BEDLAM: Mental Health and the Justice System
Issues and Problems raised in the discussion of 29 September 2012. This text does not follow the order of the discussion, nor does it necessarily indicate the speaker. It is a synthesis of issues and problems.

Steve Lancken,
Greg James,
Angela Karpin
Lorraine Rose,
Douglas Holmes,
Sergeant Mathew Ireland,

Problems identified in this paper:
These are set out in the order in which they appear in the text.

1. Many mentally ill people in the community are not receiving treatment (which they may need), unless they seek it voluntarily or unless they come to the notice of police or other agencies, and are detained or hospitalised.

2. Police have to be specific in their decision to detain, although the actual condition of a person cannot be ascertained before a medical assessment. A person affected by drugs may find themselves in mental health detention for some days. A person who is clearly affected by drink may be in the Emergency Department even if there is an underlying mental illness.

3. The Police may not have sufficient training or experience to deal with persons affected by drugs or mental illness. They have to make difficult decisions at the scene and deal appropriately with a confused and violent person, and attempt to communicate with that person. People may be arrested and dealt with inappropriately, under the wrong Act.

4. A person may be scheduled even before it is possible to make a proper diagnosis. It may take time for the effect of drugs to wear off, and for the full story to be understood. The psychiatrists often assert that the patient’s denial of mental illness shows a lack of self-awareness, thus confirming mental illness. But good psychiatrists look to more than that.

5. Having agreed to take him, the hospital may later discharge him prematurely into the care of someone, or because the condition is masked. The person may still require treatment, but there is no way to provide for this unless he seeks it voluntarily. The person may come in and out of the system in this manner, causing work for Police and not getting proper treatment.

6. Will a person with mental disorder receive appropriate treatment?

7. The legal provisions to ensure independent monitoring of mental health detention are inadequate to deal with urgent matters.

8. Imperfections in the system of detention under MHA. These failings may result in a person ending up in the justice system, where treatment is scarce.

9. Lack of facilities and treatment options for mentally disturbed young people who come to the notice of the Police.

10. Many people who could be helped by proper and adequate treatment are not getting it and are coming to the attention of authorities because of their behaviour or because they are
involved in minor offences. They become the responsibility of criminal justice time and again when they really need properly organised treatment.

11. A person with a mental illness and needing treatment, is unlikely to get it while he is in custody of the justice system. Even if the Court orders treatment it may not happen. Many are thus deprived of their right to treatment. Basic rights are denied.

[The High Court decided that prisoners could not be deprived entirely of the right to vote, but they are denied treatment for their illness.]

12. Is reform needed to introduce a verdict of “Not responsible” rather than not guilty by reason of mental illness?

13. Another failure of the system to provide treatment, rehabilitation services for persons detained with mental illness who have been through the justice system. The situation is serious enough to be considered abusive. Treatment should be available to persons found not guilty in this situation.

14. The use of medication beyond the need for harm prevention, or for therapeutic purposes, as a means of neutralisation and management.

15. General problems about the way in which those with mental illness or with mental disability are treated by those who have custody of them or power over them. Abuse of authority.

16. The principles for care and treatment of people with mental illness set out in s 68 of the MHA are not fully observed in NSW. Nor are the UN Standard Minimum Rules for the Treatment of Prisoners,

General Issues

Legislation
There are three Acts: the Crimes Act defines crimes; the Mental Health Act (MHA) provides a legislative framework for the treatment, voluntary or involuntary, of mental health patients; the Mental Health (Forensic Provisions) Act looks at the intersection between mental health issues and justice issues.

Defining mental illness
There are two different categories under the legislation, the mentally disordered, and the mentally ill, MHA sections 13, 14 and 15 (definitions for these). It can be difficult to determine the boundary where, eg, severe depression becomes mental disorder, where there is lack of control etc. It is a matter for the expert to assess. The court is guided by expert opinion.

