MODULE 8: CRIMINAL LAW AND MENTAL DISABILITY

Overall Learning Objective:

- To understand the role of provisions in national law in promoting the rights and welfare of persons with mental disabilities.
- To gain an appreciation for some of the challenges that people with mental disabilities face at each stage of the criminal justice process and the degree to which they are imprisoned in many countries.
- To understand the role that international human rights standards and normative guidance can play in setting minimum standards of fair treatment for people with mental disabilities as they engage with criminal justice systems.

Rationale: An important goal of the criminal justice system should be to ensure that no one with a mental disability is inappropriately held in police custody or prison. Very often people with mental disabilities are prosecuted and imprisoned, in some cases for relatively minor offenses, when they should remain free from in incarceration and in some circumstances, be receiving mental health treatment and care. Legislation has an important role to play in promoting and protecting the rights of people with mental disabilities who find themselves within the criminal justice system.

A. Introduction – People with mental disabilities, crime, and imprisonment

In some countries, people with mental disabilities are locked up in prisons because of a lack of mental health services or diagnosis and treatment of their condition. Many argue that "Prisons are the wrong place for many people in need of mental health treatment, since the criminal justice system emphasizes deterrence and punishment rather than treatment and care. Legislation can be introduced which allows for the transfer of prisoners to general hospital psychiatric facilities at all stages of the criminal proceedings (arrest, prosecution, trial, imprisonment). For people with mental disabilities who have been charged with committing minor offences, the introduction of mechanisms to divert them towards mental health services before they reach prison will help to ensure that they receive the treatment they need and also contribute to reducing the prison population. The imprisonment of people with mental disabilities due to lack of public mental health service alternatives should be strictly prohibited by law." WHO/ICRC Information Sheet: Mental Health and Prisons. http://www.who.int/mental_health/policy/development/MH&PrisonsFactsheet.pdf)

The International Disability Alliance (IDA) hold a different position on this issue: As outlined in Article 12 of the CRPD, people with disabilities, including mental disabilities, should enjoy the right to exercise their legal capacity on an equal basis with others, in all aspects of life. This in turn, according to the IDA, means that schemes whereby people with mental disabilities are diverted away from the criminal justice system and towards mental health treatment and care is also contrary to the CRPD. Similarly 'insanity' as a defence, is not permissible according to the Convention.

The IDA position paper on the CRPD outlines that "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 defense to imputability 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."

Persons with mental disabilities as prisoners: the figures:

- Of the 9 million prisoners worldwide, at least 1 million suffer from a significant mental illness, and a larger number suffers from common mental health problems such as depression and anxiety. http://www.euro.who.int/mentalhealth/Policies/20070921_6 (accessed March 22, 2008)
- In the United States, it is estimated that 10-15% of prisoners have severe mental illness. Treatment Advocacy Center, Criminalization of Individuals with Severe Psychiatric Disorders 1 (2007); J. Bard, Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot be Made Right by Piecemeal Changes to the Insanity Defense, 5 Hous. J. Health L. & Pol'y 1, 16 (2005).
- There are now more people with severe mental illness in the Los Angeles County Jail, Chicago's Cook County Jail, or New York's Riker's Island Jail than there are in any single psychiatric hospital in the nation. Id.
- There are 3 times as many people with severe mental illness in prison as there are in mental health hospitals. Human Rights Watch, Ill Equipped: U.S. Prisons and Offenders with Mental Illness 1 (2003)
- In a 1992 study of U.S. jails, 29% of the jails acknowledged holding people with mental disabilities – with no charges against them – awaiting psychiatric evaluation, the availability of a hospital bed, or transportation to a psychiatric hospital. These detentions were legal under state laws permitting emergency detentions of those suspected of having a mental disorder. Treatment Advocacy Center, Criminalization of Individuals with Severe Psychiatric Disorders 3 (2007).
- In the U.S., prisoners with mental disabilities are 4 times as likely than non-ill inmates to have been incarcerated for lesser crimes such as disorderly conduct and threats. Treatment Advocacy Center, Criminalization of Individuals with Severe Psychiatric Disorders 3 (2007).

A large number of people with mental disabilities within prison population have not committed crimes warranting their incarceration and many human rights defenders believe they should not be in prison at all . It is argued that they are casualties of the “criminalization” of mental illness, whereby people with mental disabilities are caught up in the criminal justice system rather the health system. Insufficient resources for mental health have contributed to this situation. Also, the process of deinstitutionalisation has not been accompanied by the development of sufficient community based alternatives in many countries.

Stigmatising and discriminatory portrayals of people with mental disabilities in the media, including sensational headlines and high-profile incidents means that very often the general public but also policymakers make incorrect assumptions that people with mental disabilities are dangerous and that those in the prison system have committed serious, violent crimes. In reality people with mental disabilities are far more likely to be victims of violence that perpetrators of it.

"Civil lunatics are people that the society doesn't want to be roaming around causing problems, unfortunately they are dumped in our prisons," says Victoria Uzamaka, controller of Enugu Prison, Nigeria. "Locking up Nigeria's Lunatics, BBC , 2009 http://news.bbc.co.uk/2/hi/africa/8023067.stm

This module examines some of the key issues that need to be considered at different stages: pre-trial, trial, sentencing and prison stages. It also looks at relevant international caselaw within the different international human rights systems. Finally the module examines key issues outlined in international standards and normative guidance that are relevant to legislation in the area if mental health and criminal justice. While this module draws on present-day examples and practices in countries from around the world it is important to note that the UN Convention on the Rights of Persons with Disabilities, and in particular Articles 12 (equal recognition before the law) and 14 (liberty and security of person), will influence how laws address issues related to mental health and criminal justice in the future.

B. Police responsibilities and the pre-trial stage

Law enforcement officers are often in the position of responding to people with mental disabilities who are in crisis, which can create dangerous situations for both parties.

- In the U.S., people with mental disabilities are killed by police in justifiable homicides at a rate nearly 4 times greater than the general public.

- In the U.S. in 1998, people with mental disabilities killed more law enforcement officers than assailants with a prior arrest for assaulting police or resisting arrest did. Treatment Advocacy Center, Law Enforcement and People with Severe Mental Illnesses 1 (2005).
- It is not uncommon for police, in an attempt to protect people with the most severe forms of psychiatric illnesses from the dangers they face on the streets, to arrest mentally ill individuals in "mercy bookings."

Police duties that are included in many national laws can be summarized under the following categories:

- *In public places*, when the police have reasonable grounds to suspect mental disorder in a person arrested for causing public disorder, the law may require the police to convey the person to the nearest accredited mental health facility for assessment by a mental health professional.
- *In private premises,* police may be required to obtain a warrant from the judicial authorities to enter into private premises and arrest a person with a mental disability who is likely to cause grave harm to self or others. It may be a requirement that the person be immediately conveyed to a mental health facility for assessment.
- In case of a *person arrested for criminal acts and in police custody*, if the police have reasonable grounds to suspect that the person has a mental disability, are requirement may be that the person be conveyed to the nearest accredited mental health facility for assessment by a mental health professional.
- In case of a person *admitted involuntarily to mental health facility,* police may be required to assist in conveying the person to the designated accredited mental health facility
- In case of a person who is *admitted involuntarily to a mental health facility and is absent without leave* the police may be required to find and return such persons to the mental health facility from where such persons have been absent without leave.

These are some examples of issues concerning police responsibilities that may be present in certain national mental health laws. It is important to note however that legislation should include restrictions on the powers of police in order to protect the rights of persons with mental disabilities and safeguard against their unjustified arrest and detention. For example it is crucially important for people with mental disabilities coming face to face with the criminal justice system to know their rights. Many people with mental disabilities or their families may not know for example that they have a right to legal representation during all interactions (including interrogation) with authorities. Provisions in national law ensuring that people with mental disabilities are informed of their rights in a manner which is understandable to them is therefore extremely important.

