supervision arrangements or their treatment plan (if recommended by the Court Liaison Officer). [226] Failure to comply with the conditions of

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[223] "Mental Health Diversion List: Procedural Manuel" (Hobart Magistrates Court, 2010, version 1.2).

[224] Newitt and Stojcevski "Mental Health Diversion List: Evaluation Report" (Magistrates Court Tasmania, May 2009) at page 66.

[225] See "Mental Health Diversion List: Procedural Manuel" (Hobart Magistrates Court, 2010, version 1.2).

[226] *Ibid*, at page 17.

participation may also result in the participant being removed from the programme by the court. Under those circumstances the participant's case will be returned to the ordinary court list for processing in the normal way. At the final review of the participant the Forensic Mental Health Court Liaison Officer provides an oral account to the Diversion List Magistrate. In this oral report the Officer outlines the participant's involvement and progress with the programme.[227] The Magistrate then takes this report into account when concluding the case. It is open to the Magistrate to withdraw the charges against the defendant if they have successfully completed the programme. However, this requires the Magistrate to discuss withdrawal with the prosecution and counsel for the defence.[228]

The available data on the operation of the Tasmanian court based programme indicates that it is operating effectively. Between May 2007 and December 2009 there were 154 referrals to the programme.[229] Of the 154 referrals 126 participants were accepted onto and completed the programme. There were 16 active cases and 110 completed.[230] There were 28 non-completions. The reasons for non-completion included that there was no mental illness or the person was unsuitable or were non-compliant with the programme or withdrew their consent to participate in the programme.[231] Of the 126 participants 56% faced between 1-2 criminal charges while 44% faced 3 or more criminal charges.[232] 110 of the 126 persons who completed the programme between May 2007 and December 2009 had 135 sentences recorded.[233] There were 74 participants (55%) who were given a conditional release order of which 16 had a conviction recorded and 58 without a conviction recorded. There were 16 (12%) participants whose charges were dismissed; 13 (9%) tendered no evidence, 12 (9%) received a suspended sentence and 20 (15%) received license

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[227] *Ibid*.

[228] *Ibid*.

[229] Hill "Tasmania's Magistrates Court Mental Health Diversion List"(PowerPoint Presentation, March 2010) at slide 15.

[230] *Ibid*.

[231] *Ibid*.

[232] *Ibid*.

[233] *Ibid*, at slide 17.

disqualification, a community service order or recognisance.[234]

Interestingly, the available data also provides a breakdown of the diagnosis of participants in the Tasmania programme.[235] The breakdown is as follows – 44% of participants were diagnosed with schizophrenia, 15% bi-polar disorder, 9% depression, 8% posttraumatic stress disorder, 6% personality disorder, 6% psychosis not otherwise specified, 3% obsessive-compulsive disorder and 9% fell into a category of "other". The available data also indicates the importance of forensic mental health services. 67% of the treatment provided to participants was by Forensic Mental Health Services and Mental Health Services. The remaining treatment was given by private psychiatrists (12%), private psychologists (11%), General Practitioners (8 %) and others (2%).[236] The available data indicated that the average number of appearances of participants prior to finalisation was 2.8.[237] 79 of the 110 finalised cases were disposed of in 1-3 hearings and there were 27 cases involving 4-5 hearings before disposition.[238] In terms of the referrals to the programme 43% came from lawyers, 33% Forensic Mental Health Services / Mental Health Service staff, 18% from Magistrates, 1% from the Police and 5% from others.[239] These statistics on referrals indicate the multiplicity of actors from which referrals are coming and the clear need for the programme and the key role the different stakeholders have in being aware of MHPs and engaging with diversion programmes.

There seems to be a commitment to the work of this programme. In 2010 the Tasmanian Mental Health Diversion List received a Certificate of Merit as part of the Australian Crime and Violence Prevention Awards.[240] The evaluations of the Tasmanian programme have indicated that it has been effective in reducing the levels of offending of

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[234] *Ibid*.

[235] *Ibid*, at slide 19.

[236] *Ibid*, at slide 20.

[237] *Ibid*, at slide 18.

[238] *Ibid*.

[239] *Ibid*, at slide 16.

[240] The Heads of Australian Governments and members of the Ministerial Council for Police and Emergency Management sponsor these awards as part of the Police as a joint Australian Government, State and Territory initiative.

participants after completion of the programme.[241] The evaluation suggested that 92% of participants committed no offences during the six months post-participation compared to just over 17% in the six months before they entered the program.[242] The evaluation also indicated that 57% of participants were apprehended for two or more offences before they commenced the programme compared with 3.8% after completion of the programme.[243]

7.6. New South Wales

NSW serves as a good comparative jurisdiction as part of this thesis as there has been a lot of consideration given to the issue of defendants with MHPs and ID. As discussed above the NSW Law Reform Commission has undertaken significant law reform project on diversion culminating in a Report in 2012 that critically evaluated diversion and made recommendation on how to more effectively divert person from the criminal justice system. The Commission took a very broad approach to diversion.[244] In its Report its definition of diversion encompassed practices that seek to minimise contact between the person with "cognitive and mental health impairments" and the criminal justice system.[245] The Commission within its conception of diversion embraced measures by courts that seek to refer defendants to treatment and or services that seek to rehabilitate the persons and to prevent further offending behaviour.[246] This is based on a therapeutic jurisprudence philosophy of "problem solving courts" that involves monitoring and control of persons with "cognitive and mental health impairments" while connecting them to rehabilitative services.[247]

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[241] Newitt and Stojcevski "Mental Health Diversion List: Evaluation Report" (Magistrates Court Tasmania, May 2009) at page 74.

[242] *Ibid*.

[243] *Ibid*.

[244] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012).

[245] *Ibid*, see chapter 3.

[246] *Ibid*.

[247] *Ibid*.

7.6.1. Identification of Persons with MHPs and ID in NSW

In NSW identification of persons for diversion is done through the Statewide Community and Court Liaison Service (SCCLS).[248] The remit of this service is limited in that it is currently only available in 20 of 148 Local Court locations.[249] As such the NSWLRC recommended the expansion of SCCLS or the creation of other services that would work on identifying, assessing and providing advice to the court on offenders across the entire jurisdiction of NSW.[250] It formed the view that assessment and the provision of support services were dependent upon referral. As such effective diversion requires police, lawyers, magistrates, court staff and other stakeholders to refer persons eligible for diversion. In order to do this effectively the NSWLRC recommended that the Department of Attorney General and Justice develop in consultation with Justice Health material that reinforces early identification of persons with MHPs and ID.[251] In addition it considered that it was particularly important for legal aid lawyers to be active in the identification and facilitating engagement of their clients in diversion. As such it recommended that specific training should be provided for legal aid lawyers in order to identify and refer clients for diversion.[252] It did not engage in a substantive discussion of some of the concerns that this therapeutic jurisprudence approach had on transforming the role and relationship between the client and their lawyer.[253] It is of note that SCCLS currently does not provide dedicated assessments of persons with cognitive impairment in NSW.[254] The NSWLRC recommended that this should be addressed by expanding its role and its geographical catchment area.

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[248] For a discussion of this see "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at chapter 7.

[249] *Ibid*.

[250] *Ibid*, see recommendation 7.1.

[251] *Ibid*, at recommendation 7.2.

[252] *Ibid*, at recommendation 7.3.

[253] See Chapter 2: Literature Review, Part 1.

[254] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 179.

7.6.2. Statutory Powers of Diversion in NSW

In NSW, Magistrates have significant legislative powers under sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990 (NSW)* to divert. These legislative provisions allow Magistrates to divert offenders with MHPs or ID who are charged with summary offences or minor indictable offences from the criminal justice system into community-based treatment. Section 32(1) provides that a Magistrate can deal with an offender under Part 3 of the Act if, at the commencement or at any time during the course of the proceedings before a Magistrate if it appears that the defendant is (or was at the time of the alleged commission of the offence to which the proceedings relate) was "developmentally disabled", or "suffering from mental illness", or "suffering from a mental condition for which treatment is available in a mental health facility". Section 32(2) of the Act provides that a magistrate can decide when dealing with these offenders that it is appropriate to adjourn the proceedings, grant bail or make any other order that the magistrate considers appropriate. Section 32(3) of the Act empowers a magistrate to strike out a charge and discharge the defendant unconditionally or into the care of a responsible person. Alternatively under section 32(3) the Magistrate can attach conditions to the offenders release such as requiring him/her to attend for an assessment of their mental health for the purposes of receiving treatment. Section 33 of the 1990 Act confers Magistrates in NSW with the power to order that persons with mental heath problems be taken to a mental health facility for assessment and detention. If an assessment at the mental health facility reveals that the offender does not have a "mentally disorder" the offender has to be brought back before a Magistrate or an "authorised officer", or be discharged unconditionally or subject to conditions, into the care of a "responsible person".

These provisions in NSW are similar to legislative provisions open to members of the judiciary elsewhere. They were introduced as a way of responding to the needs of offenders with MHPs without any provisions of any specialised court or court list. As Richardson and McSherry point out they have the benefit of allowing diversion to take place "more widely" as "any magistrate sitting on any day" can use the provisions to

divert an offender with a MHP.[255] However, the provisions "have not always been used by NSW magistrates" for a multiplicity of reasons.[256] Some of the rationale for the under use of these provisions include "a lack of confidence that the offenders will receive appropriate treatment or services in the community or that the order could be enforced against the offender if there is non-compliance".[257] It has also been identified that clear and effective treatment plans, which are required by Magistrates in exercising their discretion under the legislation are infrequently available and not of a sufficient standard.[258] Therefore, Magistrates are not provided with the assistance that they require in exercising their powers under section 32 of the Act.[259] There was reform of the legislation in 2004 that provided Magistrates with the power to summon offenders before the court in circumstances where they failed comply with the terms and conditions of their order. This has led to "far greater use of section 32".[260] This law reform and greater use of the provisions has coincided with the provision of mental health liaison nurses working in the court liaison service, which facilitates the identification of offenders with MHPs and the provision of apt clinical advice to the court in exercising its powers under sections 32 and 33.[261]

However, despite these reforms the NSWLRC in its recent review of diversion identified a number of problems with powers of diversion, not least that the powers were seldom used.[262] It reported that approximately 1% of cases in the Local and Children's Court were

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[255] Richardso Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 252.

[256] *Ibid*.

[257] *Ibid*.

[258] Gostsis and Donnelly "Diverting Mentally Disordered Offenders in the NSW Local Court" (Sydney: Judicial Commission of New South Wales, Monograph 31, 2008) at page 17.

[259] *Ibid*.

[260] Richardson and McSherry "Diversion Down Under- Programs for Offenders with Mental Illnesses in Australia" (*International Journal of Law and Psychiatry*: 33, 2010, pages 249-257) at page 252.

[261] *Ibid*, at page 252 and Gostsis and Donnelly "Diverting Mentally Disordered Offenders in the NSW Local Court" (Sydney: Judicial Commission of New South Wales, Monograph 31, 2008).

[262] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012).

disposed of under section 32. The NSWLRC also identified a number of other factors that served to explain their underuse. These included the burden imposed by the requirement of submission of a treatment plan, which was considered onerous as very often defendants had numerous diagnoses and complex needs requiring involvement of expertise from the service sector. Lawyers in NSW are charged with coming up with this plan, which was hampered by limited expertise and knowledge of services in order to come up with an adequate plan.

What was interesting in the NSWLRC's report was that one of the criticisms of section 32 was that the order was time limited to 6 months, which respondents to the consultation process felt was too short to be effective. The NSWLRC considered that in order to address the concerns of stakeholders it was necessary to extend the involvement of the courts through providing powers to amend treatment plans. The NSWLRC sought to phrase this positively in recommending that a treatment plan could be terminated early.[263] However, it also recommended that the power of the court should be extended to allow diversion plans to be extended beyond 6 months.[264] Another criticism of the NSWLRC approach is that when a person has completed the treatment programme the court will then decide whether to release or dispose of them according to the law, meaning that a sentence could be imposed upon the person. It recommended that the court in makings its determination should weigh up whether the defendant "substantially complied" with the treatment plan; their "achievements"; noteworthy changes in the defendant's circumstances as a result of engagement with the plan and any other relevant factor.[265] These wide range of factors have the potential to determine whether a person gets a custodial sentence, (which was discussed in Chapter 2: Literature Review) seems unfair given the level of monitoring and control involved in participating in theses types of court supervised programmes.

The NSWLRC also noted that the provisions governing breach of section 32 orders were considered ineffective and that non-compliance was seldom reported to the court, which was considered as part of the explanation of the underuse of these diversionary powers. The

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[263] *Ibid*, at recommendation 9.9.

[264] *Ibid*.

[265] *Ibid*, at page 272.

NSWLRC in order to address these concerns made a number of recommendations. The NSWLRC's recommendations provided for risk assessment in ensuring that concerns about the dangerousness of persons with MHPs and ID were addressed.[266] This approach embodies many of the criticisms of the therapeutic jurisprudence approach.[267] Namely that due process rights and other rights of persons engaged in problem-solving processes are at risk of giving way to public protection concerns.