Police role in picking up mental illness
If the Police see bizarre behaviour of a person, they may take the person to hospital. If the doctor considers the person poses a substantial risk of serious harm to himself or others, he may be Scheduled as mentally ill, and involuntarily treated in the hospital.

Numbers affected by mental illness
Some 16,400 people (detained on mental health grounds) came before the Mental Health Review Tribunal in the last two years. And there are many others who do not get before the Tribunal, but who may come before the justice system.

In NSW 120,000 come into the 55 Mental Health units. They fall into five categories: Most stay less than 3 days; some stay 4-10 days; others 10-28 days. Some stay 6 months, others longer. There are two factors relevant to this. The doctor’s assessment and the pressure on resources. Priority is given to those deemed to be seriously, dangerously ill. They may discharge people who need treatment, before community treatment can be arranged.
At the St Vincent’s Emergency Department, 54,000 cases presented last year. 10% of these had mental health issues and needed to be seen in the next 8 hours. 384 go into Caritas and 760 go into the psychiatric emergency care centre.

**PROBLEM**

1. Many mentally ill people in the community are not receiving treatment (which they may need), unless they seek it voluntarily or unless they come to the notice of police or other agencies, and are detained or hospitalised.

**THE HYPOTHETICAL**

**The starting scenario: A violent incident**

Lancken described the scenario: Eric, 19, has had a big night out, and a ‘friend’ has slipped him an undisclosed drug which has a strange effect on him. His friends take him out of the hotel at 1 am or so, and he gets very agitated. Someone hits him; he lunges out, smashing a plate glass window and hurting himself. His mates disappear quickly. The Police come. He is incoherent, can’t remember his name or who he is, how he got blood on his hands or how the window got broken. He is agitated and threatening violence.

**Police response: securing safety is priority**

The Police priority is to keep him safe, to prevent him causing further injury to himself, and to ensure that others are safe. He may need to be physically restrained, handcuffed. There is an apparent offence which will have to be dealt with later.

**Ambulance role: dealing with the need for treatment**

An ambulance might be called. But they may not want to take on Eric, who is still violent and incoherent. If he is injured/bleeding, the Police would try to control him so that the ambulance officers could treat him, using handcuffs or other restraint. Or a policeman would get in the ambulance with him. This is done before charging him, as the primary consideration is the safety of Eric. They would try to get him to hospital. The ambulance would take him to hospital, or, if he has been detained under the MHA, to the designated mental health facility.

**Police detention: the legal basis**

Eric could be under arrest (Crimes Act/Police Act) for the damage he caused to the window, or he could be detained by Police under the Mental Health Act, s 22. The Police must decide at the scene whether detention is under the Mental Health Act or whether the person is arrested. It is a different process, and there are different obligations by the Police. They have to make difficult judgments in relation to the Mental Health Act.

If a person appears to have some sort of mental illness or disorder which poses a ‘substantial’ risk of serious harm to the person himself or to others (eg to kill himself or others or cause serious physical harm to himself or others), the police can detain that person under the Mental Health Act. Their decision is based on their immediate observations.

**S 22 Mental Health Act NSW**

22 Detention after apprehension by police

(1) A police officer who, in any place, finds a person who appears to be mentally ill or mentally disturbed may apprehend the person and take the person to a declared mental health facility if the officer believes on reasonable grounds that:

(a) the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and

(b) it would be beneficial to the person’s welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.
(2) A police officer may apprehend a person under this section without a warrant and may exercise any powers conferred by section 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

Mentally ill and mentally disturbed are defined in the MH Act, ss 13-15.

**Mental health detention by hospital**

If the hospital accepts Eric, he is assessed, and he can be scheduled under the MHA. Charges may be laid by the Police while the person is in the hospital, detained under the MHA.

**Arrest for injury and offence**

If the only issues are the damage Eric has done and his injuries, most likely the person would be arrested, taken to hospital Emergency Dept for treatment and then taken to station to be charged. It is also important to establish who he is. He might be taken back to the police station to fingerprint him if he is to be charged.

