



Mental Health Reform

Promoting Improved Mental Health Services

Submission on the Criminal Law (Insanity Act) 2006 as amended by the Criminal Law (Insanity) Act 2010.

31 January 2012

Introduction

Mental Health Reform (MHR) welcomes this opportunity to contribute to the Department of Justice and Equality's review of the Criminal Law (Insanity) Act 2006 as amended by the Criminal Law (Insanity) Act 2010 (the 'Acts'). As the national umbrella body advocating for improved mental health services and implementation of the Government's mental health policy *A Vision for Change*, MHR believes that changes in the law relating to mental health are necessary in order to fulfil the vision set out in Government policy.

MHR understands that the Department is seeking our general views on the operation of the Acts and on the following issues:

1. The appropriateness of the terminology used in the 2006 Act, in particular, the term "insanity";
2. The role of the District Court in determining questions of fitness to be tried;
3. The extent to which the legislation could be amended to facilitate schemes for the diversion of persons with mental disorders who have committed minor offences from the criminal justice system;
4. The issue of how to deal with persons conditionally discharged or on temporary release from designated centres who leave the jurisdiction in breach of the conditions of their conditional discharge order or temporary release;
5. Whether there should be a right of an appeal for an accused person against a finding that he or she is fit to be tried; and
6. Any implications for the 2006 Act arising from the provisions of the UN Convention on the Rights of Persons with Disabilities.

Confining our comments to areas within our own competency, the below submission makes general recommendations and recommendations on issues no. 1, 3 and 6.

Background

The Criminal Law Insanity Act 2006 provided a significant improvement in the rights of people detained for mental health treatment on foot of criminal proceedings by requiring that such detention be reviewed by an independent review board. It also established the verdict of 'not guilty by reason of insanity'. Mental Health Reform also welcomes the establishment and on-going work of the cross-departmental group on mental health within the prison system. This group provides a model of how services that involve more than one department can improve service delivery through inter-sectoral collaboration.

However, while sections of the 2006 Act reflect the Mental Health Act of 2001, there are some ways in which people subject to the Criminal Law Insanity Act may have less protection of their rights than those subject to detention under the 2001 Act. While Section 3(3) of the 2006 Act provides that the

consent provisions contained in Part 4 of the Mental Health Act 2001 apply to anyone detained in a 'designated centre' (a designated hospital or in-patient unit) under the Acts, there are still some gaps in protection of people subject to the Acts. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has commented on the variance in protection between the Mental Health and Criminal Law (Insanity) Acts and recommended that "the Irish authorities introduce legally binding safeguards, including as regards consent to treatment and use of means of restraint and seclusion, for patients detained under the 2006 Criminal Law (Insanity) Act."¹ Also, in a recent judgment by Justice Sheehan at the Central Criminal Court, he remarked that "This Court notes that there is a huge discrepancy in the protection afforded to patients detained pursuant to the Criminal Law (Insanity) Act 2006 and those admitted to the Central Mental Hospital pursuant to the Mental Health Act 2001."²

Furthermore, Ireland's signing of the Convention on the Rights of Persons with Disabilities (CRPD) in 2007 provides the basis for a landmark shift in the way that people with mental health problems are treated in society both as users of mental health services and as participants in the community. The CRPD affirms that no person should be discriminated against solely on the basis of their disability, including a mental health disability. (This principle of non-discrimination is also set out in the Government's mental health policy *A Vision for Change*). The CRPD also states that people with disabilities should enjoy legal capacity on an equal basis with others in all aspects of life.³ While the CRPD did not introduce new human rights for people with disabilities, it is being seen as strengthening existing human rights. For people with experience of a mental health difficulty in particular, the CRPD affirms their equality in such a way as to suggest a reflection on the existence of separate mental health laws. If people with mental health difficulties are not to be discriminated against, then those with incapacity should have an equal right to avail of capacity legislation as any other individual, including those subject to the criminal justice system. This means that individuals who are subject to the Acts should have a right to supported decision-making to maximise their legal capacity during the proceedings provided for in the Acts.