One of aspects of section 32 is that it provides for the discharge of a person subject to orders made under it into the care of a responsible person. The NSWLRC recommended that this provision be removed. The rationale of the NSWLRC in coming to this decision is of interest. If looking at the provision through the prism of human rights and the CRPD such a provision facilitates a type of substitute decision-making or limitation on the legal capacity of the person, which is wholly at odds with our evolving understanding of Article 12 of the CRPD. However, the NSWLRC's rationale was based on its lack of use due to the unwillingness of family members to take on the role.

Therapeutic jurisprudence principles were critiqued in light of the CRPD as they facilitate a medicalised approach in solving the problems that persons with MHPs and ID, who engage in offending behaviour.[268] The NSWLRC embraced a very medicalised approach endorsing programmes of treatment for persons being dealt with under section 32. It recommended that treatment plans should explicitly set out the nature, "extent and frequency of the treatment" outline the engagement required with services.[269] Provision for psychiatric treatment was specifically required in its recommendations. There was an absence in the NSWLRC's discussion of safeguards against forced treatment and ensuring that the rights of persons subject to such orders are respected. Although there was a reference to current practice

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[266] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at recommendation 9.4.

[267] See Chapter 2: Literature Review, Part 1 and Part 2.

[268] See Chapter 2: Literature Review. Part 1 and Part 2.

[269] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012).

under section 32 that "magistrates do not confine their orders according to a medical model" opting instead to respond in ways that give practical effect. Other aspects of treatment plans indicative of a social model approach include housing, counselling, social supports, drug treatment programmes and opportunities for education and training. There is no doubt that persons subject to these orders would engage many elements of these "treatment plans". It saw treatment plans as essential to making section 32 workable, as such the treatment plans need to ensure fluidity by affording discretion to Magistrates. However, there is obvious scope to use treatment plans to force persons to accept treatment as they have little or choice as the other option is a custodial sentence. It is regrettable that the NSWLRC did not emphasise the need to respect the legal capacity and rights of persons subject to these treatment plans in its recommendations. The terminology of the "treatment plan" is problematical in and of itself. Despite its problematical title "treatment plans" have the potential to support persons to live and participate positively in the community provided they comply with the checklist of rights under the CRPD.[270]

As discussed above section 33 of the *Mental Health (Forensic Provisions) Act 1990 (NSW)* provides a power to refer a person with MHPs to a mental health facility for assessment. For the purposes of section 33 a person with a "mental illness" is a person who is considered who as a result of that illness requires care, treatment or control on the basis of risk that they pose to themselves and other persons.[271] In addition section 33 provides that Magistrates to impose community treatment orders. As with orders made under section 32, section 33 provides for limitations on the legal capacity of persons subject to the order, to be discharged into the care of a "responsible person". Again the NSWLRC recommended that this provision be repealed, however, this recommendation was not motivated by concern for the rights of the person and restrictions imposed on their legal capacity.[272] As with section 32, section 33 is seldom used in practice in NSW and the NSWLRC reported a high return rate to the

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[270] See Chapter 2: Literature Review. Part 1 and Part 2.

[271] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at chapter 10.

[272] *Ibid*.

courts of persons referred under the legislation. [273] The recommendations in relation to reform of section 33 again reflect the focus on managing risk through control. It recommended that section 33 be amended to make it clear persons referred under this section can be recalled at the discretion.[274]

The NSWLRC received a number of submissions suggesting the reasons for the return of persons to the court subsequent to referral for assessment under section 33. One of the major problems identified in NSW was that mental health facilities assessed that persons referred were not eligible for admission. As such they were either "discharged onto the streets" or referred back to the court.[275] However, some respondents to the NSWLRC's consultations reported that even where persons were referred on the basis of clinical advice or where persons were being repeatedly bounced between the court and mental health facilities in a "state of acute ill health until they are ultimately admitted".[276] This problem reflects the difficulties in accessing services England and Wales and some of the resistance in developing formal powers of diversion in Ireland.[277] It also reported that stakeholders also reported that the reason for not admitting persons referred under section 33 was that due to the lack of resources. In addition attitudinal barriers were identified in preventing admission as service providers considered that the police and prison services were more appropriate for defendants who may be considered violent. The NSWLRC recommended that in circumstances where a person was not admitted the mental health facility would be required to provide a shirt report to the court and that the court should be entitled to refer the facilities refusal to admit to a Mental Health Tribunal for review of the decision. [278] The NSWLRC considered that this would address inappropriate or ill motivated refusals. The NSWLRC was more concerned about ensuring admission to mental health facilities and

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[273] *Ibid*.

[274] *Ibid*, see recommendations 10.1 and 10.3.

[275] *Ibid*, at chapter 10.

[276] *Ibid*.

[277] See Chapter 3: Ireland and Chapter 4: England and Wales.

[278] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) see recommendation 10.7.

there was little discussion of alternative supports in the community. However, the fact that the NSWLRC recommended a formal review process to challenge appropriate or ill motivated refusal of services hints at the significant barriers faced by persons in realising their right to the highest attainable standard of mental health and the right to habilitation and rehabilitation.[279]

The NSWLRC recommended that a power under section 33 (interlocutory in nature) should be available to the Local Court in indictable cases.[280] The system as it currently operates means that the courts that deal with the more serious cases (the District and Supreme Courts) have much more limited powers of diversion than the Local and Children's Courts. This of course is to be expected given the focus is on managing the dangerousness and risk associated with offenders who commit more serious offences. As such District and Supreme Courts currently do not have powers under sections 32 and 33. The NSWLRC reported that there was strong support for the extension of powers of diversion to the higher courts, although there were concerns about the appropriateness of making diversion to persons who committed more serious offences. Despite these concerns the NSWLRC recommended that sections 32 and 33 be extended to the higher courts.

7.6.3. A Mental Health Court for NSW

As we have seen in our foregoing sections in NSW there is a very developed diversion system. The provisions in section 32 and 33 if used appropriately could ensure that persons with MHPs and ID are effectively diverted from the criminal justice system. However, the NSWLRC considered that these provisions alone were insufficient to address the over-representation of persons with MHPs and ID from the criminal justice system. As such it considered the introduction of a mental health court as part of the diversion framework.[281] The

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[279] See Chapter 2: Literature Review, Part 2.

[280] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) see recommendation 10.8.

[281] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at chapter 11.

NSWLRC recommended the introduction of a new specialist list to supplement specifically section 32.[282] This new special court list is entitled the Court Referral for Integrated Service Provision list (CRISP). Stakeholders considered that this new list could yield reductions in the rate of reoffending, a view that the NSWLRC concurred with. It is envisaged that the recommended list would deal with a "group of defendants" that could not be adequately responded to by section 32. The list was recommended to operate in Local and District Courts in NSW. Eligibility for the list is open to both men and women; persons who have "cognitive or mental impairment"; who do not contest the factual basis of their alleged offence(s) and that they fall within the geographical catchment of the list.

The NSWLRC also envisaged that when a person would be referred to the list a specialist team would assess their eligibility, with the court determining entry following a hearing. It recommended that entry to the list be reserved only for non-serious crimes (summary offences), but recommended that persons facing indictable offences could be entered if the offences could be tried summarily.[283] Effectively this list is a mental health court, requiring specialist training for judges.[284] The NSWLRC considered that a dedicated team would carry out assessments; develop diversion plans for the defendants participating on the list, and inform the court through reporting about defendants.

The modus operandi of the CRISP list is very much based on therapeutic jurisprudence and is non-adversarial in nature. However, the concerns with therapeutic jurisprudence and mental health courts discussed in Chapter 2: Literature Review also arise in certain aspects of the special list recommended. This problem solving court, as envisaged would operate in an informal manner and would not be bound by the rules of evidence.[285] Admission to the list requires the engagement of the defendant to be bound by their diversion plan, which involves regular monitoring by the CRISP team and the court. In line with other mental health court models (EG North America) if a

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[282] *Ibid*, at chapter 12.

[283] *Ibid*, at recommendation 12.3.

[284] *Ibid*, at recommendation 12.4.

[285] *Ibid*, at recommendation 12.6.

defendant fails to comply with their plan the court would use "positive reinforcement" in order to achieve compliance. Persistent non-compliance, the NSWLRC recommended, would result in removal from the list and would be dealt with through the mainstream legal processes in NSW.[286] Again in addition to the criticisms of the mental health court model successful participation on the list does not entitle a defendant to be discharged. This seems unfair given the level of control and monitoring involved in compliance. The NSWLRC at any rate was satisfied that participation in the list would be factored into the decision-making of the court and would be beneficial to the defendant in terms of their disposal.[287]

8. Barriers to Diversion in Australia

While it is the case that the different diversion processes provide for both the diversion of persons with MHPs and ID, particular problems and barriers remain for defendants with ID. For example, in relation to offenders with ID it has been argued that ID is not correctly identified early enough in the criminal justice system and that the degree to which each jurisdiction in Australia addresses the needs of persons with ID is inconsistent.[288] It has also been argued that court diversion programmes that seek to identify defendants with ID vary throughout Australia and that there is a need for "… a national approach for the diversion of persons with ID from the criminal justice system. This will be important for persons with and without coexisting mental illness and will affirm international developments protecting the rights of persons with ID (including those in the criminal justice system) to improved and accessible health care."[289]

The NSWLRC identified that aspects of the bail law in its jurisdiction was disadvantageous in respect of both persons with MHPs and ID. It identified a number of reasons why bail was more difficult for persons

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[286] *Ibid*, at recommendation 12.8.

[287] *Ibid*, at recommendation 12.8.

[288] Vanny, Levy and Hayes "People with an Intellectual Disability in the Australian Criminal Justice System" (*Psychiatry, Psychology and Law*: 15(2), 2008, pages 261-271).

[289] *Ibid*, at page 261.

with MHPs and ID to access.[290] First, the DOJ and Attorney General identified that such defendants had a record of breaching bail conditions, breaching warrants and failing to appear in court.[291] In addition defendants with MHPs and ID were considered "likely to have a history of prior convictions and potential classification as a repeat offender" and were considered to have problems stating their case for bail in court.[292] The NSWLRC also suggested that the lack of financial income as a result of unemployment or reliance on social welfare benefits disadvantages such defendants as they failed to raise sufficient funds to comply with the financial bail conditions.[293] In addition that lack of appropriate accommodation, treatment arrangements, support in the community, employment made it more difficult for persons with cognitive disabilities to be granted bail.[294] As such the lack of supports and services meant that the courts declined bail as they felt to grant applications in the absence thereof would not protect the community.[295] The NSWLRC also identified that attitudinal barriers served to disadvantage persons with MHPs and ID in accessing bail.[296]

It is of note that SCCLS does not provide dedicated assessments of persons with cognitive impairment in NSW.[297] The NSWLRC noted that there is poor provision of dedicated assessment and advice services for defendants with cognitive impairment in other Australian jurisdictions.[298] The NSWLRC as part of their discussion on pre-court diversion considered how best to respond to persons with ID who are in crisis.[299] One of the core issues was how the police should respond

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[290] See "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 47.

[291] *Ibid*, at page 84.

[292] *Ibid*, at page 152.

[293] *Ibid*.

[294] *Ibid*.

[295] *Ibid*.

[296] *Ibid*. At any rate the NSWLRC noted that NSW did not use bail provisions as a central part of their diversionary programmes and section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) provided a sufficient framework for diversion in addition to the other reforms it recommended in its Report.

[297] *Ibid*.

[298] *Ibid*.

[299] *Ibid*, at chapter 8.

to persons with ID who were in crisis and who posed threats to themselves and to other persons. The NSWLRC took the view that police custody; prison and mental health facilities were not the correct environments in which to respond to these crises.[300] The NSWLRC took the view that the "appropriate legal mechanism for taking decisions about people with cognitive impairments is the guardianship system".[301] This clearly poses difficulties in light of the CRPD, concerns that the NSWLRC did not attach any weight to, as this discourse did not feature in its discussions on this issue. Although the NSWLRC did consider that *Guardianship Act 1987 (NSW)* did provide for emergency hearings, and the NSWLRC presumably considered procedural safeguards as sufficient to protect the rights of the person if subject to the legislation. Beyond the conceptual limitations of this approach there are other more practical limitations to such an approach. As the NSWLRC acknowledged the guardianship system could not address gaps in service provision, which very well may have led to the crisis in the first place.[302]

9. Cost Benefit Analysis

It is important to consider the literature on the cost and benefits arising from diversion in Australia. There is significant evidence from Australia that reinforces research internationally that diversion yields significant cost savings particularly derived from keeping people out of prison. The literature on diversion in Australia provides an evidence-base for the cost effectiveness of the processes and practice. The NSWLRC in its final Report on diversion advocated for diversion on a number of rationales including its cost effectiveness. It was also of the view that diversion had obvious cost saving potential when considering the reductions in the number of arrests; of prosecutions; holding persons on remand; the number of psychiatric reports; the number of ineffectual court hearings and other delays within the administration of justice.[303] In addition the NSWLRC considered that the reductions in

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[300] *Ibid*, at pages 217-218.