Interrogation

"Interrogation tactics are designed to mislead. Detectives present themselves as sympathetic individuals who imply that suspects are good people in bad situations. They imply that they want to help the suspects achieve the best outcome. Interrogators often deceive suspects about the nature and extent of evidence against them, the nature of the suspects' rights, the short- and long-term consequences of confession versus denial, and much more. All the while, interrogators will dominate the conversation, interrupt attempts by suspects to deny involvement, distract them from thinking of facts and information inconsistent with the interrogators' claims, accuse suspects of lying, and explicitly and implicitly threaten suspects with dire consequences for denying wrongdoing and promise leniency for a confession."

"Suspects – even those who are innocent – must ask themselves: What evidence exists? Might it be inaccurate – as with polygraphs, eyewitnesses, and many forms of forensic evidence? Are police allowed to lie? Is the evidence really overwhelming? Is conviction guaranteed? Is it true that admitting guilt to the detective will more likely result in a better deal – or even release – than continuing to deny involvement? Is it wise to wait for the help of a lawyer or is true that the detective can provide more help now? Although these are difficult questions for any suspect who lacks knowledge of the legal system to answer, the difficulties are enhanced for those with impaired relevant knowledge, with poor cognitive abilities, and with poor chronic or acute self-regulation abilities,"

"Generally, a person must be able to exert considerable self-control—or self-regulation—in order to resist the pressures of interrogation. This includes the control of attention and cognitive processes necessary to evaluate incoming information, and to think of relevant information available from one's own knowledge and experience. It also entails the ability to control behavior. One must be able to withstand the relentless pressures to confess posed by one or more interrogators, possibly over a period of many hours, or even days. Moreover, they must control the need to confess simply as a way to end the interrogation, or satisfy the need for sleep, or to get the interrogators "out of my face." The suspect must recognize and give priority to long-term best interests over immediate, and often overwhelming, impulses. This entails being able to recognize what will or will not serve those interests and act accordingly."

W. Follette et al. Mental Health Status and Vulnerability to Police Interrogation Tactics, 22 Criminal Justice 43-44 (2007).

In certain national laws the police do not have the authority to detain in a prison facility (or police custody) any person who has been arrested on the suspicion of causing public disorder due to mental health problems. In such cases, the police powers are restricted to conveying such arrested persons to the nearest mental health facility for assessment by a mental health professional. The idea is to divert people away from the criminal justice system at the initial point of contact with law enforcement officers. Where it is impossible to convey the person immediately to a mental health facility the law can also restrict the amount of time that the person can be held in a police cell. Another important requirement is that the police promptly inform person concerned on the reasons for their arrest. Legislation may also require that records of all such arrests on suspicion of mental health problems be passed on to a Review Body.

Many argue that diversion from jail and re-entry into the community should be the primary objective for people with mental disabilities. Those who have been arrested for less serious, non-violent crimes should not go to jail and in some cases be diverted to mental health services as appropriate.

It is important to note that diversion to psychiatric institutions may in itself be problematic. Many such institutions are associated with wide ranging human rights violations and are not conducive to the health, mental health and well being of those who reside in them. Thus diversion schemes need to aim to re-orient people who may need treatment to mental health services based in the community.

C. Trial stage

Fitness to stand trial

The law in most countries does not allow trial of a person *in absentia*, meaning the person has to be present and/or be properly represented by counsel at the time of the trial. Being present at the trial means the person is both physically and mentally present. Fitness, or competence, to stand trial, therefore, pertains to the mental condition of an accused at the time of trial.

In most countries a person is deemed unfit to stand trial when, on account of his/her mental condition, he/she is unable to:

a) understand the nature and object of the legal proceedings (e.g., that he is being tried for a crime, the relative roles of prosecutor, defense attorney, and judge);
b) understand the possible consequences of the proceedings; or
c) communicate with counsel and assist counsel in his defense.

It is generally a low-level standard because the goal is to provide as many people as possible with their day in court.

If a person is found unfit to stand trial by virtue of mental health problems, criminal proceedings must be kept in abeyance until the person regains fitness. In such cases, laws in many countries a give Courts powers to send the person to a mental health facility for treatment.

Safeguards are often put in place to protect the rights of these individuals so that they do not languish for longer than necessary in mental health facilities (without having been found guilty of a crime). Regular review of the individual's placement by the Court, for example by asking for a regular psychiatric report is another important safeguard to be included in law. Legislation may also set forth what should happen if a determination is made that the person will not regain competence/fitness in the foreseeable future.

All persons under trial on criminal charges who are detained in a mental health facility on orders of the Court have the same rights as other non-criminal individuals admitted to such facilities. In particular, all legislative protections pertaining to involuntary treatment must apply to these individuals. They should also have a right to appeal to a higher Court against their detention in the mental health facility.

Sample legislation: Canadian Criminal Code, s.2:
"Unfit to stand trial" means unable on account of mental disorder to conduct a defense at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to:
(a) understand the nature and object of the proceedings,
(b) understand the possible consequences of the proceedings, or
(c) communicate with counsel.

In the U.S.:

- The test is whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding--and whether he has a rational as well as factual understanding of the proceedings against him." Dusky v. United States, 362 U.S. 402 (1960).
- This test, with its requirement of rationality as well as understanding, is stricter than Canada's.
- The Supreme Court decision in Jackson v. Indiana produced the important limit that confinement due to unfitness can last only so long as there is a "reasonable probability" that the accused will become fit to be tried during the foreseeable future. Otherwise, the state must either release the person or commence the "customary civil commitment proceeding". 406 U.S. 715 (1971).

Mental Health Courts

Mental Health Courts are usually not available in low and medium income countries, however they play an important role in certain highly resourced countries. For example there are approximately 175 mental health courts now in the U.S. (Emma Schwartz, Mental Health Courts: How special courts can serve justice and help mentally ill offenders, U.S. News & World Report, Feb. 7, 2008, avail. at http://www.usnews.com/articles/news/national/2008/02/07/mental-health-courts.html (accessed March 30, 2008).

Instead of being sentenced to jail or standard probation, defendants in mental health court are diverted to treatment programs and remain under regular supervision for a fixed length of time. These courts are generally available to non-violent offenders only. The purpose is to have courts that specialize in cases involving individuals with severe mental disabilities who are charged with misdemeanors or non-violent felonies, with the goal that these courts will divert as many cases as possible into appropriate mental health treatment and services. (J. Bard, Re-Arranging Deck Chairs on the

Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot be Made Right by Piecemeal Changes to the Insanity Defense, 5 Hous. J. Health L. & Pol'y 1, 41 (2005) (citing Nat'l Alliance for the Mentally Ill, Criminalization of Mental Illness (2001)).

"In contrast to most generalist state trial courts, which rely upon the time-honored adversarial system for ensuring justice, the [Mental Health Court] judge facilitates largely non-adversarial court proceedings with an approach balanced between treatment and punishment." Id. (quoting LeRoy L. Kondo, Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders, 28 Am. J. Crim. L. 255, 291 (2001)).

The goal of these courts is to "to move beyond standard case processing to address the underlying problems that bring people to court. In the process, they seek to shift the focus of the courtroom from weighing past facts to changing the future behavior of defendants." (Denckla, D., & Berman, G. Rethinking the revolving door: A look at mental illness in the courts 7. Center for Court Innovation (2001)).

After going through the Pittsburgh court, which started in 2001, only 10 percent of 223 graduates were rearrested, far below the 68 percent national average for all defendants.