**Cases of intoxication**

If the person appears to be intoxicated, they must go to an Emergency Department, not a mental health facility. Under the Police Act an intoxicated person can be taken to a hospital to protect life and property. An intoxicated person can be taken to the police station or somewhere else to be detained. If the person is injured, intoxicated and drugged, he is unlikely to be taken to a mental health facility first.

**Is it drink, drugs or mental illness?**

Question: How is it determined whether the person’s condition is the effect of a particular drug and not a mental illness, so that he should not go into a mental health facility but into treatment for drugs. A: Under s 16 of the Mental Health Act a person can be intoxicated and mentally ill together, eg, drunk and suicidal. The person can be detained under the Mental Health Act.

MHAct, s 16(2): Nothing in this Part prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind.

**PROBLEM**

2. Police have to be specific in their decision to detain, although the actual condition of a person cannot be ascertained before a medical assessment. A person affected by drugs may find themselves in mental health detention for some days. A person who is clearly affected by drink may be in the Emergency Department even if there is an underlying mental illness.

**Informing the person why they are detained**

The police must inform the person under what Act he is detained. This applies even though there may be problems in communicating with the person. There is an obligation when a person is arrested to tell them the reason. People sometimes complain later that they have been detained under the wrong Act.

**PROBLEM: POLICE LACK TRAINING OR EXPERIENCE**

3. The Police may not have sufficient training or experience to deal with persons affected by drugs or mental illness. They have to make difficult decisions at the scene and deal appropriately with a confused and violent person, and attempt to communicate with that person. People may be arrested and dealt with inappropriately, under the wrong Act.

**Taking a person detained under MHA to hospital**

**Taking the person to a mental health facility**

If there is mental illness apparent and the person is detained by the Police under the Mental Health Act, he will be taken by ambulance or by the Police to the nearest Mental Health facility [a hospital], which has to take him, in theory.
In the city there may be several specialist mental health facilities. In the country the nearest such facility may be several hours away. Meanwhile the person may be in the paddy wagon with handcuffs.

**Procedure on arrival at hospital in police wagon**
The hospital may be very busy, with ambulances and wagons waiting for attention. The police need to work with the hospital to avoid keeping a person in the wagon outside the hospital for a long time. They want to get the person out and into the hospital asap, particularly if he is violent.

At St Vincents they try to get the person out within 30 minutes and in most cases that happens. There are regular discussions between hospital, ambulance and police as to how to handle these matters and improve the process.

**Hospital procedures to ensure safe admission**
St Vincents has a psychiatric emergency care centre. There is a triage nurse, and a five scale weighting system. No 1 is likely to die within 30 seconds, such as accidents, heart attacks. If one of those arrives, Eric gets bumped and remains in the paddy wagon, where he is safe.

A nurse would try to engage the agitated person in conversation, eg offer water. The hospital staff would negotiate about opening the door. A senior clinician could come out and get in the back of the paddy wagon. They would try to make contact, and calm the person. Security may be called to help settle the person down. They are trained to restrain him, whatever is needed, to keep him safe.

The hospital may reject people, on the basis of an occupational health and safety problem for the staff if he is extremely abusive. If rejected, he remains in the wagon. The hospital has to assess him and decide whether to accept him or not.

**After admission to the hospital, s.22 cases**

**Keeping the person safe, preventing him from leaving**
The hospital staff take off the handcuffs and use their own restraints if necessary to keep the person safe. If it is a case of mental illness, the person may be put in M room, which is small, with just a bed. The door can be open or closed depending on what the person wants. Someone is outside, and if the person attempts to leave, the security are there to ensure he does not leave. A person held under the Mental Health Act is not permitted to leave until the hospital ascertains that it is safe for him to do so.

**Obligation to assess**
When the hospital takes a person detained under s 22, he must see a doctor within 12 hours and be examined by a psychiatrist within 24 hours. He can then be assessed. Two medical certificates are needed to schedule him; he can then be detained.

In some cases the Police may have to act with the hospital to find out who the person is. This is not always easy.