Overarching framework

Four broad principles underpin Mental Health Reform's perspective on the Criminal Law Insanity Act 2006. Firstly, people who fall within the jurisdiction of the Act should have the same protections of their human rights as those under the Mental Health Act 2001. This includes rights to review of detention, to consent to treatment and to protection from unnecessary seclusion and restraint. Secondly and in keeping with good practice in early intervention, the Act should support the diversion of individuals from the criminal justice system for the provision of mental health treatment. Thirdly, the Act should fully reflect the UN Convention on the Rights of Persons with Disabilities. Finally, in so far as the Acts concern support for individuals' mental health and protection of an individual's rights in relation to mental health treatment, they should reflect Government's mental health policy *A Vision for Change*.

The Mental Health Commission has affirmed "that the promotion and protection of the human rights of people availing of mental health services must be a core principle underpinning all practice in the mental health services. This fundamental principle is even of greater significance within forensic mental health services."⁴ Mental Health Reform supports an approach that ensures that all persons receiving treatment from forensic mental health services have their human rights respected,

¹ '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 25 January to 5 February 2010', p.68.

² D.P.P. v. B. [2011] IECC 1 at [5.17].

³ Article 12(2).

⁴ Mental Health Commission (2011) 'Position Paper: Forensic Mental Health Services for Adults in Ireland', p.9.

protected and fulfilled.

1. Equivalence of rights between the Criminal Law Insanity and Mental Health Acts, including implications of the CRPD

While the Criminal Law Insanity Act of 2006 reflected some aspects of the Mental Health Act 2001, particularly in those sections where the 2006 Act refers to the definition of mental disorder under the 2001 Act, there are some ways in which the 2006 Act provides less protection for an individual's human rights. Mental Health Reform considers that in principle people receiving mental health treatment under the Criminal Law Insanity Act should have the same rights as those receiving treatment under the Mental Health Act.

a. Review of detention

The 2006 Act provides for review of detention at least every six months. These periods are significantly later than what is in the 2001 Act which requires independent review by a tribunal within 21 days of detention and then at an interval of three months before extending this to six and in some circumstances up to twelve months. In particular, in respect of persons involuntarily transferred to a designated centre under Section 15 of the 2006 Act or involuntarily detained under Section 15(5(a) of the 2006 Act, it is critical that the Review Board review all such transfers from prison within a short period of time. All persons detained in designated centres under the Acts should have an automatic review of their detention in line with the initial time period set out in the 2001 Act, notwithstanding that there is provision under Section 13 to enable a patient to request a review of his or her detention. Amnesty International Ireland has previously highlighted that even the 2001 Act periods of detention seem excessive compared to practice in another jurisdiction (see Amnesty International Ireland 'Submission to the Department of Health and Children on the need for a substantive review of the Mental Health Act 2001', pp.62-63).

Recommendation: The 2006 Act provisions for review of detention (Sections 13 and 17) should be amended to bring the period of detention before review in line with the current Mental Health Act 2001 and should be kept in line with the 2001 Act thereafter.

b. Seclusion and restraint

The 2006 Act provides no regulations on seclusion and restraint, unlike the 2001 Mental Health Act.

Recommendation: The Mental Health Act 2001 provisions on seclusion and restraint (Section 69) should apply equally to persons subject to the 2006 Act. Any future extensions of the 2001 Act to cover chemical restraint applied in approved centres should apply equally to those subject to the 2006 Act.

c. Consent to treatment

Section 3(3) of the 2006 Act provides that the consent provisions contained in Part 4 of the Mental Health Act 2001 apply to anyone detained in a 'designated centre' (a designated hospital or in-patient unit) under the Acts. Mental Health Reform has previously submitted recommendations to the Department of Health for revision of the Mental Health Act, 2001 consent provisions. In keeping with our previous recommendations, the 2006 Act should ensure that:

Recommendation: The free and informed consent of a person transferred for inpatient treatment shall be required in all circumstances before treatment can be administered,

unless the patient lacks capacity and either

- 1) the treatment is necessary in an emergency to save the life of the patient; or**
- 2) in the case of administration of ECT, the application for treatment has been reviewed by an independent body.**

Recommendation: The 2006 Act should be amended to include a framework for advance decisions by individuals to refuse and consent to treatment as well as advance care, social and financial arrangements. This legal framework must be binding on clinicians to the same extent as a person's wishes would be if he/she had capacity at the time. A valid advance directive should only be departed from where treatment is necessary on a life-saving emergency basis; suitable procedural safeguards must be in place to ensure compliance with this provision and any treatment given in contravention of an advance directive must be of established benefit to the recipient.