While mental health courts may not become part of the judicial system in all developing countries, it is possible to train magistrates or judges in ordinary courts so that they play a similar role as mental health courts.

Mental Illness as a Defence

Legislation in most countries around the world requires that the accused should have *mens rea*, translated loosely as "a guilty mind," in order to determine the level of criminal responsibility. If it is demonstrated that, at the time of the offense, the mental faculties of the accused were impaired by virtue of a mental illness, the court may find that the person could not have met the requirements to establish a guilty mind.

The rationale behind the insanity defense is that "an actor who lacks [minimal cognitive and volitional competence] is not responsible, does not deserve punishment, and cannot justly be punished." J. Bard, Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot be Made Right by Piecemeal Changes to the Insanity Defense, 5 Hous. J. Health L. & Pol'y 1, 4 (2005) (citing Stephen J. Morse,

Excusing the Crazy: The Insanity Defense Reconsidered, 58 S. Cal. L. Rev. 779, 783 (1985).

The key element in this determination is whether the mental illness was severe enough so as to *produce incapacity* to meet the elements required to establish criminal responsibility, partially or totally. Under these circumstances, the court may find the accused to be not "responsible due to mental disability". Varying terms are used in different countries, such as "mental disorder defense," "not guilty by reason of insanity," "insane," etc.

In the U.S.:

- Each state, and the District of Columbia, has its own statute setting out the standard for determining whether a defendant was legally insane, and therefore not responsible, at the time his crime was committed. In general, the standards fall into two categories.
- About half of the states follow the "M'Naughten" rule, based on the 1843 British case of Daniel M'Naughten, a deranged woodcutter who attempted to assassinate the prime minister. Under this standard, a defendant may be found not guilty by reason of insanity if "at the time of committing the act, he was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know what he was doing was wrong." This test is also commonly referred to as the "right/wrong" test.
- Some states that use the M'Naughten rule have modified it to include a provision for a defendant suffering under "an irresistible impulse" which prevents him from being able to stop himself from committing an act that he knows is wrong.
- 22 jurisdictions use some variation of the Model Standard set out by the American Law Institute in 1962. Under the A.L.I. rule, a defendant is not held criminally responsible "if at the time of his conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of law." The A.L.I. rule is generally considered to be less restrictive than the M'Naughten rule.
- 3 states -- Montana, Idaho, and Utah -- do not allow the insanity defense at all.

In most countries, legislation stipulates that persons who are so found may be sent to a place of treatment until the person has recovered sufficiently so as to not pose any risk to the community. Sufficient improvement in the person's mental state should lead to release from detention. Once released, it would be expected that the person will continue with treatment if appropriate. For example in South Africa many people are given a "conditional discharge" that allows the state to continue treatment and monitoring of the person and which puts the patient in the hands of a custodian. If at the end of the period of conditional discharge the patient has not violated any of the conditions of their discharge and has not relapsed they are automatically unconditionally discharged. Elaborate systems have been organized to make sure that the rights of the person are protected while at the same time making sure that release is not going to put members of the community in danger. Usually, the final decision for release is vested on a variety of juridical persons, or in some countries, on mental health personnel.

There are many ethical, political, medical and human rights issues and questions arising out of the application of these rules including their compatibility with provisions of the CRPD including Article 12 (equal recognition before the law and legal capacity) Article 14 (liberty and security of person) and Article 25 (Health, including the right to informed consent). See the IDA Position Paper on the CRPD for further discussion on these issues.

“Guilty but mentally ill” verdict

In the U.S., many states have a “guilty but mentally ill” verdict in addition to a “not guilty by reason of insanity” defense. This permits juries to impose full responsibility for a crime while acknowledging that the defendant has a mental health problem. Defendants receiving this verdict serve their sentences in prison but are, in theory, provided with mental health treatment while there. When, and if, the defendant is deemed "recovered" of his mental health problem, he is required to serve out the rest of his sentence, unlike an insanity-defense acquittee who would be released from psychiatric commitment once he is deemed to be no longer dangerous.

Despite the belief to the contrary by many, the “guilty but mentally ill” verdict does not ensure that the prisoners with mental disabilities will receive mental health treatment. (J. Bard, Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot be Made Right by Piecemeal Changes to the Insanity Defense, 5 Hous. J. Health L. & Pol'y 1, 37-38 (2005).). Mental health resources in prison are scarce, and because most statutes grant substantial discretion to the facility directors to provide a level of treatment that they determine is necessary, there is no guarantee that an inmate will receive adequate treatment.

“The stark reality of the GBMI verdict is that GBMI prisoners rarely receive psychiatric or psychological treatment. As a result, GBMI prisoners are often punished in a manner identical to those prisoners who were found ‘guilty’.” (J. Bard, Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot be Made Right by Piecemeal Changes to the Insanity Defense, 5 Hous. J. Health L. & Pol'y n. 181 (2005) (quoting Mark A. Woodmansee, The Guilty But Mentally Ill Verdict: Political Expediency at the Expense of Moral Principle, 10 Notre Dame J.L. Ethics & Pub. Pol’y 341, 383 (1996)).

In the case where GBMI prisoners do have access to treatment, this may be administered against their informed consent. As discussed above, this may be considered to be contrary to Article 25 (Health) of the CRPD which

contains a provision on the right to informed consent.

Diminished Capacity/Responsibility defense

The defense of diminished capacity/responsibility exists in Anglo-American legal systems. The effect of the defense varies between the jurisdictions. In some, it is a full defense and therefore results in a not-guilty verdict. In others, it can lead to a lesser charge (e.g., manslaughter instead of murder) or a mitigated sentence. In England, Ireland and Australia, e.g., and in many U.S. states, it is a partial defense for the charge of murder such that it the defendant instead receives a manslaughter conviction. An example of a "diminished capacity" might be extremely low intelligence.

Eg.: Australia:

- 3 elements of the defense: (1) The accused must have been suffering from an abnormality of mind at the time when he committed the act or omission causing death; (2) the abnormality of mind must have stemmed from a legally recognized cause; and (3) the abnormality must have substantially impaired the accused's criminal responsibility for the act or omission causing death. Stanley Yeo, Partial Defences to Murder in Australia and India: Provocation, Diminished Responsibility and Excessive Defence 36 (2003), in Law Commission, Partial Defences to Murder: Overseas Studies Consultation Paper No 173 (Appendices).
- The Australian Capital Territory formulation of the defense is as follows: "Where, on the trial of a person for murder, it appears that at the time of the acts or omissions causing the death charged, the person was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for the acts or omissions, he shall not be convicted of murder." Id. at 34.

Country ex: the Netherlands:

- "Article 37a of the [Dutch Code of Criminal Law] created the possibility of diminished responsibility. On the basis of this, more refined degrees of criminal responsibility were introduced in the Dutch jurisprudence, and a five-point sliding scale emerged, indicating the degree of criminal responsibility: full responsibility, slightly diminished responsibility, diminished responsibility, severely diminished responsibility, and total absence of responsibility. In intermediate cases of slightly or severely diminished responsibility (i.e., when the offense is to some extent determined by a mental disorder, but cannot be explained in its entirety by this disorder), the judge may impose a prison term corresponding to the portion of psychological functioning that allowed the defendant freedom of choice (i.e., the choice not to commit the offense)." Corine de Ruiter and Robert L. Trestman, Prevalence and Treatment of Personality Disorders in Dutch Forensic Mental Health Services, 35 J Am Acad Psychiatry Law 92-97, at 94 (2007).

D. Sentencing and Treatment Including Diversion Schemes and Alternative Facilities

Some laws allow the use of non-custodial sentences or release for minor offenses committed by persons with mental disabilities as a substitute to a prison sentence. Legislation can authorize or permit judges to divert non-violent offenders with mental illness away from incarceration to appropriate treatment, including the authority for judges to defer entries of judgment pending completion of treatment programs and to dismiss charges and expunge records of individuals who successfully complete treatment programs. (The Sentencing Project, Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription 16, January 2002.)