[301] *Ibid*, at page 217.

[302] *Ibid*, at page 218.

[303] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at pages 36-37.

the number of prison sentences as a result of increased diversion of persons to appropriate community alternatives would yield considerable savings.[304] This position was supported by the available data provided by the Corrective Services in NSW. The Correction Services reported that the cost of custody services per inmate per day indicate that in 2009/2010 averaged at $197.99 per day to keep a person in prison.[305] This amount compared to the average daily cost of correctional services based in the community that amounted to $21.48 per day in the same period.[306] Other direct cost savings have been suggested by the NSWLRC through reductions in police investigations and savings arising from loss of property and reduced hospital readmissions.[307]

The evidence-base on other diversion schemes in Australia has also supported the cost effectiveness of these initiatives. For example, in NSW a review of the Magistrates Early Referral Into Treatment (MERIT) drug and alcohol treatment scheme reported that a cost savings was delivered in the range of $2.41 to $5.54 per Australian dollar spent.[308] This economic analysis was calculated by including direct savings from probation supervision, periods of imprisonment police investigation of crimes.[309] In addition to savings from reduced hospitalisation and savings resulting from a reduction in the costs of crime including damages arising from property offences.[310] The 2003 study on MERIT also reported that there were indirect cost savings associated with the scheme but that additional research was necessary to quantify these indirect savings. The study anticipated that indirect savings would be yielded from sources such as income earned from employment; a

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[304] *Ibid*.

[305] *Ibid*, at page 37.

[306] *Ibid*. The Commission noted that these figures were for community correctional services as opposed to treatment or rehabilitation services. At any rate the Commission considered that the figures suggested that treatment in the community would be a far more inexpensive alternative to custodial disposals.

[307] *Ibid*.

[308] Passey, Patete, Bird, Bolt, Brooks, Lavender, Scott, Sloan, Spooner and Vail "Evaluation of the Lismore MERIT Pilot Program: Final Report: (Lismore: New South Wales Attorney General Department, 2003) at page xi.

[309] *Ibid*.

[310] *Ibid*, at page 75.

reduction in the birth of drug dependent babies; reduction in costs to families of visiting persons in prison.[311] Other intangible benefits that were not amenable to assessment were identified as persons keeping custody of children, which would reduced care costs.[312] Other intangible benefits include enhancement of credibility of law enforcement function, the reduction of stress on families of persons diverted, a potential reduction in mortality and the greater likelihood of obtaining employment due to reduced "prison stigma".[313]

Statistics from the Victorian Department of Human Services indicate that the cost from the employment of a fulltime mental health worker for every woman with a MHP in prison is less than the funding needed for imprisonment.[314] A cost benefit analysis undertaken on the effectiveness of the Court Integrated Services Program in Victoria examined the reduced rate and length of imprisonment for sentences imposed upon completion of the programme and the reduction in the re-offending rate, in comparison to expenditure in running the initiative.[315] This research suggested that CISP resulted in a reduction in reoffending amongst participants on the programme.[316] In addition to this the research suggested that the benefit to cost ratio was very encouraging.[317] While there is a lack of research diversion and its potential to deliver savings through the costs of crime this research suggested that the main benefits of CISP related to savings from reduced imprisonment as opposed to the direct costs of crime.[318]

The NSWLRC considering the Australian and international research on the cost effectiveness of diversion programmes did note that despite the literature the reality is that diversion of persons with "cognitive or

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[311] *Ibid*, at pages 79-80.

[312] *Ibid*, at page 80.

[313] *Ibid*.

[314] See Walsh "Diverting Mentally ill Women Away from Prison in New South Wales: Building on the Existing System" (*Psychiatry, Psychology and Law*: 10, 2003, pages 227-238).

[315] See "Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP" (Department of Justice, 2009 written by Price Waterhouse Coopers).

[316] *Ibid*.

[317] *Ibid*.

[318] *Ibid*, at page 20.

mental health impairment away from incarceration" does not necessarily yield over all cost savings. As was identified elsewhere in this thesis diversion entails significant expenditure in providing for some or a combination of assessment; treatment, rehabilitation services, management services and other forms of support services such as accommodation. The NSWLRC noted that these outlays could constitute significant costs, particularly in circumstances where these were not previously been funded. However, given that crime imposes significant costs on individuals and society the returns on diversion do not need to be very significant to justify the substantial costs needed for diversion programmes.[319] The NSWLRC was persuaded to this position also in consideration of the ineffectiveness of high costs short custodial sentences for persons with MHPs and that prison was not the appropriate setting for such persons.[320] The NSWLRC recommended that creation of a statutory scheme for pre-court diversion, which it considered would yield very positive benefits cost savings.[321]

10. Legal Capacity and the Criminal Justice System in Australia

As discussed in Chapter 2: Literature Review Australia entered a reservation in respect of Article 12 of the CRPD.[322] Despite the reservation on Article 12 there has been consideration of existing guardianship laws. The issue of legal capacity has been given renewed focus with the Australia Law Reform Commission recently receiving the terms of reference of a law reform project on legal capacity.[323] The issue of criminal responsibility and capacity is clearly evident in Australian laws on diminished responsibility, the Australian versions of the insanity defence and indeed as we have seen in the eligibility requirements for participation in diversion programmes. In *R v Harrison* Hunt CJ expressly acknowledged that mental incapacity shielded defendants from the imposition of deterrent sentences:

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[319] "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (Sydney: New South Wales Law Reform Commission, Report 135, 2012) at page 39.

[320] *Ibid*.

[321] *Ibid*, see chapter 230.

[322] See Chapter 2: Literatre Review, Part 2.

[323] See "ALRC Review of Equal Recognition Before the Law and Legal Capacity for People with Disability Announced" (Australian Law Reform Commission, 23 July 2013).

"Except in well-defined circumstances such as youth or the mental incapacity of the offender … public deterrence is generally regarded as the main purpose of punishment, and the subjective considerations relating to the particular prisoner (however persuasive) are necessarily subsidiary to the duty of the courts to see that the sentence which is imposed will operate as a powerful factor in preventing the commission of similar crimes by those who may otherwise be tempted by the prospect that only light punishment will be imposed."[324]

11. Diminished Responsibility in Australia

Some but not all jurisdictions on Australia provide for the partial defence of diminished responsibility. Provision is made for this type of partial defence in NSW[325], the Australian Capital Territory[326], Northern Territory[327] and Queensland.[328] The terminology for the partial defence differs from jurisdiction to jurisdiction. In NSW the partial defence is known as "substantial impairment"; in the Australian Capital Territory, Queensland and the Northern Territory the defence is known as "diminished responsibility". As in other jurisdictions in Australia the defence deals with the circumstances where the person is considered to have experienced an "abnormality of mind" at the time of the commission of the offence to an extent that it substantially impairs their mental responsibility for the killing.[329] The standard for raising this defence in the jurisdictions is a lower standard than a finding that a person is not guilty because of mental impairment.[330] It is not possible to provide an analysis of the partial defence across all Australian jurisdictions. However, it is worthwhile considering the work of the NSWLRC who considered reform of the partial defence and recently published its final report on this topic and other related areas.[331]

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[324] (1997) 93 ACR 314 at page 320.

[325] See sectional 23A of the *Crimes Act 1900 (NSW).*

[326] See section 14 of the *Crimes Act 1900 (ACT).*

[327] See section 159 of the *Criminal Code (NT).*

[328] See section 304A of the *Criminal Code 1899 (Qld).*

[329] For a discussion on this see "Guardianship" (Melbourne: Victorian Law Reform Commission, Report 24, 2012) at page 105.

[330] *Ibid*.

[331] See "People with Cognitive and Mental Health Impairments in the Criminal Justice System:

In Chapter 2: Literature Review it was argued that it was unlikely that the position of user and survivor groups of psychiatry and the OHCHR that the insanity defence required abolition and replacement with a disability neutral defence. The approach of the NSWLRC the issue of criminal responsibility of persons with MHPs appears to support this position. The NSWLRC in Chapter 4 of its Report considered the abolition of the partial defence of "substantial impairment", which it decided against. The rationale of the NSWLRC was that the "balance of opinion" of the relevant stakeholders was in favour of retention, the defence is an appropriate legal response to the complexity and nature and extent of ID and mental illness. In addition it was considered that it was not appropriate to label a person as a murderer in circumstances where the defendants "capacity to understand, make judgments or control her or himself was substantially impaired".[332] As such this could also be better reflected in sentencing as manslaughter provided flexibility in mitigating the defendants impaired capacity. The NSWLRC made a number of other recommendations to address technical elements of the defence. Similarly, NSWLRC in considering the NSW version of the insanity defence the defence of "mental illness" endorsed the retention of the defence and made a number of recommendations on reformulating aspects of the defence. The approach of the NSWLRC in relation to these defences reflected examining approaches in other "cognate jurisdictions" and was not at all influenced by the paradigm shift in thinking on legal capacity.[333]

12. Australia and the Insanity Defence

What is striking from reading the relevant language used in Australia relating to their versions of the insanity defence is the different terminology. The terminology opts to use the term "mental impairment" in substitution for the insanity defence. The defence in most Australian jurisdictions refers to ID and mental illness. The mental impairment terms could be used to address the criticisms of the use of the term insanity in the relevant Irish legislation the *Criminal Law (Insanity) Act 2006*. However, this could be problematical given the variations of different terms used in a host of different statutes in

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Criminal Responsibility and Consequences" (Sydney: New South Wales Law Reform Commission, Report 138, 2013).

[332] *Ibid*, at page xvii, see also chapter 4.

[333] *Ibid*, at page xvi.

Ireland. However, it is important to note that while Australian jurisdictions have reviewed and updated the language used in their statutes on the insanity defence the reform has not involved substantive law reform of the defences.[334]

In a number of jurisdictions the release of persons acquitted under the insanity and other similar offences is dependant upon orders from the Executive based on advice provided by mental health professionals.[335] The Executive is generally not bound by this advice. The criticism of the Executive based system of release is that is runs the risk of politicising the process and can result in "decision-making that is extremely risk adverse, cautious, and not adequately informed by clinical experience".[336] It is evident that in the different jurisdictions examined as part of this thesis other jurisdictions have moved to divest this power of review and release from the Executive and situate it instead in the courts or to multi-disciplinary tribunal.

The Executive controls the way of reviewing the detention of persons who successfully raised the not guilty by reason of mental impairment defence. The *Commonwealth Crimes Act 1914* provides that a court can order an acquitted person under this defence to be released without conditions, subject to conditions (for up to a period of three years) or be detained in prison or hospital for a specified period of time.[337] Where a person is not released without condition the Attorney General is required to reconsider the persons release on a regular basis (6 months). This reconsideration requires that the Attorney General takes into account relevant material supplied by experts and representations submitted on behalf of the acquitted person. The test that is applied is that the Attorney General cannot order a persons release unless the Attorney General is satisfied that the person does not pose a threat to themselves or to the community.[338]

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[334] For a discussion on this see "Mental Impairment Decision-Making and the Insanity Defence" (Wellington: New Zealand Law Commission, Report 120, 2010) at page 39.

[335] For a discussion on this see Freckleton "The Preventative Detention of Insanity Acquittees" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011).

[336] *Ibid*, at page 83.

[337] See section 20BJ, Division 7-Acquittal because of mental illness.

[338] See section 20BL(2) of the *Commonwealth Crimes Act 1914*.

As discussed in Chapter 2: Literature Review the release of persons who successfully raise the insanity defence is strongly controlled.[339] This reflects the belief that such acquitted persons are dangerous and will be dangerous in the future and as such need to be controlled and managed. In Australia mental health professionals are centrally involved in assessing the risk of violence that persons with mental disorders are considered to pose in a number of different points in the civil mental health system and in the criminal justice system.[340] Involvement includes providing risk assessments to inform decision-making in civil detention, bail hearings, sentencing and in probation and parole hearings.[341] McSherry has noted that the involvement of mental health professionals in the criminal law field "has been particularly important in the area of sentencing and preventive detention".[342] McSherry has expressed concern that Australian courts take a cautious approach in its decision-making regarding preventive detention.[343]

The Australian High Court has developed a significant amount of case law on the principle of proportionality in sentencing. In *Veen (No 1)*[344] and *Veen (No 2)*[345] the High Court discussed the relationship between proportionality and risk. In *Veen (No 2)* the High Court placed a premium on the principle of proportionality, however, the court also held that the issue of public protection was also very relevant.[346]

> "[S]entencing is not a purely logical exercise, and the

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[339] Freckleton "The Preventative Detention of Insanity Acquittees" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 86.

[340] See McSherry "Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour" (Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, 2004).

[341] *Ibid*.

[342] *Ibid*, at page 5.

[343] *Ibid*.

[344] (1979) 143 CLR 458.

[345] (1988) 164 CLR 465.

[346] For a discussion on this case see McSherry "Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour" (Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, 2004).