Recommendation: The 2006 Act should be amended to require the provision of information to persons detained for mental health treatment under the Act including:

- their entitlement to legal representation**
- the proposed treatment to be administered**
- their entitlement to communicate with the Inspector of Mental Health Services**
- that their detention will be reviewed by the independent review board and the timing of that review**
- their right to request a review of their detention**
- their rights to informed consent to treatment, to advocacy and to appeal**

Recommendation: The 2006 Act should be amended to provide a statutory basis for a care and recovery plan for each individual transferred for inpatient treatment.

d. Advocacy

The Acts make no provision for the right to advocacy, as distinct from legal representation, in the review process or in the process of making decisions about treatment. Support to assist a person with a disability to exercise their decision making capacity is a key requirement under the CRPD. Article 12 of the CRPD guarantees the right of people with impaired capacity to participate to the fullest extent possible in decisions which concern them and this entails providing assistance to enable them to do so. In line with Mental Health Reform's previous recommendations on the Mental Health Act, 2001, the following changes should be made to the 2006 Act.

Recommendation: Individuals subject to the Acts should have a right to advocacy including the right to an advocate to assist in making a complaint.

Recommendation: The Acts should be amended to provide for the right of those detained under the Acts to have an advocate present in all hearings/reviews.

Recommendation: Individuals receiving mental health treatment under the Acts should have direct access to a complaints mechanism independent of the service provider.

e. Court-ordered outpatient treatment

Under Sections 4(3)(ii) and 4(5)(ii) of the 2006 Acts (concerning 'fitness to be tried') an

individual can be ordered to attend an outpatient facility for out-patient treatment if they suffer from a mental disorder. Also, under Section 13A(1) of the Acts a person may be required to undergo out-patient treatment as a condition of their discharge. These sections do not specify that such treatment must be provided with the informed consent of the individual concerned. In a recent case in England that concerned conditional discharge, the judge included a recommendation in his judgement that when imposing conditions on a discharge, the wording of the conditions should include "subject always to his right to give or withhold consent to treatment or medication on any given occasion".⁵

Mental Health Reform is concerned that the current Acts provide a wide scope for court-ordered out-patient treatment that could result in a failure to protect an individual's right to informed consent to treatment.

Recommendation: Sections 4 and 13A of the 2006 Act should be amended so that where out-patient treatment is being ordered:

- a) the Court or Review Board must be satisfied that the person genuinely consents to the treatment according to the definition of consent contained in the Mental Health Act, 2001, Section 56; and
- b) the Court's or Board's order must affirm that the person continues to have a right to right to give or withhold consent to treatment or medication.

f. Membership of the Mental Health (Criminal Law) Review Board

With regard to the Mental Health (Criminal Law) Review Board, Mental Health Reform notes that Section 11 (Schedule 1) does not require at least one member of the Board to be a layperson. Section 48 of the Mental Health Act, 2001 requires that at least one member of the Mental Health Tribunal be a person other than a practising barrister, solicitor, medical practitioner or nurse, i.e. a layperson. This provision has ensured that the views of laypeople inform the decisions of Tribunals.

Recommendation: Section 11 (Schedule 1) of the 2006 Act should be amended to require that at least one member of the Mental Health (Criminal Law) Review Board is a layperson, e.g. someone other than a barrister, solicitor, medical practitioner or nurse.

2. Other implications of the CRPD

a. Definition of fitness to be tried

⁵ *R. (S.H.) v Mental Health Review Tribunal* [2007] E.W.H.C. Admin. 884; [2007] M.H.L.R. 234.

Section 4(2) of the 2006 Act provides a definition of fitness to be tried. It is important that this definition is in line with the CRPD in terms of the conception of legal capacity. The UN Committee on the Rights of Persons with Disabilities' observation on Spain's compliance with the CRPD is an important reference here in guiding States to move away from a substitute to a supported decision-making model. Referring to Spain, the Committee stated:

"The Committee recommends that the State party review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences."⁶

For example, the definition of fitness to be tried should reflect a presumption of capacity and the provision of support to maximise an individual's capacity. Where, after all efforts to support the individual to exercise his/her capacity have failed, an assessment of capacity is still necessary, the functional approach to assessment should be used to emphasise the temporary, decision-specific nature of incapacity for mental health service users.