Some of the different options available in different countries include probation orders, community treatment orders, and hospital orders. The aim of these alternatives is to ensure that persons with mental disabilities receive the care and treatment they may require rather than punishment for minor offenses.

- The person who is the subject of a probation order is allowed to live in the community subject to certain restrictions, which include regular reporting to a Probation Officer, allowing access to professional staff including mental health professionals, and participating in treatment and rehabilitative activities.
- Community treatment orders (CTO) require that persons with mental disabilities reside at a specified place, attend specified treatment programmes including counselling, education and training, grant access to mental health professionals to their homes, and submit to compulsory (involuntary) psychiatric treatment.
- Legislation that provides for hospital orders allow the court to send offenders with a mental disabilities to a hospital for treatment, if it is felt they need hospital treatment. Ordinarily, the hospital order is imposed for a duration longer than the possible sentence for the particular offense. If further hospital treatment is needed at the end of this period, the hospitalisation is continued through normal admission and treatment procedures.

However it may be argued that these options are no longer feasible and in violation of a number of Articles of the CRPD including Article 17 (the right to physical and mental integrity), Article 12 (equal recognition before the law, including legal capacity) and Article 25 (health including the right to free and informed consent.

Some studies have found that the use of CTOs has led to reduced hospitalization, shorter hospital stays, improved access to support and treatment services and familial relationships, and lessened the person's

vulnerability. Jim Campbell et al., International Perspectives on the Use of Community Treatment Orders: Implications for Mental Health Social Workers, 36 Brit. J. Soc. Work 1101, 1102-03 (2006). However a comprehensive review by the Institute of Psychiatry in London and a Cochrane Review of randomised control studies both found that there is no robust evidence about either the positive or negative effects of CTOs on outcomes such as hospital readmission, length of stay in hospital, improved medication compliance or patients' quality of life. Some people argue that the coercion required in CTOs may lead to the breakdown of trust between practitioner and patient and given the lack of evidence of the benefits that this is an unnecessary inclusion in law. Whether CTOs would have different or the same outcomes when applied specifically to people who have been sentenced and diverted to community care has, as far as is known, not specifically been researched. (Churchill R. International experiences of using community treatment orders. Institute of Psychiatry, London (2007); Kisely S, Campbell LA & Preston N. Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review). Cochrane Review (2005))

Laws also include provisions for regular and periodic reviews of all such alternative treatment orders.

In the U.S.:

- The U.S. Supreme Court has found that a State cannot detain persons with mental disabilities who are not dangerous and can live outside of a hospital either by themselves or with the help of their family or friends. O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).
- In the U.S., all but 8 states have mechanisms for mandatory treatment in community settings. In those 8 states, however, with hospitals closing and the number and availability of inpatient beds consequently dwindling, people who are in mental health crises often end up in the streets or in jail instead of in treatment. Treatment Advocacy Center, Law Enforcement and People with Severe Mental Illnesses 3 (2005).
- Connecticut has a program in which its courts can send certain categories of offenders who are deemed to have serious mental health problems into mental health treatment programs. Human Rights Watch, Ill Equipped: U.S. Prisons and Offenders with Mental Illness 27 (2003).

In the EU:

- Winterwerp v. the Netherlands established the requirements (within the meaning of the European Convention) for a person to be detained (admitted to psychiatric hospital treatment on a compulsory basis) on the grounds of 'unsound mind'. According to this judgment, except in emergency cases, the individual concerned should not be deprived of his liberty unless 1) he has been reliably shown to have a true mental disorder evidenced by objective medical expertise; 2) the mental disorder must be of a kind or degree warranting compulsory confinement; and 3) the validity of continued confinement depends on the persistence of such a disorder. Winterwerp v. the Netherlands, 1979, ECtHR Application no. 6301/73; Judgment 26.09.1979. para. 36–43.
- The meaning of "mental disorder of a kind or degree warranting compulsory confinement" has become the subject of increasing debate as the possibility of compulsory treatment in the community becomes a reality in many jurisdictions.

Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557 (citing P. Fennell, The third way in mental health policy: Negative rights, positive rights, and the Convention, Journal of Law and Society 26 (1) (1999), 111, n. 19).

- Confinement beyond the "tariff period" (required for the punishment of the offense) requires the same review of their mental state as any other person confined on the basis of unsoundness of mind. Further confinement can be justified only if there is evidence that the individual's mental disorder is such that it will lead to dangerous behavior. The burden of proof (i.e., to prove that the person is still suffering from a mental disorder with the potential for dangerous behavior) is on the government. Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557.

In Japan:

- History of institution-based mental health services: Over the three decades 1960 to 1990, the number of people in Japan's mental health institutions tripled, in contrast to a trend in other industrialized countries to move patients into the community. As the result of reforms in 1998, this growth plateaued and gradually declined. Beds per 10,000 population reportedly stood at 10.1 in 1960, reached a peak of 29 in 1990 and had declined to 27.5 by 2000. In 1996 this was six times the US bed ratio, and in 2000 it was three times the UK ratio. (Wiesstub 87 n.1)
- Act for the Medical Treatment and Supervision of Insane Persons who Caused Serious Harm came into effect in mid-2005
- This new legislation provides a hybrid solution that provides additional procedural protections and straddles the criminal and civil systems. The District Court serves as the "gatekeeper" for identifying and adjudicating who qualifies for the new legal process, using a new in-court interdisciplinary panel of a judge and psychiatrist.
- A person may be introduced into this system in three ways. First, prosecutors must refer serious offenders to the District Court process—and in the process decline to prosecute these offenders for charges either on the grounds of insanity or diminished responsibility—unless it is apparent that treatment is not needed (Art 33(1)). Before this change was implemented, prosecutors referred more than half of serious offenders directly to mental hospitals with direct review. A second option is for a serious offender to be referred to the District Court after judicial findings of insanity at trial.
- Once the matter is referred to the District court, the court will issue a hospital order for psychiatric examination and risk assessment (during a period of up to 3 months). Then its internal panel of a judge and psychiatrist meets to confirm whether or not the person has a mental illness and/or is partially responsible, and if so, to decide whether involuntary inpatient care or compulsory outpatient management is warranted; or instead determine that treatment under this law is not appropriate.
- Community treatment orders are capped at 5 years, while the length of in-patient care is at the court's discretion, though a period of 18 months is expected to be the norm.
- "One of the contentious implications of this appears to be that insanity acquittees can be made to stay longer than the statutory maximum sentence for the crimes originally charged, as a form of "preventive detention". Weisstub & Carney 89.
- Other limitations of this approach are that it does not cover people charged with certain summary offences such as homicide, rape, robbery, arson, manslaughter, assault, and violent obscenity; also it does not cover offenders who were not diagnosed at the time. These exceptions call into question the effectiveness of these diversion programs.

* David N. Weisstub & Terry Carney, Forensic mental health law reform in Japan: From criminal warehousing to broad-spectrum specialist services?, 29 International Journal of Law and Psychiatry 86-100 (2006).