**Delayed assessment and scheduling**
If Eric is affected by drugs and alcohol, he can’t be properly assessed until he dries out [query: will he be accepted in this case?]. That slows things down a bit. In practical terms the hospital will schedule a person brought in on mental health detention, even if this has to be queried later. This is reasonable, as they have to keep the person safe while they try to find out his condition, whether he is drunk or psychotic. The assessment has to be made by a qualified person, a psychiatrist.

**Compulsory treatment in hospital if scheduled**
The Medical Superintendent has to do what is necessary to try to get the person in a state where they can listen to the information and understand as far as possible. The Medical Superintendent is a designated person, but can delegate his powers. When a person is scheduled, the Medical Superintendent can administer the drugs he/she considers appropriate, sedatives or anti-
psychotics. There is a limiting factor: the Act also requires the Medical Superintendent to act within the accepted parameters of drug treatment, but the person can be treated with sedatives or anti-psychotics against his will within that period, once he is scheduled, not before.

[Note: s 84 authorises involuntary treatment.]

The Medical Superintendent can decide at any time to discharge Eric, and send him out of the hospital just like that. There is no scrutiny or accountability, even if the person still requires treatment.

**Patient/Consumer liaison**

A person who is scheduled is termed a “consumer”, as a person using or likely to use mental health services. A Consumer Participation Office works with hospital staff to make contact with the person, give him information. Try to get him to listen and understand his rights. DH showed the forms he uses. He tries to find out if the person is in a state where they can deal with the information. He tries to explain to people that they have to stay for the next six days.

**PROBLEMS IN DIAGNOSIS**

4. A person may be scheduled even before it is possible to make a proper diagnosis. It may take time for the effect of drugs to wear off, and for the full story to be understood. The psychiatrists often assert that the patient’s denial of mental illness shows a lack of self-awareness, thus confirming mental illness. But good psychiatrists look to more than that.

**PROBLEMS OF DISCHARGING BEFORE FULL ASSESSMENT**

5. Having agreed to take him, the hospital may later discharge him prematurely into the care of someone, or because the condition is masked. The person may still require treatment, but there is no way to provide for this unless he seeks it voluntarily. The person may come in and out of the system in this manner, causing work for Police and not getting proper treatment.

**Review of decision to schedule by MHRT**

**Length of detention, mental disorder and mental illness**

If the doctor considers that the person has a mental disorder he can be kept only for three days [s 31], though there may be further periods of short detention. Mental disorder does not show the risk factors involved in mental illness. To detain him further the hospital must have determined that he has a mental illness and presents a risk of serious harm to himself or others. If not, he must be sent out.

**PROBLEM**

6. Will a person with mental disorder receive appropriate treatment?

**Patient rights**

The patient must be given a statement of rights. It is now mandatory to notify carers that their person is in hospital. It is important to involve them.

S 72 - Nomination of primary carer; s 78 - notification of primary carer.

**Inquiry by MHRT**

As soon as reasonably practicable, arrangements are made for the MH R Tribunal, a single member, a lawyer, to come to the hospital to conduct an inquiry into the case to decide if the person is mentally ill and whether the person should be detained, etc. This is said to be of limited value. It may take some weeks for it to happen. Also, it takes some time to stabilise a person, work out a diagnosis and the proper medication. This rarely takes less than 6 days.

**Patients right to go to MHRT**

A scheduled person has the right to ask the Medical Superintendent for an immediate discharge. If this is refused, or no action is taken after three days he can ask for the MHR Tribunal, the full
panel, to consider whether the situation is appropriate. It can be done by video for remote hospitals. It can be done urgently, though this happens seldom. There is no point in having a review unless a proper assessment has been made and someone has been able to produce proper evidence the Tribunal can look at. This takes time.

Civil liberties are in theory protected, but not where the evidence is coming from only one side. Patients are seldom able to use these rights effectively because of the condition in which they come to the hospital and because of the reluctance of the hospital to act within the six days.