> troublesome nature of the sentencing discretion arises in large measure from unavoidable difficulty in giving weight to each of the purposes of punishment. The purposes of criminal punishment are various: protection of society, deterrence of the offender and of others who might be tempted to offend, retribution and reform. The purposes overlap and none of them can be considered in isolation from the others when determining what is an appropriate sentence in a particular case. They are guideposts to the appropriate sentence but sometimes they point in different directions."[347]

A majority of the High Court in *Veen (No 2)* drew a distinction between increasing a sentence for the purpose of preventative detention, which is not allowed and the use of sentencing discretion that seeks to protect society, which is permitted. As such the High Court held that it was lawful for the Government to establish schemes for indefinite detention. As McSherry has noted this judgment has facilitated "the introduction of legislative provisions that enable indefinite terms of imprisonment on the basis that the offender is a serious danger to the community".[348] However, the High Court in *Kable v DPP* (NSW)[349] held that legislation that sought to impose indefinite detention upon an individual offender by way of the *Community Protection Act 1994* (NSW), which was based on the *Community Protection Act 1990* (Vic) was unconstitutional. Gleeson CJ in *R v Engertafter* discussing the judgment in Veen (No 2) stated

> "A moment's consideration will show that the interplay of the considerations relevant to sentencing may be complex and on occasion even intricate… It is therefore erroneous in principle to approach the law of sentencing as though automatic consequences follow from the presence or absence of particular factual circumstances. In every case, what is called for is the making of a discretionary decision in the light of the circumstances of the individual case, and in the light of the

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[347] (1988) 164 CLR 465, at page 476.

[348] McSherry "Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour" (Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, 2004) at page 4.

[349] (1996) 189 CLR 51.

purposes to be served by the sentencing exercise". [350]

A number of jurisdictions in Australia have made provision for the imposition of indefinite sentencing. Generally a court can order indefinite sentences acting upon its own initiative or on foot of an application from the prosecution.[351] McSherry has argued that the indefinite detention legislation has created tension between the principles of proportionality and concerns about risk and public protection.[352] The development of preventative sentencing provisions in Australia had been criticised as placing too emphasis on risk.[353] It has also been suggested that the development of the legislation has been politically motivated as a response to the demand for public protection.[354] Other commentators have suggested that the Australian preventative detention legislation does not adequately define the key terms in an intelligible and consistent way and in turn intelligible and inconsistent ideas of risk lead to confusion when weighed against concepts of proportionality.[355]

The High Court subsequently in *McGarry* established that indefinite detention could be provided for on a statutory basis. [356] However, the High Court held that there was a need to provide more evidence in advance of sentencing to assist the judge in determining whether or not the person posed risks in terms of reoffending.[357] However, in this

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[350] (1995) 84 ACR 67, at page 68.

[351] The following is a list of statutory provisions in Australian jurisdictions that provide for indefinite sentencing. See section 65 of *Sentencing Act 1995 (NT);* section 163 of the *Penalties and Sentences Act 1992 (Qld);* section 13 of the *Dangerous Prisoner (Sexual Offenders) Act 2003 (Qld);* Part 2, Division 3, Section 22 of the *Criminal Law (Sentencing) Act 1988 (SA);* section 19 of the *Sentencing Act 1997 (Tas);* section 18A of the *Sentencing Act 1991 (Vic)* and section 98 of the *Sentencing Act 1995 (WA).*

[352] McSherry "Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour" (Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, 2004) at page 4.

[353] *Ibid*.

[354] *Ibid*.

[355] Morgan, Morgan and Morgan Risk Assessment in Sentencing and Corrections (Perth: University of Western Australia, 1998) at pages 24-25 cited in McSherry "Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour" (Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, 2004) at page 4.

[356] (2001) 207 CLR 121.

[357] *Ibid*.

case the High Court stated that despite legislative provisions for indefinite detention, in this case the *Sentencing Act 1995 (WA)*, "does not oblige a sentencing judge to make an order for indefinite imprisonment in every case in which the conditions specified in that sub-section are met".[358] As such the judge retains discretion always when sentencing.

Kirby J in a separate judgment stressed that the imposition of an indefinite sentence should be a very serious and unusual move and represented a "serious and extraordinary step". As such he stated that it needed to be based on reports by persons with professional training as mental health professionals (EG psychiatrics, psychological). Justice Kirby also noted the acknowledged in this judgment that judges and others in the criminal justice system had a limited ability to predict accurately the dangerousness of people.

> "In part, the reason why the system of criminal justice treats an order of indefinite imprisonment as a serious and extraordinary step, derives from the respect which the law accords to individual liberty and the need for very clear authority, both of law and of fact, to deprive a person of liberty, particularly indefinitely. In part, this approach rests upon the indisputable feature of almost all criminal sentencing in Australia that limits the sentence imposed to one that is proportionate to the offence of which the person has been convicted. In part, it reflects a tendency to recoil from preventive detention that involves punishing a person "not for something that he has done but because of something it is feared he might do". In part, it represents a realistic acknowledgment of the limitations experienced by judicial officers, parole officers and everyone else in predicting dangerousness accurately and estimating what people will do in the future".[359]

As discussed in Chapter 2: Literature Review the insanity defence has and the disposal of persons who "successfully" raise the insanity defence has been a very controversial area that has been in flux over

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[358] *Ibid*, at page 126.

[359] *Ibid*.

the past quarter of a century.[360] As Freckleton noted in Australia there has been great variance in legal responses in different jurisdictions in dealing with persons who successful raise the insanity defence and even within Australia there is great variances.[361] Despite the development of diversion programmes throughout Australia, which have embedded a therapeutic jurisprudence philosophy it is argued that concerns with the risks posed by offenders with MHPs still dominate law and policy in Australia. That is highlighted by the use of preventative detention and the limitation imposed upon the eligibility of participation in diversion programmes.

13. Preventative Detention and the Insanity Defence

The following section discusses the development of preventative detention systems for persons who successful raise the insanity defence across Australia.

In the Australian Capital Territory when there is a verdict of not guilty by reason on mental impairment the Supreme Court makes an order for the detention of the acquitted person until such time as the Australian Capital Territory Tribunal makes an order to the contrary. The Australian Capital Territory Tribunal has a number of options in relation to making orders in respect of the acquitted person. The Tribunal can make a mental health order under section 323 of the *Crimes Act 1900 (ACT)*, which can take the form of a psychiatric treatment order under section 26 of the *Mental Health (Care and Treatment) Act 1994 (ACT)*. The Tribunal can also make an order for community treatment under section 36 of the *Mental Health (Care and Treatment) Act 1994 (ACT)* or restrictions under sections 30 and 36B of the same piece of legislation.

In the Northern Territory the legislation provides that a person who successfully raises a mental impairment defence can either be released unconditionally or that they are required to undergo supervision.[362] In the Northern Territory supervision orders can be provided for on an

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[360] Freckleton "The Preventative Detention of Insanity Acquittees" in McSherry and Keyzer *Dangerous People: Policy Prediction and Practice* (New York: Routledge, 2011) at page 83.

[361] *Ibid*.

[362] See section 43I(2) of the *Criminal Code Act 1983 (NT).*

indefinite basis and can be custodial or non custodial in nature.[363] In deciding on making orders relating to an acquitted person in the Northern Territory including orders in relation to a persons release the court is required to have regard to whether the person is likely to, or would if released be likely to endanger themselves or other persons because of their "mental impairment, condition or disability"; the need to protect people from danger; the nature of the mental impairment, condition or disability; the relationship between the mental impairment, condition or disability and the offending conduct; whether there are adequate resources available for the treatment and support of the supervised person in the community; whether the accused person or supervised person is complying or is likely to comply with the conditions of the supervision order and any other matters the court considers relevant.[364]

In Queensland a person found not guilty by reason of insanity is ordered by the court to be detained under "strict custody, in such place and in such manner as the court thinks fit" until such time as they can be dealt with under the *Mental Health Act 2000 (Qld)*.[365] In Queensland if the responsible Minister is satisfied that it is necessary for the person to receive the proper care and treatment then he/she can make a forensic order for the acquitted person to be admitted and detained in a high security unit. The Minister can also make an order that a persons can be detained in an "authorized mental health service" if the Minister considers that this can be done safely.[366] The detention of person who successfully raises the defence is then determined by a Mental Health Review Tribunal, which is required to review the person's detention every six months.[367] Section 203(6) of the *Mental Health Act 2000 (Qld)* provides that in making decision in relation to revoking or affirming a persons forensic order the tribunal should take into account the patient's mental state and psychiatric history; each offence leading to the patient becoming a forensic patient; the patient's social circumstances and the patient's response to treatment and willingness

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[363] See the *Criminal Code Act 1983 (NT),* section 43ZC (indefinite orders), section 43ZA (custodial or non-custodial orders).

[364] See section 43ZN(1) a-g of the *Criminal Code Act 1983 (NT).*

[365] See section 647 of the *Criminal Code 1899 (Qld).*

[366] See section 302 of the *Mental Health Act 2000 (Qld).*

[367] See section 200(1) of the *Mental Health Act 2000 (Qld).*

to continue treatment.

The system in South Australia is very similar to the provisions operating in the Northern Territory. In South Australia the court has the power to release a person acquitted on the basis of the defence of not guilty by reason of mental impairment, in addition to making a supervision order or subject to a licence or conditions that are equivalent in length to the term of imprisonment or supervision that could have been ordered if the person had been found guilty of the criminal offence.[368] In South Australia the court retains a role in relation to persons so acquitted and the court can vary or revoke a supervision order under section 269P of the *Criminal Consolidation Act 1935*. In making decisions in varying and revoking orders the court in South Australian is required to have regard to the nature of the persons mental impairment; whether the person if released would be likely to endanger other persons, whether there are adequate resources available for the treatment and support of the person in the community; whether the person is likely to comply with the conditions of a license and any other matters that the court considers relevant.[369]

In Tasmania the court has a number of options following a not guilty by reason of mental impairment verdict. The court can make a restriction order; release the defendant and make a supervision order; make a continuing care order; release the defendant and make a community treatment order; release the defendant on conditions that the court considers appropriate or release the defendant unconditionally.[370] Restriction orders require that the person be detained in a secure mental health unit until such time as the court orders otherwise.[371] Only the Supreme Court is entitled to make restriction orders. Section 26 of the *Criminal Justice (Mental Impairment) Act 1999 (Tas)* provides that the Secretary of the responsible Department in relation to the *Mental Health Act 1996 (Tas)* or the Chief Forensic Psychiatrist can apply to the Supreme Court to have a restriction order discharged. However, this application cannot be made be for a 2-year period after

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[368] See section 269O *Criminal Consolidation Act 1935 (SA).*

[369] See section 269T Criminal Consolidation Act 1935 (SA).

[370] See section 21 of the Criminal Justice (Mental Impairment) Act 1999 (Tas).

[371] See section 24 of the Criminal Justice (Mental Impairment) Act 1999 (Tas).

the application was initially made. The criteria for discharge is similar to those principles in place in South Australia and the principle of least restriction subject to public safety "court is to apply, where appropriate, the principle that restrictions on the defendant's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community".[372]

In Western Australia when a person successfully raises a mental impairment defence the court is required to make a custody order.[373] Under this order the acquitted person is detained in an authorised hospital, declared place, detention centre or prison. A tribunal called the Mentally Impaired Accused Review Board decides upon the place of detention.[374] Section 33 of the Act requires that the Board submits a report to the acquitted person within 8 weeks of making the custody order and following the initial report and subsequently annually to the Minister. In Western Australia this Board can only make recommendations as to release. Again the Board is required to make its recommendations taking into account the degree of risk that the persons is considered to pose to the personal safety of people in the community or of any individual in the community; the likelihood that if released on conditions that they would comply with the conditions; the extent to which their mental impairment might benefit from treatment, training or any other measure.[375] The Board is also required to consider the likelihood that if released the acquitted person would be able to take care of his or her day-to-day needs, obtain any appropriate treatment and resist serious exploitation. In addition in Western Australia consideration has to be given to the objective of imposing the least restriction of the freedom of choice and movement of the accused that is consistent with the need to protect the health or safety of the accused or any other person. The Board is also required to take into account any statement of the victim of the person's alleged offences.

NSW has unlike South Australia, Victoria and the Australian Capital

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[372] *Ibid*.

[373] See section 21 of the *Criminal Law (Mentally Impaired Accused) 1996 (WA).*

[374] See section 24 of the See section 21 of the *Criminal Law (Mentally Impaired Accused) 1996 (WA).*

[375] See section 33(5) of the See section 21 of the *Criminal Law (Mentally Impaired Accused) 1996 (WA).*

Territory did not revise the insanity defence terminology of "mental impairment". Instead in NSW the terminology used is "special verdict by reason of mental illness".

The relevant law in Victoria is the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*. Section 21 of the 1997 Act provides that a person must be found not guilty because of mental impairment if at the time they engaged in the conduct resulting in the offence they had a mental impairment that had the effect that they did not know the nature and quality of the conduct or that they did not know that their conduct was wrong. This test involves an assessment as to whether that could not reason with a moderate degree of sense and composure as to whether their conduct, as perceived by a reasonable person, was wrong.