Fitness to be Sentenced

Sentencing usually follows soon after conviction and the state of being fit to stand trial, whether proven or presumed, continues in effect. However, any jurisdiction which embraces long-term preventive or retributive sentencing can expect longer sentencing processes and longer delays pending the imposition of sentence. It is during these periods that a deteriorating mental condition may raise questions of fitness. (Allan Manson, Fitness to be sentenced: A historical, comparative and practical review, 29(4) International Journal of Law and Psychiatry 262, 263 (2006)). In other words the convicted person may not be able to instruct counsel and competently address the relevant sentencing issues

“While guilt may have been found, the consequential issue of pains and penalties depends on the gravity of the offence, blameworthiness, degree of participation, and relevant mitigating and aggravating factors. These may not have been fully canvassed at trial. Also, the offender's background and character bears on relevant issues like rehabilitative prospects, the efficacy of certain community sanctions, the need for individual deterrence, and future risk. A fairness model pre-supposes that the offender be given a fair opportunity to address these issues. Consequently, it is unfair to proceed to impose a sentence on someone who cannot, by reason of mental disorder, play this role.” Allan Manson, Fitness to be sentenced: A historical, comparative and practical review, 29(4) International Journal of Law and Psychiatry 262, 269 (2006).

According to Scottish philosopher and writer R.A. Duff, sentencing is “a rational process that seeks a response mediated by the other person's understanding”. It is “a communicative enterprise that aims to communicate to offenders the censure they deserve for their crimes”. According to this view, it is fundamental that the offender have the capacity to participate in a moral communicative process. Allan Manson, Fitness to be sentenced: A historical, comparative and practical review, 29(4) International Journal of Law and Psychiatry 262, 270 (2006) (citing R.A. Duff, Punishment, Communication and Community (Oxford University Press, Oxford: 2001)).

Concept has been utilized, by statute or in common law, in Canada, Australia, New Zealand, and in several states in the U.S.

Example of legislation: New York state (McKinney's Consolidated Laws of New York Annotated, Criminal Procedure Law, s.730.50):

- For felonies there can be initial confinement orders for one year, followed subsequently by “retention” orders after a court hearing.
- The first retention order is for 1 year and then every two years after that, subject to a cap of “two-thirds of the authorized maximum term of imprisonment for the ...highest class felony of which he was convicted”.
- After that time, the criminal proceedings “shall terminate for all purposes...”.

E. Serving Sentence in Prison

Prisoners can have mental health problems:

a) that they had when they entered prison,
b) that they developed following incarceration, or
c) that were exacerbated during incarceration.

At a global level, of the nine million prisoners worldwide, at least one million suffer from a significant mental disorder, and a larger number suffers from common mental health problems such as depression and anxiety. http://www.euro.who.int/mentalhealth/Policies/20070921_6 (accessed March 22, 2008)

Prisoners are particularly vulnerable to mental ill health and distress. The majority come from the most disadvantaged groups in society. Many have histories of:

• Damaging experiences in childhood, such as physical, sexual or emotional abuse, or neglect;
• Truancy, leaving school early and low educational attainment, leading to impaired employment prospects;
• Experimentation with, or addiction to, drugs or alcohol, which may have been a factor in their crimes;
• Mental disorders, suicide attempts and self-harm;
• In some cases, extremely traumatic events, such as torture.

(WHO Regional Office for Europe Health in Prisons Project, Consensus Statement on Mental Health Promotion in Prisons, contained in WHO Regional Office for Europe, Mental Health Promotion in Prisons: Report on a WHO Meeting, 1999, EUR/ICP/LVNG 02 08 01, E64328, EUROPEAN HEALTH21 TARGET 6. Page 6.)

There are certain factors inherent in incarceration that can exacerbate mental health problems:

- Isolation from social networks
- Insecurity about future prospects (work, relationships, etc.)
- Feelings of guilt or shame about the offenses they committed and the effects of their behavior on others

(WHO/ICRC Information Sheet: Mental Health and Prisons; WHO Regional Office for Europe Health in Prisons Project, Consensus Statement on Mental

Health Promotion in Prisons, contained in WHO Regional Office for Europe, Mental Health Promotion in Prisons: Report on a WHO Meeting, 1999, EUR/ICP/LVNG 02 08 01, E64328, EUROPEAN HEALTH21 TARGET 6. Page 6.)

There are additional, variable factors in many prisons:

- Overcrowding
- Dirty and depressing environments
- Aggression and violence (physical, verbal, racial, sexual)
- Enforced solitude or, conversely, lack of privacy and time for relaxation/reflection
- Lack of meaningful activity
- Availability of illicit drugs
- Inadequate health services, especially mental health services
- Lack of access to regular physical exercise

(WHO/ICRC Information Sheet: Mental Health and Prisons; WHO Regional Office for Europe Health in Prisons Project, Consensus Statement on Mental Health Promotion in Prisons, contained in WHO Regional Office for Europe, Mental Health Promotion in Prisons: Report on a WHO Meeting, 1999, EUR/ICP/LVNG 02 08 01, E64328, EUROPEAN HEALTH21 TARGET 6. Page 6.)

The behaviour of some people with mental disabilities, influenced by their mental health condition, can make them particularly susceptible to violence from fellow inmates. Treatment Advocacy Center, Criminalization of Individuals with Severe Psychiatric Disorders 4 (2007).

“Inmates with severe mental disorders adapt to incarceration demonstrably more poorly than inmates without severe mental disorders . . . .” Manifestations of maladaptation include:

- Suicide
- The worsening of psychiatric symptoms
- Frequent and intensive mental health hospitalization or treatment
- Exclusion from programs in the prison
- Disciplinary infractions
- Disproportionately long terms of incarceration relative to inmates without severe mental disorders.

“Inmates with severe mental disorders are unable to adjust to the demands of prison life and to the significant control over routine behavior and punishment for infractions. Inmates with severe mental disorders are disproportionately punished for prison infractions because of their significantly reduced coping abilities.”
(T. Howard Stone, Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy, 24 Am. J. Crim. L. 283, 299-300 (1997).)

Treatment of Prisoners with mental disabilities

In some countries legislation contains provisions for transfer of prisoners with severe mental health problems to a mental health facility for treatment if necessary. In many countries, prisons have specially designated hospital units where prisoners are transferred if they are deemed to be ill. A key role of legislation is to ensure that such units are monitored by a Review Body to ensure quality of care and all rules relating to accreditation of mental health facilities must apply to such units. As a matter of good practice, such units should be under the direct supervision of qualified mental health personnel and not the prison authorities. Prisoners who are transferred to such units are entitled to the same human rights protections afforded to other persons with mental disabilities, in particular taking informed consent for treatment. Issues around procedures for the authorisation or prohibition of involuntary treatment may also need to be included.

Ex. of legislation: UK Mental Health Act 1983, Section 47 (Removal to hospital of persons serving sentences of imprisonment, etc.”):
(1) If in the case of a person serving a sentence of imprisonment the Secretary of State is satisfied, by reports from at least two registered medical practitioners -

(a) that the said person is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; and

(b) that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition;

the Secretary of State may, if he is of the opinion having regard to the public interest and all the circumstances that it is expedient so to do, by warrant direct that that person be removed to and detained in such hospital . . . as may be specified in the direction; and a direction under this section shall be known as "a transfer direction".
(Available at http://www.markwalton.net/guidemha/index.asp#part3)

* It is noteworthy that the Act provides for enforced treatment of mental disorder only in a hospital. As a prison is not defined as a "hospital" by the Act, no prisoner can be treated against his or her wishes under the Act in prison, even in a prison healthcare wing. Instead, Sections 47 and 48 provide for prisoners to be transferred to a hospital for treatment of a mental disorder.

* The Mental Health Act 2007, to be implemented in Fall 2008, revises the language of (1) (b) above to read “that the mental disorder from which that person is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment; *and that appropriate medical treatment is available for him*”. (italics added)

Some jurisdictions include provisions ensuring that prisoners transferred to prison-hospital units or to a dedicated mental health facility for treatment can only be detained there for the duration of their sentence. At the expiration of their sentence term, they are no longer subject to detention in

such facilities. If further involuntary admission is necessary due to their mental health condition, the applicable civil commitment provisions under law are followed, as with any other persons not facing a criminal penalty.