**PROBLEM 7.** The legal provisions to ensure independent monitoring of mental health detention are inadequate to deal with urgent matters.

**A Community Treatment Order**
A Community Treatment Order is an order which the MHRT can make which provides for involuntary treatment of a person in the community, requiring them to have treatment at a community treatment facility. It applies to a person who has been scheduled by the hospital who comes before the Tribunal; [it does not apply where a person is detained pending trial]. It may involve medication, particular terms as to how life is managed, It needs to be the least restrictive, safe and effective option. Medication is ordered only if a clear psychiatric opinion favours that particular medication. It is based on a care plan that has to be furnished to the Tribunal and which the facility has to be capable of implementing.

The person can live in the community, and a community treatment order requires the community agency to treat that person.

**Review issues: looking at the wider context**
The doctor’s focus is on the patient and on doing what is best for the patient. Sometimes the doctors are unable to see beyond the particular state of distress of the patient to the wider circumstances. Sometimes the person affected has support, their family can take them out and give them private, voluntary care. They may need only to go back on their regular medication.

The doctor can exercise power that may prevail over the circumstances.

The doctor responsible must be sure that the person is safe. The question is, is the person a risk to himself or others. The test is substantial risk of serious harm. Harm to reputation is no longer a specific issue under the present law. However, if a person’s behaviour resulting from mental illness presents a serious risk to the maintenance of his/her relationships, and they are important to an individual’s welfare, that can be taken into account.

**PROBLEM 8.** Imperfections in the system of detention under MHA. These failings may result in a person ending up in the justice system, where treatment is scarce.

**Role of Consumer Participation Officers**
The Consumer Participation Officers are assisting NSW Health to make the system more consumer friendly. This was explained by DH. Documentation is being developed.

**Juvenile issues**
A young person, say 15 or 16, in the situation of our test case can be dealt with under the Young Offenders Act if the Police are considering charging him. That has or can have a different pathway to the adult system.

But if the Police are acting under the Mental Health Act there is no age limit, up or down. [MI]

It is hard to get the hospital to deal with a young person who is mentally disturbed. There is only one place, Westmead. Kids as young as 10 or 11, who have been suicidal or highly psychotic, cannot easily be placed in a hospital, particularly out in western Sydney.
For a young person, 10 - 15, to have to be in the wagon for a long time while the Police drive around finding a place where he can get care is really appalling.

**PROBLEM: juveniles**

9. Lack of facilities and treatment options for mentally disturbed young people who come to the notice of the Police.

**Part 2: Court process**

**Minor issues**

Where a person has not been scheduled as a “mentally ill person”, and has been discharged from hospital, the police can pick him up at the door and process him through the regular criminal system.

**Discretion to charge**

Police may have a discretion in relation to charging a person in minor matters. Under the Crimes Act a diversion to mental health care is possible if it is a minor offence. But if it is a serious matter, as in our scenario, the Police would press charges.

**Court power to divert to mental health care**

In the case of a person with some degree of mental illness (not a “mentally ill person”), where the offence is not a serious one, the magistrate can divert it out of justice system and into mental health care under s 32 Mental Health Forensic Provisions Act (other options also available).

Community treatment orders or plans under s 32 are extremely important. They give the person the right to be treated and to have that treatment. It compels the agencies to give that person the support and treatment that can break the cycle. It is not desirable to involve a person with mental health problems in the criminal justice system.

**Bail on conditions**

Bail may be granted on condition that the person gets treatment voluntarily. If, over a period, a person shows themselves capable of abiding by such conditions it makes a difference to how the matter will proceed. If he is medication compliant etc, this is far different to those who do not turn up, and have consequential problems.

**Restorative justice programs**

Restorative Justice programs can apply where there is some degree of mental disturbance and in regard to minor offences. Offenders can be brought together with victims and stakeholders and a plan is agreed to, eg anger management, some sort of therapy or other kinds of community processes. That model works well in the adult sector and can soak up some of those people. It can be a better outcome.