14. Conclusions

Diversion is firmly rooted as a key component of policy at the State and Federal level in Australia. The foregoing discussion reveals that diversion is based on principles of therapeutic jurisprudence. Diversion policies have potential to support persons with MHPs and ID coming into contact with the criminal justice system. However, as with England and Wales despite a policy of promoting diversion significant problems remain with current arrangements for diversion in Australia. However, attempts at the national level place a premium on looking comparatively through ascertaining best practice, which is a positive element of the policy context in Australia and is something that is clearly absent in Ireland. However, given the recent development of many of these diversion programmes and the lack of outcome based evaluations, more research may be need to convince policy-makers to continue to continue to invest resources into diversion and indeed commit additional resources.

One of the more innovative aspects of the NSWLRC's significant body of work on diversion is its research on the effective use of pre-court diversion. In particular, the creation of a statutory scheme for pre-court diversion would place a greater emphasis on diversion at the earliest stages of the process and has the potential to connect persons to supports in the community. The effective use of pre-court diversion with all of the benefits of certainty and clarity in diverting persons from the criminal justice system has much potential as part of a coherent

policy on diversion in Ireland. However, policy and practice on pre-court diversion lags behind the expanded use of mental health courts. Mental health courts have been developed as the response of choice to address the over representation of persons with MHPs and ID in the criminal justice system. There is an evidence-base suggesting that mental health courts are delivering on their objectives. However, the research is in its infancy and does not provide a complete evidence-base, particularly in respect of the impact of these programmes on recidivism. Longitudinal studies are needed to amass the evidence-base for the effectiveness of these programmes.

Despite the critiques of the mental health court model the foregoing analysis of the different courts in Australia, the fledging research indicates the potential effectiveness of these initiatives in responding to offenders with MHPs and ID in contact with the criminal justice system. These initiatives have the potential to improve the interface between the health system, community services and justice systems in a way that better respects the rights of persons with MHPs. This is particularly evident from the operation of the court in South Australia.

The literature on the effectiveness of the different programmes has clear gaps and the current evaluations have not adequately critically considered the reasons why these special programmes were established. Future research evaluating the effectiveness of diversion initiatives in Australia ought to consider the provision of adequate supports in the community. It is argued that a focus of provision of supports in the community in conjunction with pre-court diversion better respects the rights of persons who are currently ending up in the criminal justice system. As was indicated in Chapter 2: Literature Review inadequate community supports and services are key factors in greater numbers of persons with MHPs coming into contact with the criminal justice system. The lack of supports and services in the community and barriers in accessing them has also been identified in the literature in Australia. In that sense the development of diversion programmes may serve to mask the lack of services and supports. The lack of services and removing the barrier to accessing existing services is a difficult task. This is evidenced by the NSWLRC recommendations to address refusal of services through a review process. The suggestion being that even when access to services for defendants with MHPs were sought through formal diversion processes inappropriate or ill motivated refusals still existed.

Statutory provisions are in place across the various jurisdictions in Australia that can be used to divert offenders with MHPs from the criminal justice system. However, as was the case with similar provisions on England and Wales (see Chapter 4) these provisions have been underused. A legal basis for diversion in and of it is clearly insufficient to effectively to respond to the needs of defendants with ID and MHPs. This was most clearly illustrated by the underuse of sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW). The NSWLRC as part of its recommendations in promoting use of statutory powers of diversion recommended providing for risk assessment in ensuring that concerns about the dangerousness of persons with MHPs and ID were addressed. This is problematical as what are potentially very positive and useful provisions serve to stigmatise and control persons in the community on the basis of their disability. A weakness of the mental health court model in Australian jurisdictions is the exclusion of defendants who face charges for more serious and violent offences. Responding to the needs of persons who are suspected of committing more serious offences is a particular challenge for policy-makers and service providers.

As we have seen above the appeal of mental health courts in Australia is that they facilitate a collaborative approach between mental health providers, the courts and providers of other social services. This approach seeks to ensure that mental health providers are more accountable to the court for the provision of services. Given the problems encountered by the drug court in effectively achieving it goals in Dublin and the limited scope that a mental health court would have it is concluded that a mental health court model would be unlikely to address the current lack of provision of diversion in Ireland. If a court were to be established it would probably only operate in a large urban centre like Dublin. It is considered that the collaborative approach necessitated between mental health providers, the courts and providers of other social services could be better delivered through the creation of specific powers of diversion, service agreements between the Gardaí, courts and the HSE and through the creation of mental health liaison service. Other elements of the diversion framework that would need to be developed include adequate training for all stakeholders in the Irish criminal justice system, in particular Gardaí, lawyers (both defence and prosecution), members of the judiciary and prison personnel.

The CRPD is received increased consideration in Australia, particularly through the referral for a law reform project to the Australian Law Reform Commission on equal recognition before the law. As discussed above the NSWLRC despite receiving one submission on the implications of the CRPD from the perspective of Articles 12 and 14 did not consider it necessary to engage in this debate opting instead to suggest that diversion was consistent with Articles 5 and 13 of the CRPD. This supports the suggestion in Chapter 2: Literature Review that the CRPD and some of the more challenging interpretations of Articles 12, 14 and 17 are unlikely to deliver any substantive law reform in the short to medium term, particularly in the intersection of law and in the criminal justice and mental health fields.

Chapter 8: Conclusions and Recommendations

1. Background

Persons with MHPs historically have been the objects of discrimination. Connections between disability and criminality have a long history. Initial policy and regulatory responses resulted in the creation of large asylums that segregated persons with disability from their communities. The deinstitutionalisation movement from the 1970s onward has facilitated greater visibility and participation of persons with MHPs and ID in the community. However, the deinstitutionalisation movement has corresponded to an increase in the prevalence of persons with MHPs in the criminal justice system and in the prison population. While there are inconsistencies in the literature explaining this increase, there is a consensus that persons with MHPs are over-represented in the prison population, when compared to the general population across Western Europe, North America and Australia. The literature suggests that increased visibility of persons with ID in the community has resulted in greater contact with the criminal justice system.

Against this backdrop diversion has become increasingly important as a response to these issues. This thesis sought to provide a critical analysis of current Irish law and policy relating to defendants and offenders with MHPs and ID. As other jurisdictions have developed a range of diversion provisions and processes a comparative study of law and policy in England and Wales, NI, Scotland and Australia was undertaken to inform the discourse on diversion in Ireland.

2. Research Question

In Chapter 1: Introduction, the central research question for this thesis was identified, as follows:

1) **What (if anything) can Ireland learn from the approach of other jurisdictions to diversion from the criminal justice system of persons with MHPs and ID?**

The literature review identified 5 broad categories of diversion; diversion in the community; diversion following arrest; diversion before the trial; diversion at the court and diversion following conviction. It was suggested that diversion in the community has great potential to connect persons with services and avoid contact with the criminal justice system in the first instance. However, the provisions, processes

and initiatives for diversion in the community are underdeveloped with diversion kicking in later in the criminal justice system process. All of the different diversion processes at the different stages are considered important. However, an emphasis was placed on prevention and early intervention (EG Bradley Report) and referral for treatment. Court liaison services are essential in identifying defendants with MHPs and allow the courts to divert using their statutory powers. Mental health courts based on principles of therapeutic jurisprudence have emerged as a prevailing feature of diversion at the pre-trial stage of the criminal justice system, particularly in North America and Australia. While the literature on mental health court programmes is voluminous, the literature does not give a clear identification of what constitutes best practice, as it is mainly descriptive as opposed to evaluative.

There was a perception that law and policy in Ireland providing for the diversion of defendants and offenders with MHPs and ID was underdeveloped. Ireland is unique in having no statutory provisions to facilitate diversion. The research in this thesis confirms that Ireland has significantly underdeveloped diversion provisions, processes and initiatives. This is clear from the discussion of law and policy in the jurisdictions selected for the comparative element of this study. The only discernible formal diversion initiative in Ireland is the in reach and court liaison service in the large remand centre, Cloverhill. No other formal diversion provisions, processes and initiatives exit.[1] The High Support Unit in the State's largest prison, Mountjoy, which treats mentally ill prisoners, highlights the need to develop diversion earlier in the criminal justice system. Therefore, the answer to this question is that Ireland has much to learn from other jurisdictions regarding law and policy on diversion.

The literature reveals that there are many advantages to diversion. The objective of diversion is to address the over-representation of persons with MHPs in the prison population. Diversion avoids the harmful impact of prison on persons with MHPs and ID, who are considered to be particularly vulnerable for a variety of reasons in the prison setting. Diversion also can also address discrimination experienced by defendants with MHPs seeking bail. Another rationale for diversion is

[1] The only other exception relates to the power to transfer mentally ill prisoners and to remand a person to the CMH following a successful invocation of the insanity offence.

the potential savings yielded from diversion from the criminal justice system. In addition diversion is considered to reduce recidivism amongst participants, a benefit that appeals to policy-makers and secures commitment to diversion policies. Persons with MHPs face discrimination in accessing a range of services in the community, which may lead to involvement with the criminal justice system. The research suggests that diversion serves as a pathway to access mental health services and other social services in the community.

However, a number of disadvantages to diversion were also identified in the literature. Disadvantages include, the ineffectiveness of diversion, its processes can be stigmatising in connecting MHPs to crime and espousing a medical model of disability. Users and survivors of psychiatry criticise diversion initiatives such as mental health courts, on the basis that participation is not voluntary and facilitates social control through forced psychiatry in the community. Notwithstanding these criticisms of diversion, the rationale for diversion enjoys broad support as a policy goal, with principles of therapeutic jurisprudence informing problem-solving approaches to persons with MHPs in contact with the criminal justice system.

Other jurisdictions have a clear policy or a clear set of policies committed to the development of diversion at different points in the criminal justice system. This contrasts with the situation in Ireland where "A Vision for Change" makes commitments to creating services to support diversion. While these commitments are considered to represent a policy of diversion it is argued that there is no clear policy on diversion in Ireland. A process outside both the Department of Health and the Department of Justice developed "A Vision for Change" and while it represents official government policy on the modernisation of mental health services it does not represent a clear, committed policy to diversion. It is concluded that a clear policy on diversion has to be endorsed by the Department of Justice and has to have at the heart of it principles that reflect the rights based approach espoused in the on-going review of the *Mental Health Act 2001*. The stigma associated with persons accessing mental health services through the criminal courts means that the dangerousness and risk concerns will pose difficulties in developing human rights based diversion programmes that respect choice and autonomy. However, by no means does a clear and committed policy on diversion guarantee successful implementation of that policy. In England and Wales there

has been a clear, committed policy on diversion, supported by legislation. Despite a clear commitment to diversion for a variety of reasons diversion has not been successfully implemented in England and Wales. However, the research indicates pockets of good practice in England and Wales and examples of where diversion worked very well. Notwithstanding failures in delivering on effective diversion, there were clear commitments to diversion policy across all jurisdictions included in the comparative element of this thesis.

It is clear from the comparative study that diversion seeks to enhance co-operation between the different agencies and stakeholders in the criminal justice system and health and social services. However, in the jurisdictions studied enhancing co-operation between the different agencies and stakeholders was extremely difficult and undermined delivering on the policy.

The research indicates that diversion of persons with MHPs from the criminal justice system can deliver benefits in terms of cost savings some caution needs to be expressed. While the research in England and Wales and Australia suggests that diversion is cost effective and yields significant savings, the research may have little direct use to Ireland, as the legal environment is different, as is the service delivery environment. The literature on the success and effectiveness of diversion schemes is incomplete; particularly with regard to mental health courts. Very often resources are not available to facilitate review and evaluation of diversion programmes and there is a lack of longitudinal studies that have evaluated initiatives and schemes over longer periods of time. The studies that are available in the different jurisdictions were largely descriptive in terms of outlining practice and procedure of the diversion programmes.

The research revealed that mental health legislation across the different jurisdictions differed in relation to including personality disorder. Defendants and offenders with a diagnosis of personality disorder are vulnerable to discrimination in accessing diversion and community disposal on the basis of their diagnosis. A lack of services or supports for persons with personality disorder was identified in the different jurisdictions with few treatment options available either within the prison system or in the community. Given the use of preventative detention and the premium placed on prisoners successfully

participating in offending programmes in order to secure release, the lack of provision of services and supports is troubling.

The available literature on mental illness and crime is very fragmented with many contradictions. It is clear that there has been a move towards managing risk and responding to perceptions of dangerousness posed by persons with MHPs and ID. It is suggested that the dangerousness and risk considerations are now the dominant theoretical perspective informing law and policy. It is suggested that while there is much attention given to the therapeutic jurisprudence approach, the concerns with risk and dangerousness prevail as evidenced by the proliferation of indeterminate sentencing in other jurisdictions, which has been described as "reverse diversion". It is a well-established principle of Irish constitutional law that the sentence imposed by the court must be proportionate to the offence and the personal circumstances of the offender. This robustly defended principle has meant that mandatory and indeterminate sentencing is not a dominant feature of criminal justice policy in Ireland. Indeterminate sentencing was discussed in detail in this thesis. The literature suggests that indeterminate sentencing may undermine or reverse diversion policy. While Ireland has yet to develop diversion, it is suggested that diversion if developed would not be undermined by indeterminate sentencing.