The WHO does not recommend the creation of separate psychiatric prison hospitals. In addition to concerns about cost effectiveness, there is a danger that people will be stigmatized, which could in turn put them at risk of human rights violations. (WHO/ICRC Information Sheet: Mental Health and Prisons) Instead, people with mental disabilities should be treated outside the prison. As mentioned above human rights violations are rife in many psychiatric institutions and the recovery process can be halted due to the appalling conditions and lack of acceptable treatment and care. Prisoners should, as far as possible, have access to mental health services in general hospitals as well as in primary health care and community based services where appropriate.

"International human rights standards require officials to ensure the highest attainable standard of mental health, including accessible, acceptable, and appropriate and good quality mental health services, provided by trained professionals." Human Rights Watch, Ill Equipped: U.S. Prisons and Offenders with Mental Illness 10 (2003). Indeed, access to assessment, treatment, and (when necessary) referral of people with mental disabilities, including substance abuse, should be an integral part of general health services available to all prisoners. The health services provided to prisoners should, as a minimum, be of an equivalent level to those in the community. This may be achieved by providing mental health training to prison health workers, establishing regular visits of a community mental health team to prisons, or enabling prisoners to access health services outside the prison setting. Those requiring more specialist care for example, can be referred to specialist mental health providers where in- patient assessment and treatment can be provided. Primary health care providers in prisons should be provided with basic training in the recognition and basic management of common mental disorders. (WHO/ICRC Information Sheet: Mental Health and Prisons)

Prison staff should receive training on mental health issues, associated human rights issues, stigma, recognition and prevention of suicides, and mental health promotion. (WHO/ICRC Information Sheet: Mental Health and Prisons)

United States

In the U.S., the Supreme Court has held that the State is responsible for meeting prisoners' health care needs. Estelle v. Gamble, 429 U.S. 97, 103-05 (1976). "While the Supreme Court has not held explicitly that the right to medical care includes the right to mental health care, the current presumption, supported by the Fourth Circuit's opinion in Bowring

v. Godwin, supports the belief that psychological or psychiatric treatment is included under the definition of medical care." J. Bard, Re-Arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot be Made Right by Piecemeal Changes to the Insanity Defense, 5 Hous. J. Health L. & Pol'y 1, 20 (2005).

Mental health treatment in the U.S.:

- As of 1999, only 17% of state prison inmates and 11% of jail inmates reporting mental illness receive treatment for mental illness while incarcerated. Denckla, D., & Berman, G. Rethinking the revolving door: A look at mental illness in the courts 3. Center for Court Innovation (2001).
- "The bottom line is that there is a severe shortage of treatment for people with mental illness while they are incarcerated. Even when treatment programs are available, their effectiveness is limited by long waiting lists, lack of incentives to participate, a dearth of trained counselors and the stigmatization of those who participate." Id.

Solitary confinement

The UN Human Rights Committee specifically mentions "prolonged solitary confinement" as a practice that may amount to inhuman and degrading treatment in violation of the ICCPR (Article 7 – "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."). General Comment 22(40), in UN Manual on Reporting, supra note155, ¶ 6.

This is echoed in the UN Special Rapporteur on Torture's 2008 Interim report which concludes (in relation to institutions) that prolonged use of restraints and of solitary confinement and seclusion, may amount to torture or ill-treatment in violation of the UN Convention on Torture and of Article 15 of the CRPD. (See Module 3 and 7 for further discussion on this) (Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, July 2008 (A /63/175))

UN Standard Minimum Rules

UN Standard Minimum Rules for the Treatment of Prisoners, adopted Aug. 30, 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, U.N. Doc. A/CONF/611, annex I, E.S.C. res. 663C, 24 U.N. ESCOR Supp. (no. 1) at 11, U.N. Doc E/3048 (1957), amended E.S.C. res. 2076, 62 U.N. ESCOR Supp. (no. 1) at 35, U.N. Doc. E/5988 (1977):

- According to the guiding principles, the purpose of a sentence of imprisonment is to protect society against crime, a purpose which can only be achieved, "if the period of imprisonment is used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life." Paras. 58-59.
- "The medical services . . . shall seek to detect and shall treat any . . . mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary . . . psychiatric services shall be provided to that end." Paras. 62.
- "Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible." 82(1)

- "Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management." 82(2)
- "During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer." 82(3) "The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment." 82(4)

As discussed above the IDA position paper on the CRPD holds that the transfer of prisoners to mental health facilities, as outlined in the UN Standard Minimum Rules for the Treatment of Prisoners, is superseded by the Convention.

F. International human rights caselaw relevant to mental health and criminal justice

Inter-American Commission

The Inter-American Commission on Human Rights and, in particular, the European Court of Human Rights have issued case law on the issue of whether particular conditions faced by criminal offenders with mental disabilities constituted inhuman or degrading treatment in violation of their respective charters.

In the first case in which the Inter-American Commission considered the rights of a person with a mental disability, Case of Victor Rosario Congo (1997), the Inter-American Commission recognized the importance of looking at the particular vulnerability of people with mental disabilities who are subject to detention.

- The facts of the case: A 48 year-old man in Ecuador was placed in detention at a Social Rehabilitation Centre after he was charged in a criminal case. He appeared depressed, unresponsive to questions by the guards, and "behaved in a way that suggested mental disorder." When he was still not cooperating with interrogators 2 days after his detention, a guard "shouted questions over and over at him, which clearly made him more demented..." The guard later beat him and left a wound in his scalp. Congo received no medical treatment and was detained in an isolation cell naked and virtually incommunicado for 40 days. A medical expert who interviewed Congo three weeks after his detention stated that he had developed psychiatric symptoms as a result of the trauma he experienced in detention. On October 23, 1999, a judge ordered Congo transferred to a hospital where he could receive appropriate treatment. Both a psychiatric hospital and a general hospital refused to admit him. On October 25, 1999, Congo was transferred to another Social Rehabilitation Center, where he was found to be in a "critical state of health" due to severe dehydration. He was brought immediately to a hospital where he died of

dehydration hours after he was admitted. ¶¶ 7-19.

- The Inter-American Commission found that the government of Ecuador violated Congo's right to life under Article 4(1) of the American Convention and subjected him to inhuman and degrading treatment under Article 5. ¶101
- The Commission found that Congo did not die of the wound inflicted by the beating but because of dehydration that resulted from the lack of diligence to Congo's mental and physical health. Even though the government did not actively deprive Congo of food and water, it failed to take the care, including psychological care, necessary to ensure that Congo would be protected.

- The Commission stated that it would apply "special standards to the determination of whether the provisions of the (Inter- American) Convention have been complied with in cases involving persons suffering from mental illnesses." ¶ 53. The Commission also stated that the protection against inhuman and degrading treatment under the Inter-American Convention "must be interpreted in light of the" MI Principles. ¶ 54.
- The Commission held that "international standards applicable establish that every detention center shall possess the services of at least one qualified physician, who must possess some psychiatric knowledge. This physician must be responsible for the physical and mental health of the inmates and must see those with health problems every day as well as those drawn to his attention." ¶ 80.
- The Commission noted that detention of a person in a small, isolated cell "can itself constitute inhumane treatment. [But]... when the person kept in isolation in a penitentiary institution has a mental disability, this could involve an even more serious violation of the State's obligation to protect the physical, mental and moral integrity of persons held under its custody." ¶ 58.
- The Commission found that detention "under deplorable conditions and without medical treatment" constituted an additional form of inhuman and degrading treatment. ¶ 66.
- Finally, the Commission noted that "the right to physical integrity is even more serious in the case of a person held in preventative detention, suffering a mental disease, and therefore in the custody of the State in a particularly vulnerable position." ¶ 67.
- Citation: Inter-American Commission on Human Rights Report 29/99, Case 11,427, Ecuador, adopted in Sess. 1424, OEA/Ser/L.V/II.) Doc. 26, March 9, 1999, available at www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm.