**Treatment is not always available or provided for many people, who cycle in and out**

Where a person commits an offence, perhaps minor, the court can take action to secure treatment. However, there are many persons in the community who lack support, fail to take medication and as a result come and go in and out of the justice system over many years. There are vast files of people who for years have been coming in and out.

Since the closing of mental hospitals, there have been many problems, even tragedies for persons who are not capable of surviving on their own, are not medication compliant, not socialised. Often they are misunderstood, people are frightened of them. Things happen and they find themselves ending up in court, cycling in and out.

Research carried out with the University showed that the highest number of presentations to police by a single mentally ill person was 600 (that is a couple of times a day). Not everyone, thankfully, reaches this total. The top 10% of persons presenting under MHA represent 33% of the police workload. [MI]
**PROBLEM:**
10. Many people who could be helped by proper and adequate treatment are not getting it and are coming to the attention of authorities because of their behaviour or because they are involved in minor offences. They become the responsibility of criminal justice time and again when they really need properly organised treatment.

**Serious charges: remand and treatment options for scheduled persons**

Our scenario continues: The Police have discovered that Eric may have committed a very serious offence causing serious bodily harm; a security guard is in the hospital fighting for life. It also appears that Eric was not just drunk, but has a mental illness. He has been scheduled under the MHA as a “mentally ill person”.

**Charging while in hospital**
The Police can come to the hospital to take criminal action even if the person is scheduled. They would take the case to court as soon as possible, while the person is still in hospital. The Police would contact the DPP to alert him to the potential problem.

**Moving from hospital to jail**
The person could be discharged by the hospital on the basis that he is taken straight to jail and is treated by Justice Health.

**Legal assistance**
If it is a serious offence, as here, the person would be contacted in the hospital by the Mental Health Advocacy Services, or other service, and would have a lawyer.

**Indictable**
There are different processes for summary and indictable matters. A serious injury will result in an indictable offence.

**Assessing mental state**
His mental condition is relevant to how the case is handled. The court makes a finding of fact about this, after hearing expert evidence from a psychiatrist or sometimes a psychologist about the mental state of the person, and the question of risk.

**Questions of bail or remand**
Bail can be set. In serious cases, such as the scenario, it is most likely that he would be required to remain in hospital as a condition of bail. However, it is for the Court to determine where and how the person is to be detained. The Mental Health Tribunal has no power to interfere to determine conditions of custody (other than where custody is solely referable to detention under the MHA). If the court has detained Eric, refusing bail, MHT can do nothing about it.

**Remanded person may not be in mental hospital, may not be treated**
If a person is detained by the Court, (not under MHAct), he is unlikely to be detained in a mental health hospital. The likelihood of him getting treatment depends on how sick he is.

If he is seriously ill, he may make it to the Long Bay prison hospital which has only 40 beds available. It is said there are 50 people at Long bay waiting treatment; but the numbers may be much greater than that.

He is more likely to be detained in the mental health screening unit at the MRRC [Metropolitan Remand & Reception Centre, Silverwater] which is not a declared mental health establishment. He will get some treatment, but only if he is one of the 120 people who can be accepted there.

The most likely outcome for many is to sit in jail in misery with NO treatment and no order that can require anyone to provide treatment. It has been recently estimated that there are over 1,000 detained in the NSW correctional system at present with mental illness who are not receiving treatment (and without assessment the figures are hard to determine).
**Court ordered treatment may not occur**
The Courts can make orders for treatment, but the person will have to wait to get treatment, and usually it will not happen. Unfortunately Justice Health does not or is unwilling to implement the order. [Only 3 cases known] Although the equivalent to a community treatment order is available in theory to people in jail under the Act, Justice Health is reluctant or cannot implement these orders. Detention for most will make the mental health issues worse.

**Right to treatment is denied**
The numbers in the criminal justice system with mental health issues is hugely disproportional [estimated by some as 1/3 or more?]. Some are getting treatment, but not all.