Defendants and offenders with ID were given separate consideration in the different chapters of this thesis. The reason for this is that many of the diversion initiatives have been specifically developed to respond to persons with MHPs. For example, a defendant with ID may not be permitted to participate in a mental health court programme unless they have a co-occurring MHP. The deinstitutionalisation movement means that defendants and offenders with ID are now more visible in the community. However, the research indicates that defendants and offenders with ID are less visible in the criminal justice system. The literature is not clear on whether persons with ID are over-represented or under-represented in the criminal justice system. Nonetheless, the increased visibility of persons with ID in the community means that any anti-social or criminal behaviour is also more visible, and is increasingly being dealt with in the criminal justice system. Diversion may happen informally through generic ID services that are required to respond to complex and risky cases.

The literature suggests that persons with ID enter the criminal justice system in the same way as other offenders, meaning that diversion processes are necessary to respond to their needs. However, the experiences of defendants and offenders with ID within the criminal justice system are dependent upon recognition of their disability. The research also suggests that traditional therapeutic approaches of the criminal justice system are inappropriate and ineffective for persons with ID and they face the risk of being rejected by mainstream services, as their needs are considered excessively challenging and not amenable to treatment. Persons with ID who engage in offending behaviour also face rejection from ID services as they are considered to pose an unacceptable risk to others in the service. If access to an ID service is possible defendants and offenders with ID embroiled in the criminal justice system may be required to live in institutional settings indefinitely for rehabilitation purposes and there are no formal processes of redress or adequate safeguards around their detention. A number of jurisdictions have sought to address the difficulties facing persons with ID through the creation of diversion programmes and specific procedures (EG New Zealand and Western Australia).

There is a need to explore the informal responses to persons with ID engaged in anti-social or criminal behaviour. These informal processes may result in deprivation of legal capacity and deprivation of liberty. It was identified that guardianship law may be used to control persons with ID in other jurisdictions and guardianship orders are provided for as part of the legislative framework for diversion elsewhere. Problems with guardianship orders were identified such as their underuse and reluctance on the part of family members to act as a guardian for a defendant or offender. The use of guardianship to facilitate diversion, based on substitute decision-making, is at odds with the CRPD. Regardless the NSWLRC acknowledged that the guardianship system could not address gaps in service provision, which it considered led to the crisis in the first place. However, if the supported decision-making model (required by Article 12 CRPD) replaced guardianship its processes could facilitate diversion. Supported decision-making could ensure that the defendant or offender understood what was involved in diversion, what was required of them and connect them to supports and services in the community. Such an approach would be consistent with the CRPD and neutralise criticism of diversion.

The failure to develop dedicated services for defendants and offenders

with ID may be a result of falling between different services and the absence of dedicated funding. There has been a failure to deliver upon commitments for specialised services for defendants and offenders with ID in Ireland and NI. In fact it has been suggested there is an emerging trend of criminalisation of the persons with ID as a result of limited resources and funding in the community. Specialised services may be coercive and restrict the rights of the defendant or offender. However, if detailed care plans based on CRPD principles were provided, these services could *inter alia* facilitate recovery and community living.

Suspects with ID are considered more likely to be arrested, make a confession or implicate themselves in the crime, be more susceptible to leading police questioning and plead guilty. Nonetheless it should be recognised that a number of jurisdictions have sought to address the vulnerability of persons with ID through the creation of safeguards around questioning in police stations and prosecution policies. Other jurisdictions have developed systems for dealing with suspects considered to be vulnerable, for example through the appropriate adult scheme, to support the person during questioning and to ensure fairness. While problems were identified with the appropriate adult scheme across NI, Scotland and England and Wales the system is much more advanced than the arrangements currently in place in Ireland. The 1987 Order applies only to suspects with ID, is rarely used and is not available to suspects with MHPs. In addition, to the appropriate adult scheme there is evidence in other jurisdictions of additional statutory procedural accommodations, such as the use of intermediaries for vulnerable defendants. It is clear that Ireland needs to develop safeguards and supports for defendants with MHPs and ID. Creation of these accommodations will be all the more pressing when Ireland eventually ratifies the CRPD.

In order for defendants and offenders with MHPs to have access to supports, services and reasonable accommodations in the criminal justice system, it is essential that the disability is identified and disclosed. The need to raise awareness about offenders and accused persons with ID through education in the legal system has been identified. While fitness to plead provisions aim to ensure a fair trial for defendants with ID, there are a number of concerns. Embedding a functional approach to mental capacity in determining fitness to plead has been identified as an emerging law reform trend across the

jurisdictions included in this study. This raises issues from the perspective of the CRPD (see below).

There is a lack of research relating to defendants and offenders with ID in Ireland. It is suggested that in line with trends in other jurisdictions defendants and offenders are dealt with informally in services in Ireland. This raises concerns from a human rights perspective as restrictions on liberty are not subject to safeguards and inspection of residential services commenced for the first time in 2013. Ireland does not have modern guardianship legislation as such deprivations of liberty in services have no legislative basis or formal independent oversight, regular review or even guidance. The development of forensic mental health services for persons with ID might enhance visibility within the criminal justice system. However, service users with ID who are dealt with informally in services will remain invisible unless HIQA, in exercising its new powers of inspection, require service providers to comply with minimum standards when depriving or restricting liberty.

A final but important point is the demarcation between persons with "moderate" ID or a "learning disability" and persons with a more significant ID. It was identified in Ireland and elsewhere that persons with "moderate" ID are over-represented in the Irish prison population. Additional research is needed to identify the needs of this group and the accommodations required to overcome the barriers they experience as participants in the criminal justice system. However, it appears that persons with mild and moderate ID are unlikely to be diverted compared to defendants with MHPs and significant ID. Western Australia is an interesting jurisdiction in that it has a specific diversion programme operating in relation to offenders with ID since 2003. However, eligibility for participation is based upon restrictive criteria. Therefore, defendants and offenders with moderate or borderline ID are ineligible to benefit from diversion.

While Ireland has an abysmal record on facilitating diversion, public policy in Ireland is quite flexible. Rigid and reactionary responses to crime and criminals have generally not dominated the discourse. Given this fluidity and flexibility, law and policy can be reformed to provide for diversion provisions, processes and initiatives, which are framed positively and consistent with the principles set out in the CRPD. Ireland can learn from the experience of other jurisdictions and

develop diversion provisions, processes and initiatives that are effective and responsive to the needs of persons with MHPs and ID.

3. Research Sub-questions

This thesis identified three research sub-questions; the answer to which are outlined below:

1) **Why has Ireland not developed provisions, processes and initiatives aimed at diverting defendants and offenders with MHPs and ID from the criminal justice system?**

Inquiries from the 1960s into responses to persons with MHPs and ID have recognised the deinstitutionalisation process required law and policy reform. Accordingly, recommendations were made that prisons and detention centres ought to make arrangements with local health authorities to provide the necessary psychiatric services. These recommendations remain unimplemented. The publication of the Report of the Henchy Committee in 1978 represented another key moment in identifying that Ireland was out of step with other jurisdictions, in not providing powers to the courts to divert persons with MHPs to mental health services. The Henchy Committee considered that the inability or restricted ability of the courts to facilitate "appropriate psychiatric treatment" was a "grave defect" with the law. Thirty-five years later this "grave defect" persists as recent policy proposals on crime, criminal justice and penal policy failed to consider the development of diversion.

In the early 1990s the Green Paper on Mental Health adopted a progressive approach to diversion, acknowledging the need to develop mental health services for defendants and offenders with MHPs. However, the subsequent publication of the White Paper on Mental Health, questioned the desirability of the courts referring persons engaged in criminality to general psychiatric services. This concern was largely expressed by psychiatrists, fearful of the presence of defendants and offenders with MHPs in general psychiatric services. There was an apprehension that the recovery ethos of general psychiatric services would be undermined. The official explanation for the omission of diversion provisions in the *Mental Health Act 2001* was based on the need to speed the legislation through parliament so as to comply with the friendly settlement reached in the ECtHR case of *Croke*

v Ireland. This explanation is unsatisfactory. Given that the Report of the Henchy Committee contained a comprehensive Bill, detailing how powers of diversion would sit within mental health legislation, it is not clear why these provisions were not included in the Bill. The extensive work by the Henchy Committee on drafting statutory provisions would have made inclusion of diversion provisions possible. While the Minister intended "to return to the issue after the Bill has been enacted", this did not happen. There was approximately a 5-year gap between the passage of the 2001 Act and its commencement in 2006 a sufficient period of time in which to insert the provisions on diversion.

Specialised mental health services are an integral part of the diversion system operating in England and Wales, Scotland and throughout Australia. The failure to develop specialised mental health services in Ireland may also partly explain the failure to develop diversion at the different points of the criminal justice system. Greater consideration is given to the human rights of persons with MHPs, in contrast to a weak pursuit of the human rights of persons with MHPs in contact with the criminal justice system. Reflecting on the failure to deliver on the commitments to develop non-contentious community mental health services in "A Vision for Change", it would seem unlikely that these specialised services for "criminals" will be prioritised.

A further explanation for the failure to develop diversion in Ireland may be the curious but life limiting ailment (afflicting Government) – the "implementation deficit disorder". This disorder coupled with the Department of Justice's obsession with power, control and secrecy and aversion to criticism make the creation of an effective well-resourced diversion system seem unrealistic. A further complicating factor that needs resolution is the rigid dividing lines drawn between the competencies of the Department of Health and the Department of Justice. Mental health policy is exclusively within the remit of the Department of Health, while criminal justice policy is exclusively within the remit of the Department of Justice. As is evident from the comparative study in this thesis a co-ordinated approach is essential to diversion. Criminal justice agencies, health services and the relevant government departments have to collaborate and work effectively if a policy of diversion is to be successfully implemented.

Ireland has not developed legislative provisions for compulsory treatment in the community in the same manner as other jurisdictions.

From the perspective of service users and human rights law this is positive. Powers compelling treatment in the community are used to mitigate the risks posed by diverting persons with MHPs from the criminal justice system into the community. The failure then to develop provisions mandating community treatment may have restricted the development of diversion provisions. The absence of control over persons with MHPs diverted to the community, would be essential given the Gallagher controversy, which resulted in concern amongst politicians, psychiatrists and officials in the Department of Justice with the limitations of power to recall persons released from care into the community.

It is important to emphasise that key moments presented, where opportunities opened up to develop diversion (EG the Henchy Report and the formation of the *Mental Health Act 2001*). Perhaps it is a combination of the factors discussed above that led to the failure to seize these key moments. However, it is suggested that the opposition of psychiatrists to proposals for legislative powers of diversion for judges and their fears of contaminating general psychiatric services may have been key to excluding provisions of diversion from the 2001 Act.

2) Do provisions, processes and initiatives aimed at diversion comply with international human rights law and if not how can diversion comply with international human rights law?

Diversion until recently was understood to involve the transfer of a defendant or prisoner from prison to mental health services or other social services. This was uncontroversial, diversion in this way was considered best practice and consistent with a human rights based approach. However, certain Articles of the CRPD (EG Articles 12, 14 and 17) challenge the legitimacy of diversion practice. The CRPD calls into question diversion policy, which may involve mandatory admission to hospital, forced treatment or any other disability discriminatory practices. However, there are a number of different sources of international human rights law that support diversion from prison to mental health services (EG MI Principles, the jurisprudence of the ECtHR and the CPT inspection standards).

While the insanity defence is only raised in a small number of cases it is an important component of the criminal law. The failure of the OHCHR

to adequately explain its call for its abolition is regrettable, particularly as the defence is central to debates about the effect of the defendant's mental condition on their criminal liability. Similarly, it is regrettable that the UN Committee on the Rights of Persons with Disabilities has failed to engage with the issue in its Draft General Comment on Article 12. One of the main rationales for the development of the CRPD was to provide greater clarity on the application of human rights to the circumstances of PWDs. The CRPD on the whole was successful in expressing this in the text of the Convention. However, the calls for the abolition of the insanity defence and mental health laws has resulted in confusion and uncertainty, which is manifestly evident within the UN system itself where it endorses the old paradigm in its Draft General Comment on Liberty and Security of the Person. It is coming as a surprise for State Parties that negotiated the Convention that their compliance with the Convention now requires abolition of the insanity defence and replacement with a nebulous disability neutral equivalent. The repeal and replacement of the insanity defence with a disability neutral defence opens up the insanity defence in a way that would be repugnant to legislators and the public who often view the defence with much distrust and scepticism. Given the risk of institutionalisation faced by PWDs, it is argued that a replacement disability neutral law aimed at managing risk may further contribute to the upward trend in institutionalisation of person with disabilities in prisons. A more workable suggestion for law reform would be to address the core human rights concern with the insanity defence, the indefinite detention of persons who successfully raise the defence.