Recommendation: The Acts should be amended to incorporate a presumption of capacity to make decisions and the provision of support to maximise an individual's capacity. Where, after all efforts to support the individual to exercise his/her capacity have failed, an assessment of capacity is still necessary, the functional approach to capacity assessment should apply to all determinations of capacity under the Acts.

b. Future review of the Act as CRPD evolves

The CRPD is a relatively new document in human rights terms. Over time the UN Committee on the Rights of Persons with Disabilities will interpret the Convention in a way that will explain how the Convention applies to people with a mental health disability. This may have implications for legislation that covers people with a mental health disability in Ireland in the future.

Recommendation: Government should commit to reviewing the 2006 Act in the light of interpretation of the CRPD by the UN Committee on the Rights of Persons with Disabilities.

3. Diversion from the criminal justice system

Mental Health Reform is concerned that there may be individuals ending up in the prison system whose primary need is for mental health support. In 2006, the Expert Group on Mental Health Policy recommended in *A Vision for Change* that legislation be put in place to provide for diverting people whose primary issue is their mental health condition away from the prison system into mental health services. In 2011, the Mental Health Commission recommended:

"The establishment of Appropriate Person, Police and Court Diversion Schemes must be a priority."⁷

In recent years a non-statutory court diversion programme has been developed by the forensic mental health services that is available at Cloverhill and Dochas prisons however it is not available at all prisons in the country and is not underpinned by legislation. In practice it is not possible for the current service to provide evidence to courts around the country. Neither is there yet a national policy on diversion that would promote diversion from the criminal justice system at a range of

⁶ UN Committee on the Rights of Persons with Disabilities, Sixth Session, 19-23 September, 2011 (CRPD/C/ESP/CO/1), para.34.

⁷ Mental Health Commission (2011) 'Position Paper: Forensic Mental Health Services for Adults in Ireland', p.27.

stages throughout the criminal justice process. In its Position Paper on Forensic Mental Health Services for Adults, the Mental Health Commission refers to models of court diversion in different jurisdictions and specifically to the Sainsbury Centre for Mental Health's 'all stages model or framework for diversion'. The Commission also emphasised the need to ensure that court diversion schemes "rely on consent and cannot override the right to due process..."⁸

Recommendation: Legislation should be put in place to provide a statutory basis for diversion of people whose primary issue is poor mental health away from the prison system into mental health services if they so consent.

Recommendation: The Department of Justice and Equality should commission research into criminal justice diversion schemes and on foot of this research, should develop a national policy to promote greater diversion from the criminal justice system into mental health services.

4. Operational issues

In his Judgment in *D.P.P. v. B*⁹, Justice Sheehan notes that the Central Mental Hospital is the only designated centre. The fact that the CMH continues to be the only designated centre in the country means that prisoners from distant prisons must be transferred to Dublin for treatment, removing them from proximity to any social supports they may have such as family and friends. The human rights principle of community-based treatment must apply to prisoners as to any other patients and this includes having inpatient treatment within a reasonable distance to one's own community. There is an urgent need to establish other designated centres to enable a wider range of options for treating individuals within the criminal justice system.

Recommendation: The Department of Health and the HSE should urgently progress establishing regional, appropriate acute inpatient units that can be designated centres under the Acts.

5. Title of the 2006 and 2010 Acts

The titles of the Acts refer to 'insanity' which is an old-fashioned term that does not reflect current conceptions of poor mental health. The title does not reflect the definition of 'mental disorder' under the 2006 Act itself which includes mental disability and dementia.

Recommendation: The titles of the Acts should be changed to the Criminal Law (Capacity) Acts.

Conclusion

The 2006 and 2010 Criminal Law (Insanity) Acts represented positive steps in modernising Irish legislation relating to incapacity and the criminal justice system. However, currently people with poor mental health have less protection of their rights under the Acts than they do under the Mental Health Act, 2001. Mental Health Reform believes that significant improvements can be made to the Criminal Law (Insanity) Acts to provide stronger protection for individuals' human rights, including rights to protection from arbitrary detention, seclusion, restraint and to informed consent. MHR would welcome the opportunity to discuss our recommendations at the Department's convenience.

⁸ See Mental Health Commission (2011) 'Position Paper: Forensic Mental Health Services for Adults in Ireland', p.24.

⁹ *D.P.P. v. B.* [2011] IECC 1 at [5.18].