If those people were outside the justice system they would be diagnosed as psychotic for the purpose of being able to receive drugs and treatment. The right to treatment is a basic human right, regardless of whether in custody.

**PROBLEM:**
11. A person with a mental illness and needing treatment, is unlikely to get it while he is in custody of the justice system. Even if the Court orders treatment it may not happen. Many are thus deprived of their right to treatment. Basic rights are denied.

[The High Court decided that prisoners could not be deprived entirely of the right to vote, but they are denied treatment for their illness.]

**Legal advice; Fitness to stand trial [30]**
Where the person is charged with an indictable offence it goes to the DPP, who takes charge of getting the evidence, and then to the magistrate.

**Right to legal assistance**
A person affected by mental illness, who is detained awaiting trial for an indictable offence, is provided with legal advice by the Mental Health Advocacy Service, specialised lawyers in the Legal Aid system. There are also private practitioners who specialise in this. There could be difficulty in getting an explanation from the person, and instructions about a plea for example. This might indicate unfitness for trial.

**Fitness for trial is an issue for the Court**
If the person appears unfit to stand trial, the lawyer must raise this issue with Court, so that it can get information and decide whether he can have a fair trial according to law, which he cannot do if he cannot understand what is going on, can’t instruct his lawyer and can’t accept advice.

If the magistrate considers the evidence is sufficient for a prima facie case, Eric is committed by the magistrate to the District Court or the Supreme Court. When the question of unfitness to trial or to plead is raised, the Court has a preliminary hearing to determine fitness for trial.

**MHRT is asked if he will be fit in 12 months**
If, after a hearing, he is found by the court to be unfit to stand trial, the matter is referred to the MHRT. The MHRT determines whether he will be fit for trial within 12 months. If so, the case will be held over, on the basis that a proper trial can be held in due course, in a situation where he is able to understand and give instructions etc.

**Treatment remains responsibility of Justice Health**
The MHRT cannot in this process make a compulsory treatment order. His treatment at this point remains within the purview of Justice Health within the correctional system.

**Special hearing for person unfit to stand trial**

_The special hearing where found “unfit”_
If it is determined that he will NOT be fit to stand trial after 12 months, the case goes back to court for a special hearing by a Judge alone to determine if he did the acts charged. This is as near to a trial as it can be, and involves exactly the same evidence.

This whole process can take a long time, 18 months or more.

**Discharge if evidence insufficient: treatment options**

If, at the special trial, the evidence is insufficient, he is discharged, without any option of treatment available to the Court.

He still may have a mental illness, and may still be scheduled under the Act. If so, once he is discharged, the MHRT can make an order for compulsory hospital treatment. If there is no risk of harm, he is likely to be discharged. He could be ordered by MHRT to have compulsory treatment in the community.

**If he did the acts, a limiting term is imposed**

If the Court considers that he did the acts in question, he can’t be convicted and he can’t be sentenced. However the court holds a special hearing (a quasi sentencing hearing) to impose a period of detention called a "limiting term" [Mental Health (Forensic Provisions) Act s 23]. This sets a maximum period that he is to be detained arising from the commission of the offence.

23(1) If, following a special hearing, it is found on the limited evidence available that an accused person committed the offence charged or some other offence available as an alternative, the Court:

(a) must indicate whether, if the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for the offence which the person is found to have committed, it would have imposed a sentence of imprisonment, and

(b) where the Court would have imposed such a sentence, must nominate a term, in this section referred to as "a limiting term", in respect of that offence, being the best estimate of the sentence the Court would have considered appropriate if the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for that offence and the person had been found guilty of that offence.

[Cloud Cookoo Land]

[It appears that if a limiting term is nominated, the person will be detained for that period, but the place of detention will depend on whether MHRT considers the person is or remains mentally ill.]

All this time he is in jail; hopefully he could get into a prison hospital for treatment; it depends on the number of beds and whether his condition is considered sufficiently serious to take a place otherwise occupied by others.