It is argued that diversion does not necessarily involve a deprivation of legal capacity (EG by stripping away criminal responsibility). Diversion generally happens where the defendant or offender has engaged in non-serious offending and participation in the diversion programme is voluntary. Therefore, unlike the insanity defence and other similar defences, Article 12 may not require abolition of diversion provisions, processes and initiatives. At any rate the invocation of the insanity defence is generally a decision taken by the defendant, in Ireland the Supreme Court robustly rejected the suggestion that the defence can be imposed.

The comparative study indicates that diversion involves "evolving models of practice" that can change and adapt. The CRPD with its "paradigm shift" in thinking can challenge objectionable aspects of

diversion practice and ensure that human rights compliant approaches are followed. Diversion practice should be flexible and should be responsive to the needs of PWDs in contact with the criminal justice system. It is suggested that the CRPD (EG Articles 13, 16, 19, 25 and 26) can be used to reformulate diversion practice to address the concerns from the user and survivor groups. Persons with MHPs face significant barriers in accessing services in the community, which may result in involvement with the criminal justice system. Diversion serves as a conduit to accessing services and supports in the community. As such conceptual objections to diversion based on the CRPD need to be strategically considered and targeted so as not to undermine the right to health, habiliation, rehabilitation and recovery.

3) To what extent is the CRPD influencing law and policy on diversion from the criminal justice system of persons with MHPs and ID?

The comparative study of law and policy on diversion in Ireland, England and Wales, Scotland, NI and Australia reveals that the CRPD is having a very limited impact. Some policy documents and official reports reference the CRPD, however, the implications of Articles 12, 14 and 17 do not feature in the discourse around diversion. A number of institutional law reform bodies have recently considered reform of the insanity defence, automatism, diminished responsibility, fitness to plead and diversion. While there were tokenistic references to the CRPD there was no substantive discussion of its implications. This is surprising and calls into question whether the CRPD will have an impact at the national level. The NSWLRC in its excellent work on diversion endorsed diversion highlighting the positive therapeutic benefits that the provisions, processes and initiatives deliver. The jurisdictions that have recently or are currently examining fitness to plead (NI and England and Wales) have sought to reform the law by adapting the mental capacity approach in the *Mental Capacity Act 2005*. This substitute decision-making approach is at odds with the CRPD and there is no evidence to suggest that the institutional law reform bodies see the CRPD as an impediment to reforming the law on fitness to plead in this manner. Therapeutic jurisprudence principles inform and motivate diversion law and policy across the jurisdictions included in this study. There is little evidence to suggest that the CRPD will be interpreted in a way that will restrict the development of diversion provisions, processes and initiatives in these jurisdictions or in Ireland.

While the CRPD has been and will continue to be instrumental in advancing the rights of PWDs and driving law reform agendas across the world there is little evidence to suggest it is or will have a significant impact on diversion law and policy in the short term.

4. Recommendations

- The Law Reform Commission should undertake a law reform project or series of projects on the law on the insanity defence, fitness to plead, diminished responsibility and diversion. A project on diversion in particular should spark a debate and the consultation process involved would provide an opportunity for all stakeholders to express their views. Such a process would challenge the dominance of forensic psychiatrists who control diversion policy. The terms of reference of the law reform project should be wide, adopting a broad definition of diversion.

- The Department of Justice and the Department of Health should develop a specific policy committed to diversion of defendants and offenders with MHPs and ID from the criminal justice system. This policy should be developed through a consultative process with all stakeholders and should be informed by principles of international and regional human rights law. The policy should be informed or amended to take on-board the work of the Law Reform Commission's proposed work in this area.
- The research identified one of the main challenges in implementing effective diversion provisions, processes and initiatives is the development of effective relationships amongst the different stakeholders dealing with defendants and offenders with MHPs and ID across criminal justice, health and social service agencies. The process of developing diversion policy should place a particular emphasis in securing effective cooperation from the outset.

- As diversion schemes are developed in Ireland provision should be made to evaluate their effectiveness and these evaluations should examine substantively the effectiveness of these programmes in meeting their objectives and goals. Dedicated funding should be inbuilt into these programmes to facilitate these evaluations, which should collect outcome and process based data.

- While the Interim Report of the Steering Group on the Review of the *Mental Health Act 2001* was silent on diversion and defendants and offenders with MHPs, the pending process of amending the Act should consider the inclusion of provisions to facilitate diversion.

- It was identified in the research that diversion yields substantial savings in a number of different ways. However, diversion at the different points of the criminal justice system requires a significant investment in specialised services (locally regionally and nationally), police liaison schemes, court liaison schemes etc. As such the IPRT should commission research identifying the costs involved in creating the diversion infrastructure assessed against the potential savings.

- A cautious approach should be taken to suggestions to develop mental health courts as part of the diversion policy in Ireland. At nay rate mental health courts if developed should be seen as only part of the diversion framework.

- Given the centrality of psychiatry to policy development in Ireland, in particular through expert review, it is suggested that it is unlikely that a formalisation of diversion processes is likely to happen in the near future. It is similarly contended that the National Forensic Mental Health Service's opposition to the diversion programmes earlier in the criminal justice process (before in-reach in remand centres) will stall progress in developing diversion programmes envisaged in "A Vision for Change". As such it is recommended that civil society organisations (EG Irish Penal Reform Trust and Mental Health Reform) should develop informed policy positions on diversion and campaign for reform.

- In contrast to Ireland there is much greater transparency around decisions to prosecute persons with MHPs in England and Wales. The decision-making around prosecution in England and Wales is based on a clear policy of weighing up the decision not to prosecute with the public interest. In other jurisdictions principles of therapeutic jurisprudence and principles of reasonable accommodation are present in this weighing up

process (EG the factors to be taken into account include the impact of the prosecution on person's physical and mental health and their age). In Ireland, there is little guidance for Gardaí and the DPP in making decisions to prosecute persons with MHPs or ID, a situation that requires consideration. Separate Garda and DPP policies on diversion of persons with MHPs and ID should be developed. This should be supported with codes guiding diversion and enhanced disability awareness training for prosecutors and Gardaí.

- The NDA commissioned and published research on the experiences of disabled victims of crime in Ireland. This research has added significantly to the understanding of the barriers in accessing justice in Ireland (Article 13 of the CRPD). It is recommended that the NDA should build upon this Report by commissioning research that examines the experiences of defendants, offenders and prisoners with MHPs and ID in Ireland. This research identifying first person narratives could be used to lobby for the development of diversion provisions, processes and initiatives in Ireland.

- HIQA in exercising their powers of inspection should examine how ID service providers respond to service users in contact with the criminal justice system. This examination should extend to identifying responses to service users considered to pose risk to others. In its inspections HIQA should pay particular attention to restrictions on the service users liberty. The information should be collated in a thematic way and published in its Reports. The NDA should also commission research on ID services to identify practice in this area. The NDA (building on its previous work on inspection standards of ID services) should in partnership with HIQA develop guidance for service providers on how to respond to service users engaged in anti-social or offending behaviour.

- Across all jurisdictions Ireland, England and Wales, NI, Scotland and Australia problems with data collection were identified in respect of defendants and offenders with MHPs and ID. The lack of information restricts the ability to plan services and supports for defendants, offenders and prisoners with MHPs and ID. Deficits with statistical information may also serve to mask failures of the State in delivering on the right to health,

habiliation, rehabilitation and recovery. Article 31 of the CRPD concerns statistics or rather the collection of statistics. Effective and responsive policy requires accurate information on the status of PWDs. As such the CRPD requires the collection and analysis of data in order to deliver on the rights it contains. Civil society organisations and other stakeholders should use Article 31 to lobby for better data collection on defendants, offenders and prisoners with MHPs and ID.

- The Bamford Review and "A Vision for Change" represent ambitious plans for the development and modernisation of mental health services both north and south of the border. Unfortunately both plans have faced significant barriers in implementation of their core recommendations. There may be potential to develop North South cooperation to propel implementation in both jurisdictions. When the Regional Forensic Network is established in NI it should create links with the National Forensic Mental Health Service based in Dublin.

- The research reveals that an effective diversion system requires that all stakeholders have adequate training on mental health and ID. As such all stakeholders in the Irish criminal justice system, health and social services should receive on-going awareness training (EG Gardaí, lawyers (both defence and prosecution), members of the judiciary, prison officers, probation officers, mental health professionals and prison personnel).

- The UN Committee on the Rights of PWDs should clarify its position on the insanity defence and other similar defences in light of Article 12 of the CRPD.

- The EU has funded research previously mapping forensic mental health laws across a number of EU Member States and diversion practice. This research was concluded before the finalisation of the CRPD and a future research project could explore the implications of the CRPD on the law and policy for Member States of the EU. The FRA would be in a good position to commission this work given its other work on the CRPD.

- In light of the criticisms of Sheehan J in *DPP v B* the Minister for Health should consult with the Mental Health Commission in

considering designating other mental health services as "designated centres" under section 3 of the *Criminal Law (Insanity) Act 2006*.

5. Suggestions for Further Research

In line with the research questions outlined above it is necessary to limit the scope of this thesis to analysis of law and policy relating to adult defendants and offenders with MHPs and ID. As such it is outside the scope of this thesis to consider a number of other important issues that ought to be considered in future research on this area. The following is a list of these areas:

- Future research should explore the implications of the CRPD for the diversion of minors with MHPs and ID from the criminal justice system.

- Further consideration should be given to the prison abolition literature, building upon the conceptual links with the discourse on diversion and the right to community living as provided for in the CRPD.

- The comparative element of this thesis should be expanded to include an examination of jurisdictions where abolition of the insanity defence has taken place. This study should also examine related defences such as diminished responsibility and the law on fitness to plead and the law reform trend to embed mental capacity tests into the criminal law in this area.

- Future research should further explore the connections between diversion, non-discrimination and reasonable accommodation. A broader comparative element should be undertaken and identify the relevant case law and best practice.

- Homelessness, drug and alcohol abuse and other factors are significant issues for defendants and offenders with MHPs and ID in contact with the criminal justice system. Further research should critically evaluate law policy and related matters.

- There is a lack of research exploring the tensions between the social model of disability and mental illness. There is even less

research exploring the social model of disability and its application to defendants and offenders with MHPs. A research project identifying the perspectives of service users with experience of civil mental health services and service users with experience of prison or forensic mental health services would facilitate a useful dialogue on diversion and the reconciliation of differing views.

- Further research should also examine barriers to diversion for defendants and offenders with a dual diagnosis of ID and a MHP.

- The literature on diversion does not comprehensively address the issues facing women with MHPs and ID in contact with the criminal justice system. There is virtually no discourse of diverting women with MHPs and ID from prison in Ireland. The lack of comparative research is of concern given the vulnerability of women to abuse in institutional settings. Greater consideration has been given to the committal of women with MHPs to prison in England and Wales, although the tougher criminal justice climate has been identified as a reason for an increased committal of women to prison. Short prison sentences were identified as having a detrimental impact on families with children taken into care. In England and Wales it was suggested that community mental health services failed to adequately address the mental health needs of women and to facilitate diversion earlier in the criminal justice system. Given the prevalence of women with MHPs and ID in the Australian prison population a need for separate, dedicated forensic mental health facilities was identified. Research should be undertaken on the gender-based aspects of diversion in light of the CRPD. The NDA and the MHC should commission or undertake research on the experiences of women with MHPs and ID in contact with the criminal justice system in Ireland.

- In light of the experiences of defendants and offenders with personality disorder research should be carried out in Ireland identifying services and supports that can facilitate diversion in Ireland.

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Appendix 1: Statutory Powers of Diversion Scotland

1. Assessment Orders

Assessment orders can be issued in circumstances where a defendant has been granted bail or has been remanded in custody. The Procurators Fiscal under section 52B has the power to apply for an assessment order, where a person has been charged with an offence and a relevant disposal has not been made in respect of that offence; and where it appears to the Procurators Fiscal that the person has a mental disorder. This happens before the defendant's trial and under section 52D (6) they can be detained in hospital for up to 28 days to allow a psychiatrist to carry out an assessment of their mental health. The assessment report prepared by the psychiatrist serves to assist the court in deciding whether the defendant is fit to stand trial or whether they need to stay in hospital for treatment until such time as they are considered fit to stand trial.

Under section 130 52G (4) the court, after receiving a report and where it considers it necessary, can make an order extending the assessment order for a period not exceeding 7 days beginning with the day on which the order otherwise would cease to authorise the detention of the person in hospital. Section 130 52G (5) also provides that the court can, under subsection (4) extend an assessment order in the absence of the person subject to the order where the person is represented by counsel or a solicitor; that counsel or solicitor is given an opportunity of being heard; and the court is satisfied that it is impracticable; or inappropriate, for the person to be brought before it. This order authorising the extension of 7 days is in addition to the 28 days permitted for assessment. There are a number of safeguards surrounding detention for assessment. For example, there is a right of appeal provided for against the order. In addition the psychiatrist is placed under an obligation to notify the court if the defendant's circumstances have changed or if the order needs to be terminated or modified.