European Court of Human Rights

- The European Court of Human Rights has also considered the particular vulnerabilities of mentally ill prisoners. In Keenan v. United Kingdom, the Court found that the prisoner had been subjected to **inhuman or degrading treatment** (in violation of Article 3 of the European Charter of Human Rights) when he was placed in solitary detention for 7 days without the appropriate level of medical care and committed suicide.
    - The Court found lack of effective monitoring and informed psychiatric input by prison officials demonstrated "significant defects in the medical care provided to a mentally-ill person." 964. The prisoner had been taking anti-psychotic medication and was known suicide risk, but the medical personnel didn't keep adequate daily records of his condition. Id.
    - Taking into account the prisoner's vulnerability and the authorities' obligation to protect his health, the court determined that the serious disciplinary punishment "threatened his physical and moral resistance." Id.
    - Citation: European Court of Human Rights, App. No. 27229/95, 33 Eur. H.R. Rep. 913 (2001) (Court report).

- In the case of Price v. United Kingdom The European Court highlighted the importance of considering the entire context of a case when looking at Article 3 inhuman/degrading treatment. It stated that: "The Court recalls that ill-treatment must attain a minimum level of severity if it is to fall within the scope of [the European Convention.] The assessment of this minimum level of severity is relative; it depends on all the circumstances of the case, such as the duration of treatment, its physical and mental effects and, in some cases, the sex, age, and state of health of the victim."
    - In this case, the prisoner had significant physical disabilities. She was detained in jail for seven days for contempt of court, placed in regular cell that did not have appropriate facilities for a person with disabilities; as result, she was forced to sleep in wheelchair and was unable to use the toilet facilities or access the light switches or emergency buttons. Id. at 158. She experienced serious medical problems as a result. Id.
    - Court found she had been subject to degrading treatment. Id. at 165.
    - Citation: European Court of Human Rights, 2002-VII Eur. Ct. H.R. 154 (2001).

- This emphasis on "all the circumstances of the case" is very important in the context of people with mental disabilities in detention. "Recent decisions of the European Court and Inter- American Human Rights

Commission suggest that the standard that applies for people with mental disabilities is rapidly evolving and that courts recognize that extra vigilance is required on the part of governments to protect against inhuman and degrading treatment of people with mental disabilities." World Health Organization (E. Rosenthal & C. Sundram), The Role of International Human Rights in National Mental Health Legislation 53 (2004).

- The European Court of Human Rights has also considered the **therapeutic nature of the detention of prisoners with mental disabilities**. It held in Aerts v. Belgium that, in instances in which a person is detained on the grounds of unsoundness of mind, the **facility in which the detention takes place must be equipped to provide minimally adequate care and treatment.** In this case, where the conditions of the prisoner's detention in the psychiatric wing of a prison were not commensurate with the aim of the detention because the person received no medical care and the environment was not therapeutic, the detention was unlawful.
    - Article 5(1) of the European Charter lists the only circumstances in which governments may justifiably deprive a person of liberty, including, in subpara. (e), "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." Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11, Nov. 1, 1998, available at www.echr.coe.int/Convention/WebCovenENG.pdf.
    - The Court held that the term "lawful" in this provision requires conformity with the domestic law and with the purposes of deprivation of liberty permitted by Article 5(1). Aerts v. Belgium, 1998-V Eur. Ct. H.R. 1939, 1962.
    - The Court also held that the reason for confining a person must be directly related to the means or method of confinement. Id. "[T]here must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the 'detention' of a person as a mental health patient will only be 'lawful' for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution."
    - The psychiatric wing in this prison fell far short of international standards for psychiatric care.
    - Citation: Aerts v. Belgium, 1998-V Eur. Ct. H.R. 1939, 1962.

    - "The European Court's jurisprudence is still too undeveloped to predict whether it will formulate robust criteria for ensuring that mental health facilities provide minimum standards of treatment,

care, and protection from abuse. It is not difficult to form a theory supporting a 'right to therapeutic conditions' under Article 5." L. Gostin and L. Gable, The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health, 63 Md L. Rev. 20, 88 (2004).

- "This is not to say that a psychiatric wing in a prison is per se an inappropriate place of detention for offenders with a mental disorder, but rather that certain standards of care had to be maintained." Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557.
- "The most important part of this judgment was that it affirmed the necessity of following through on the basis for detention — if it is for therapeutic purposes, then the therapy must be provided. . . . This was a milestone case in the development of a jurisprudence of positive rights for mentally ill offenders, in particular that 'there has to be relationship between the grounds for detention under Article 5.1 (e) and the location and conditions of detention' (Richardson, 2005: 130)." Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557.
- "However, the question of appropriate psychiatric treatment is a complex one, as many offenders with a diagnosed mental illness are not detained within the psychiatric system, mainly because of the fact that their original conviction was not related to their mental disorder. Many receive treatment within the ordinary prison system where standards of care are extremely variable." Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557.

Detention following criminal conviction is addressed by the ECHR under Article 5(1)(a) (which allows "the lawful detention of a person after conviction by a competent court"). - "Presumably, the justification for detention under sub-paragraph (a) ceases once the person has been confined for a period of time that is proportional to the gravity of the offense." (L. Gostin and L. Gable, The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health, 63 Md L. Rev. 20, 74 (2004))

Detention in mental hospitals requires compliance with both 5(1)(a) *and* 5(1)(e). The Court retains the power to verify that the person is of unsound mind under (e). (L. Gostin and L. Gable, The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health, 63 Md L. Rev. 20, n. 384 (2004)). When people with mental disabilities are detained, the Court requires **periodic review of**

the lawfulness of the detention, to ensure that the person's mental state continues to require detention.

- In Silva Rocha v. Portugal, the Court held that the state could detain a person found not guilty by reason of insanity under sub-para. (a) for 3 years given the seriousness of the offense and the risk to the public. After the 3 years had expired, the applicant had the right to further judicial review. (Silva Rocha v. Portugal, 19960V Eur. Ct. H.R. 1913, 1921-22.)
- "As with other rights under the European Convention, the right to liberty (under Article 5 . . .) is a qualified right — it is not an absolute right. It can be restricted after a conviction or on the basis of 'unsoundness of mind'. This means that a person's right to liberty can be limited by criminal law and mental health law, but only if procedures to detain an individual comply with 'fair trial' guarantees set by the European Convention and its jurisprudence. The difficulties surrounding the care or containment of offenders with mental disorders are related to the fact that they may be held indefinitely under laws aimed at the protection of the public, rather than the treatment of the individual." Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557.
- "Drawing on case law developed during the 1980s, including the case of Weeks v. the UK, 1987, the ECtHR made clear that when individuals had served what is regarded as the 'tariff' period required for the punishment of the offence, then they are entitled to the same review of their mental state as any other person confined on the basis of unsoundness of mind. Further confinement can only be justified if there is evidence that their mental disorder is such that it will lead to dangerous behavior (for further discussion, see Wachenfeld, 1991: 175). It was also clarified that the onus is on governments to prove that the person is still suffering from a mental disorder with the potential for dangerous behavior. Though research points to the difficulty in predicting behavior ([Litwack et al., 1993] and [Monahan and Steadman, 1994]), psychiatrists are asked constantly to make this judgment.
- Because [in the case of The case of Thynne**,** Wilson and Gunnell v. United Kingdom], Thynne, Wilson and Gunnel had no entitlement to a regular review of their cases by an authority with power to discharge them, the ECtHR found that there was a violation of Article 5.4. It was clear from this case that there is no situation in which a review is not necessary after the tariff time is complete, even if the original offence was very serious or carried a life sentence. These and other cases established the rights of mentally disordered offenders to a regular judicial review to a body that has

the power to discharge, and to appeal any decisions that arise from these reviews." Pauline M. Prior, Mentally disordered offenders and the European Court of Human Rights, Int'l J. of L. and Psych., Volume 30, Issue 6, November-December 2007, Pages 546-557.