**Not guilty be reason of mental illness**

If it is found that he was mentally ill at the time of the offence, there is verdict of “Not guilty by reason of mental illness.” The Court has power, if satisfied that he presents no significant risk, to make an order discharging him.

Otherwise, he continues to be detained - in the mental health section of prison. He goes back to the MHRT to see whether he can be discharged into the community. This used to be solely the power of the Governor on the advice of the executive council. The Tribunal can now make this determination. The Tribunal must be satisfied that there is no significant risk, on the evidence of an independent psychiatrist as well as on the evidence of the hospital presenter. Eric has to prove to MHT that he is worthy to be ‘liberated’.

A difficult provision of the Act says that the Tribunal can ‘liberate’ a person, but only if satisfied that they have spent a “sufficient” time in custody. This is hard to interpret.

**Reactions to verdict of not guilty by reason of mental illness**

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A lot of people, particularly the families of those injured or killed by persons suffering mental illness are outraged that the person who did it might be found “not guilty”. But they are not found not guilty at all, they are merely being found to be not responsible in law. It would get rid of a lot of problems if they were not found guilty and not found not guilty, but simply to be found “not responsible” and then treated within the health system.

**PROBLEM**

12. Is reform needed to introduce a verdict of “Not responsible” rather than not guilty by reason of mental illness?

*Conditions of persons detained after not guilty by reason of mental illness*

The Forum was told that persons detained after being found not guilty by reason of mental illness have very poor conditions, and may wait for years before being transferred to a facility where they can be treated.

**PROBLEM:**

13. Another failure of the system to provide treatment, rehabilitation services for persons detained with mental illness who have been through the justice system. The situation is serious enough to be considered abusive. Treatment should be available to persons found not guilty in this situation.

**Observations on medication, treatment**

Several people at the Forum raised the problem that within the prison system, treatment for mental illness, if any, is limited to medication, and little is available in the form of counselling or other rehabilitative or therapeutic services.

The problem is compounded by the fact that medication is used as a management tool, to neutralise people, whether or not it helps in any way to overcome their mental problems. This is a problem with occurs in nursing homes as well as in prisons.

Medication may be needed to prevent violence or self harm, but this its use should be restricted. It should be used only for therapeutic purposes, together with other rehabilitative measures, for proper treatment.

The issue of wrong diagnosis was also raised, and the difficulty for getting reversal of a diagnosis.

**PROBLEM**

14. The use of medication beyond the need for harm prevention, or for therapeutic purposes, as a means of neutralisation and management.

15. General problems about the way in which those with mental illness or with mental disability are treated by those who have custody of them or power over them. Abuse of authority.

**Failure to accord rights**

The MHA sets out principles for the treatment of mental illness. The UN Standard Minimum Rules for the Treatment of Prisoners provides that prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.

**MHA s 68 Principles for care and treatment**

It is the intention of Parliament that the following principles are, as far as practicable, to be given effect to with respect to the care and treatment of people with a mental illness or mental disorder:

(a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,

(b) people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,
(c) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,

(d) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,

(e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment,

(f) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,

(g) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised,

(h) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care,

(i) people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,

(j) the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect.

**PROBLEM**

16. The principles for care and treatment of people with mental illness set out in s 68 of the MHA are not fully observed in NSW. Nor are the UN Standard Minimum Rules for the Treatment of Prisoners

**Reforms under consideration**

The Ministry of Health is considering reforms, is consulting widely and seeks contributions, Also the NSW LRC. They are very interested in these issues and want submissions. The more the better. [GJ]

END

**What is to come**

The first of the series examines processes relating to the first stage of the journey, our subject’s arrest or detention. We then move on to the second stage, where our subject appears before a court or tribunal depending on the system they are travelling through.

Next year, the second in the series will deal with the third stage of our subject’s imprisonment or detention in a mental health facility. The fourth stage will follow, where our subject is released or discharged back into the community.

Papers will be prepared and distributed describing the issues identified in the first two sessions to enable us to examine solutions to those issues in the third and final session which will also take place, next year.

**Tape references**

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