2. Treatment Order

Treatment orders are provided for in section 130 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*.[1] In circumstances where a defendant had been given bail or has been remanded in custody awaiting trial the court has the power to detain a defendant in hospital for the purposes of treatment for their mental disorder. The Act provides that a Procurators Fiscal is entitled to make an application for a treatment order in respect of a defendant but is under an obligation to inform the defendant as soon is as reasonably practicable after making the application. Section 130 52M (2) (a) requires that two "medical practitioners" have to give written or oral evidence that the defendant requires treatment. At least one of the doctors has to be a psychiatrist. There is no fixed time limit on this order and it can stay in place until such time as the court makes its final decision about the defendant's case or until the court issues another order such as a hospital order (see discussed below. There is no right of appeal under the Act against an order).[2] There is a limited safeguard in that the defendant's "psychiatrist has a responsibility to notify the court at any time if your circumstances change and the order needs to be cancelled or changed in some way".[3]

3. Temporary Compulsion Order

In Scotland if the court makes a decision that a defendant's trial cannot start or cannot continue because they are considered to be unfit to stand trial the court is empowered to detain the defendant in hospital for treatment under a temporary compulsion order. The court can only make this order where medical practitioners who have undertaken an examination of the defendant have recommended it. After the court has issued a temporary compulsion order they can proceed to explore the facts of the offender's case by carrying out a procedure called an "Examination of Facts". This procedure allows the court to establish if the defendant carried out the offence with which they have been charged. There is no fixed time limit on this order and it can last until

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[1] See "The New Mental Health Act: A guide for people involved in criminal justice proceedings" (Edinburgh: Scottish Executive, 2005) at page 6.

[2] *Ibid*, at page 7.

[3] *Ibid*.

the court makes its final decision about the case or until such time as the court makes a different order such as a hospital under. There is no right of appeal under the Act against temporary compulsion orders.

4. Acquitted but detained

Following the completion of the "Examination of Facts" procedure or the trial the court if it is not satisfied "beyond reasonable doubt" that the defendant carried out the act that they are charged with the court is required to acquit the defendant. In circumstances where the court receives two recommendations from "medical practitioners" that the defendant needs care and treatment for their mental disorder, the court has the power to detain the defendant for 6 hours so that a doctor can examine the defendant.

5. Remand on bail for enquiry

Section 132 of the 2003 Act amended section 200(9) of the 1995 Act, which provided for the remand of defendants in custody to allow inquiry into their physical or mental health. Under the previous provision there was a 24-hour time limit for an offender to appeal against an order for committal to hospital, or renewal of an order. Section 132 removed this requirement, which permits a defendant to appeal at any time during the committal to hospital process. Further amendments of section 200 are contained in paragraph 8(13) of schedule 4 to the 2003 Act.

6. Committal to hospital for enquiry

If a defendant is convicted of an offence where the punishment is imprisonment, the court is entitled to commit the defendant to hospital for 3 weeks for the purposes of examination. A court is entitled to make this order where it wants supplementary information relating to the defendants mental disorder and in advance of making a final decision in relation to how it is going to dispose of the case. The court only makes this order if a medical practitioner examined the defendant and made a recommendation to that effect. Under the 2003 Act a person who is committed to hospital under this order and leaves is considered to have committed a criminal offence and is liable to be arrested and returned to court. The defendant does have a right of appeal against being compelled to the hospital.

7. Interim Compulsion Order

The *Mental Health (Care and Treatment) (Scotland) Act 2003* provides that where the court decides that the defendant's trial cannot proceed or continue due to unfitness to stand trial the court may detain the defendant in hospital for treatment under an interim compulsion order. [4] Interim compulsion orders apply in respect of persons convicted in the High Court or the Sheriff Court of an offence punishable by imprisonment (other than an offence the sentence for which is fixed by law); or where the persons is remitted to the High Court by the Sheriff under any enactment for sentence.[5] The court is empowered to make interim compulsion orders where two medical practitioners have examined the defendant stating that it is necessary to make the order. There is no fixed time limit in respect of interim compulsion orders. These orders can last until the court comes to a final decision about the case or until the court commits a defendant to hospital by way of another order under the 2003 Act.[6]

If a defendant has been convicted of an offence attracting a penalty of imprisonment the court can detain the defendant in hospital for 12 weeks as an alternative to imposing the prison sentence. The rationale here is that this facilitates the defendant receiving a comprehensive assessment of their mental health and the identification of treatment before the court makes a final decision disposing of the case. In order for the court to make an Interim Compulsion Order they must have received reports from two doctors stating that it is necessary to make the order. If the doctors have not reached a clear opinion as to whether the defendant has a mental disorder and the necessary treatment. Interim Compulsion Orders can be extended for 12 weeks up to one year. There is a right of appeal to the court against the order being initially imposed but there is no right of appeal against the renewal of the order. The treating psychiatrist has responsibility for informing the court if the circumstances of the defendant change during the duration of the interim compulsion order.

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[4] See section 131 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*.

[5] Section 132 53 (1).

[6] There is no right of appeal under the Act against this order.

8. Compulsion Order

When a person is convicted of an offence where the penalty is imprisonment, as an alternative to the custodial sentence the court can make a Compulsion Order that will detain the defendant in hospital for a period of 6 months. Alternatively, the court can impose strict conditions on the defendant's release into the community. Conditions that can be imposed include a requirement that the defendant attend a particular place on a regular basis, in order to receive treatment, care or other services. This particular place does not necessarily have to be a hospital. Other conditions attaching may include living at a specific address, allowing people (EG a doctor or any person that the doctor has authorised to administer treatment, care or other services) to have access to their residence in order to receive treatment, care and other services. Other conditions that can be attached to a Compulsion Order include a requirement that the offender must inform their mental health officer should they change address and the mental health officer must consent to the proposed change.

Failure to comply with the conditions attaching to a Compulsion Order can be refereed to the Tribunal (discussed below) with a view to amending the conditions of the Order. A person can be detained in hospital if it is considered that it is necessary to safeguard their health. In order to make a Compulsion Order it is necessary for two doctors (one of whom must be a psychiatrist) to consider whether the offender is suffering from a mental disorder that makes it necessary for hospital treatment. The doctors will also consider whether the Compulsion Order is necessary for the offender's health and safety or for the protection of third parties that they receive the treatment. Regardless of whether the Compulsion Order mandates treatment in the hospital or treatment in the community, the offender's psychiatrist has responsibility for keeping the order under review. When the circumstances of the person subject to the order changes the psychiatrist is required to apply to the Tribunal to have the order altered or terminated. When the Order has been in place for 6 months the person's psychiatrist has the option of extending the order for an additional 6 months. Thereafter it can be extended for periods of 12 months at a time. There is a right of appeal to the court against the Compulsion Order being made in the first instance. The offender and their named person are entitled to make an application to the Tribunal at different times to request that the Order be varied or cancelled. It is

also within the power of the Mental Welfare Commission to cancel the Compulsion Order or to refer the offender's case to the Tribunal for review in circumstances where it is considered necessary or appropriate to do so.

9. Restriction Order

A person who is subject to a Compulsion Order can also made subject to a Restriction Order if the Court is of the view that this measure is required. A person subject to both a Compulsion Order and a Restriction Order cannot be transferred to another hospital or granted leave from the hospital without the approval of the Scottish Ministers, which is seen as necessary to protect the public, but also serves to politicise the process. A person subject to a Restriction Order is bound by the terms of the Compulsion Order without any time limit until the Tribunal terminates the Restriction Order. The timescales for the Tribunal in reviewing cases is different than cases solely involving a Compulsion Order. The Tribunal will review the offender's case every 2 years unless the offender's psychiatrist or the Scottish Ministers refer the case to the Tribunal during the 2-year period. The person's psychiatrist and the Scottish Ministers keep the need for the Restriction Order under review. If the circumstances of the offenders change their case should be referred to the Tribunal. In terms of safeguards there is a right of appeal to the court against the Restriction Order being granted in the first instance. Subsequent to that the offender and their named person is entitled to make an application to the Tribunal at specific times for a review of the offender's case. The Tribunal does have statutory powers to direct a full or conditional discharge in certain circumstances. The Mental Welfare Commission is also empowered to refer a Restriction Order to the Tribunal if they consider it to be appropriate.

10. Hospital Direction

In circumstances where a person has been convicted of an offence attracting a penalty of imprisonment the court, in addition to imposing a custodial sentence, can direct that the offender be detained first in hospital with a view to providing care and treatment for their mental disorder. The court can only exercise this power where there has been a recommendation by two doctors, one of whom must be a psychiatrist. The doctors must consider that the offender is suffering from a mental

disorder that requires treatment in hospital and that it is needed in order to protect the offenders health and safety or for the protection of third parties. The review procedures are the same as those provided for persons subject to Compulsion Orders and Restriction Orders. The Scottish Ministers approval is required before an offender subject to a hospital direction can be transferred to another hospital or allowed to leave the hospital.

Again under this a Hospital Direction a psychiatrist and the Scottish Ministers are required to keep the person's detention under review. There is a politicisation of the law here in that in certain cases the Scottish Ministers can direct that an offender be transferred to prison to serve the remainder of their sentence. Importantly, the time that an offender spends detained in hospital is taken into consideration. There is a right of appeal to the court against the Hospital Direction being imposed in the first instance. Following that an offender and their named person are entitled to make an application to the Tribunal at different times to ask for the direction to be cancelled. The Tribunal has the power in certain circumstances to order the termination of the Hospital Direction and discharge of the offender from hospital. The Scottish Ministers also have the power to terminate the Hospital Direction and discharge the offender from hospital in certain circumstances. The Mental Welfare Commission for Scotland can refer cases to the Tribunal.

The Hospital Direction terminates at the same time as the offenders sentence. If the direction is cancelled and the offender is discharged from hospital before the end of their sentence they are required to go to prison, or an alternative institution to serve the remainder of their sentence. In circumstances where a person comes to the end of their sentence and the treating psychiatrist considers that the person should continue to be detained in hospital for treatment, the psychiatrist has the power to apply to the Tribunal for an order to extend the person's detention. There is a corresponding entitlement for the "patient" to appeal the order being issued by the Tribunal.

11. Transfer for Treatment Direction

There are provisions governing the transfer of prisoners who are serving a sentence in Scotland to be transferred to hospital for treatment. The procedural safeguard is that two doctors one of whom

must be a psychiatrist must form the view that the prisoner is suffering from a mental disorder, and requires the treatment in hospital, which is necessary for their own health, safety and welfare or for the protection of third parties that they receive the treatment. The Scottish Ministers again have the power to direct the transfer of prisoners to hospital for care and treatment. The review procedures for Transfer for Treatment Directions direction are the same as for Compulsion Orders with a Restriction Orders. It is necessary for the Scottish Ministers to authorise the transfer of a "patient" to another hospital or if they are to be granted leave.

Psychiatrists and the Scottish Ministers keep under review the need for prisoners to be detained in hospital in certain circumstances; the Scottish Ministers can direct transfer back to the prison to serve the remainder of the offender's sentence. However, the time spent in hospital is taken into consideration. The offender and their named person can appeal to the Tribunal against the Transfer for Treatment Direction being issued. Following that the offender and the named person can apply to the Tribunal at different times to ask for the direction to be terminated. Under different circumstances the Tribunal can order that the direction be terminated and that the offender is discharged from hospital. The Scottish Ministers are similarly entitled to cancel the direction and discharge the offender from hospital in certain circumstances. The Mental Welfare Commission for Scotland is entitled to refer cases to the Tribunal if it considers that it is appropriate to do so.

The Transfer for Treatment Direction comes to an end at the same time as the offender's sentence. In circumstances where the Transfer for Treatment Direction is terminated the offender is discharged from hospital before the end of their sentence they will be returned to prison, or another institution to serve the remainder of their sentence. In circumstances where a offender is in hospital at the end of their sentence and the treating psychiatrist is of the view that the offender's mental disorder requires continued detention they are entitled to apply to the Tribunal for an order to continue the offender's detention. However, there is a corresponding right for the offender to challenge the order.

12. Probation Order with Requirement of Treatment

The court can also make a requirement for treatment a part of a Probation Order, meaning that an offender is required to attend a specified place such as a hospital, surgery or clinic for treatment either in an in-patient or outpatient basis. Interestingly, there is an element of choice for the offender in respect of a Probation Order with Requirement of Treatment, in that the court is not permitted to subject a person to this type of order without their consent. These orders can last for periods of up to 3 years. Probation Orders with Requirement of Treatment must be recommended by the offender's psychiatrist and the doctor or psychologist that will be giving the treatment. In circumstances where the local authority is providing a supervising officer their recommendation is also relevant. There is a significant element of coercion and control of persons subject to this order. If an offender is being treated on an outpatient basis and does not keep their medical appointments, or if they are residing in hospital for treatment as an in-patient and they leave the hospital without authorisation, or if they attend appointments and refuse treatment, their supervising officer is informed and the offender may be returned to court for breaching the conditions of the order. Other conditions may also be imposed as part of this order such as good behaviour and an abstention form engaging in criminal conduct. If an offender does not comply with the conditions of the order their supervising officer is under an obligation to notify the court and the offender can receive an alternative sentence.