G. International standards and normative guidance - key issues for considerations

Legislative provisions relating to offenders with mental disabilities are a highly complex area covering both the criminal justice and forensic mental health systems. There are wide variations in policy and practice in different countries, and forensic mental health is often part of the criminal code (or criminal procedure) rather than of mental health law, though in some countries these issues are covered in both.(WHO Resource Book on Mental Health Law and Human Rights, 2005)

A number of international standards and normative guidance documents can be useful in the process of both assessing existing law in this area and developing new legislation.

The MI Principles for example, contain provisions related to mental health and criminal justice issues. It is important to note however that provisions of the CRPD supersede the MI Principles. The MI Principles, which are not legally binding, will no longer be considered relevant to the extent that they conflict or are inconsistent with the more recent and legally binding CRPD articles. However, where the MI Principles are in agreement with the CRPD, these principles can be useful in understanding some of the central issues on this topic. **MI Principle 20** addresses criminal procedure. It states that all persons who are determined to have a mental illness "or who it is believed may have such an illness" and who are serving criminal sentences or who are detained in the course of criminal proceedings should receive the best available mental health care. (§§ 1-2) It also states that domestic law may authorize a court, "acting on the basis of competent and independent medical advice" to order that such a person be admitted to a mental health facility. (§ 3)

In 1996, the WHO issued guidelines to provide more detail and context to the MI Principles. **(Guidelines for the Promotion of Human Rights of Persons with Mental Disorders**, WHO/MNH/MND/95.4, 1996). They provide questions – a sort of checklist – by which to assess national laws related to mental health and criminal justice. In developing national legislation the following issues may need to be considered and debated:

- Who is considered a criminal offender?
- Is there a status for those deemed not guilty by reason of insanity (NGRI)?

- If so, what are the specific procedures for those deemed to be NGRI?
- What about people with mental disabilities out on bond? Can they be forced to seek treatment as a condition for their freedom? How is this treatment verified?
- Within the prison system, what is the nature of health care for prisoners?
- Is health care guaranteed to prisoners?
- Is there a hospital section within each individual prison?
- Is mental health care guaranteed to prisoners?
- Is there a specific forensic hospital in which people with mental disabilities can receive treatment locally?
- Are people experiencing mental health problems in prison kept with the general prison population, or are they placed in private or semi-private cells or within the hospital section of the prison, assuming one exists?
- May prisoners be admitted to mental health facilities? If so, which ones, and for what purpose?
    a) Restoration to competency? Before or after trial?
    b) As part of sentencing? May part or all of the sentence be served within the mental health facility?
    c) By whom may they be admitted?

- Is the prisoner's right to informed consent to treatment respected? How is the voluntariness of treatment safeguarded in light of restoration to competency to stand trial? For example, if the prisoner is deemed not competent but nevertheless considered to have the potential for restoration to competence, may he/she refuse the treatment which it is assumed would restore him/her to competence?
- What are the special safeguards regarding the personal integrity of people with mental disabilities in prisoners, particularly with regard to limits on personal restraint and privacy?
- Are the guards and prison officials trained to be aware of the basic symptoms of mental disorders?
- Are the guards and prison officials trained to be sensitive and responsive to the needs of people with mental disabilities?
- Are people with mental disabilities disproportionately represented in the local prison system? Are there any indications that mental illness is in effect being criminalized?
- Is the prison system, as opposed to the health care system, being used to 'house and protect' people with mental disabilities?

The **WHO Checklist on Mental Health Legislation** (reproduced in Annex 1 of the WHO Resource Book on Mental health, Human Rights and Legislation) also provides guidance for assessing and developing the content of legislation in relation to mental health and criminal justice. Questions that need to be considered, for example, include:

- Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the communities interest in prosecution?
- Does the law make adequate provision for people who are not fit to stand trial to be assessed and for charges to be dropped or stayed while they undergo treatment?
    a) Are people undergoing such treatment given the same rights in the law as other involuntary admitted persons, including the right to judicial review by an independent body?
- Does the law allow for people who are found by the courts to be Not Responsible Due to Mental Disability to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?
- Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders rather than being sentenced to prison?
- Does the law allow for the transfer of a convicted prisoner to a mental health facility if they become mentally ill while serving a sentence?
    a) Does the law prohibit keeping a prisoner in the mental health facility for longer than their sentence unless civil commitment procedures are followed?
- Does the legislation provide for secure mental health facilities for mentally ill offenders?

The **WHO Resource Book on Mental Health, Human Rights and Legislation** (see pages 75 to 80) more generally highlights a number of key issues to be considered in relation to the different stages of the criminal justice process including;

- Prosecution
- trial stage
- post-trial (sentencing) stage
- post-sentencing (serving sentence in prison) stage

- The **WHO/ICRC Information Sheet on Mental Health and Prisons** provides information on mental health and criminal justice issues and a number of suggestions for provisions to be considered for legislation including:
- the rights to quality treatment and care, to refuse treatment, to appeal decisions of involuntary treatment, to confidentiality, to protection from discrimination and violence, and to protection from torture and other cruel, inhuman and degrading treatment (including abusive use of seclusion, restraints and medication, and non-consensual scientific or medical experimentation), among others.

- procedural protections within the criminal justice system equivalent to those granted other prisoners
- independent inspection mechanism such as mental health visiting boards to inspect prisons as well as other mental health facilities in order to monitor conditions for people with mental disorders.

Other useful resources for the assessment and development of legislation related to mental health and criminal justice include:

- International Disability Alliance (IDA) Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments, April 25, 2008 www.internationaldisabilityalliance.org/documents_working_group/IDA_CRPD_paper_final.doc
- UN Standard Minimum Rules on the Treatment of Prisoners http://www.unhchr.ch/html/menu3/b/h_comp34.htm
- WHO EURO Trencín statement on prisons and mental health. Adopted in Trencín, Slovakia on 18 October 2007

H. Conclusion

Most statutes acknowledge that people who did not have control of their actions due to a mental disorder at the time of the offence, or who are unable to understand and participate in court proceedings due to mental illness, require procedural safeguards at the time of trial and sentencing. But how these individuals are handled and treated is often not addressed in the legislation or, if it is, it is done poorly, leading to abuse of human rights. Mental health legislation therefore plays a key role in laying down procedures for ensuring the protection of people with mental disabilities within the criminal justice system at various stages of the legal process (WHO Resource Book on Mental Health, Human Rights and Legislation, 2005).

As noted above, it will be important to understand the implications of the UN Convention on the Rights of Persons with Disabilities in this area, as it is likely to have an important influence on how legislation related to mental health and criminal justice is drafted in the future.

Core reading

WHO Resource Book on Mental Health, Human Rights and Legislation. (2005) World Health Organisation, Geneva. Pgs 72-80.

International Disability Alliance (IDA) Position Paper on the Convention on the Rights of Persons with Disabilities (CRPD) and Other Instruments, April 25, 2008

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Additional reading

International Convention on the Rights of Persons with Disabilities. Adopted by the United Nations General Assembly in December 2006
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UN General Assembly, Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. G.A. Res. 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc. A/46/49 (1991).

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MIND UK website: www.mind.uk.org

Consensus Project website: http://consensusproject.org/