Court Mandated Outpatient Treatment for Mentally Ill Offenders in New South Wales

Abstract

Section 32 of the *Mental Health (Criminal Procedure) Act* 1990 (NSW) came into being in 1990 and introduced an option for magistrates to divert mentally ill offenders, who were not ill enough to require hospitalisation, into treatment in the community under an order similar in effect to a community treatment order made under the *Mental Health Act* 2007 (NSW). In this comment the author examines the history and philosophical justification of s 32 and its amendments, the elements of s32 and some procedural matters. As research regarding s32 itself is almost non-existent, the author examines evidence regarding the efficacy of mandatory outpatient treatment (MOT), which has been conducted, in the main, with non-offenders and considers whether such evidence is applicable in the forensic setting. The author concludes that s32 orders may deliver positive outcomes; however, as with all therapeutic interventions, these orders should be based on good evidence, and therefore further research is essential.

Introduction

New South Wales is unique amongst the state jurisdictions in Australia in having a statutory regime that allows mentally ill defendants charged with summary offences to be diverted into community treatment. In other jurisdictions within Australia, generally there are only provisions to enable a suspected mentally ill defendant to be detained in a hospital.[1] That this should be so in other jurisdictions would seem to be somewhat out of kilter with the history of psychiatry over the past forty years wherein deinstitutionalisation has led to most patients being treated in venues outside the traditional, large psychiatric hospital (Collins 2005:214).

When a defendant, who is before the Local Court in New South Wales, appears to be mentally ill but does not require care and control in a hospital, s32 of the *Mental Health (Criminal Procedure) Act* 1990 (NSW) (MHCP Act) gives a Magistrate broad powers including the power to order the person to 'attend on a person or at a place ... for assessment of the defendant's mental condition or treatment or both' (s32(3)). In practice, the place would usually be a community health centre or the clinic of a community mental health team. This provision to enable the magistrate to impose conditions on a mentally ill defendant that the person attends a place for treatment makes s32 orders similar, in practice, to community treatment orders (CTO) made under Chapter 3, Part 3 of the *Mental Health Act* 2007. There is, however, a major difference between a s32 order and a CTO in respect of what may happen if a person breaches the conditions of either order. In the case of a breach of a CTO, ultimately, the person may be taken to a health care agency for treatment and assessment, whereas a breach of a s32 order may result in the person being returned to court and ultimately into custody.

1 For example, in Western Australia, a 'hospital order' made under s5 of the *Criminal Law (Mentally Impaired Accused) Act* 1996 (WA) allows a defendant who is refused bail to be detained in an authorised hospital for assessment by a psychiatrist

Whilst there is a growing body of evidence of the effectiveness or otherwise of mandatory outpatient treatment (hereafter MOT)[2] (Kisely et al 2007:3), there has been little, if any, research into either the effect of the s32 amendments or the efficacy of s32 orders in themselves. At Tamworth Local Court in New South Wales, a group of researchers from the Statewide Community and Court Liaison Service[3] conducted a case-control study of 53 persons made subject to s32 orders and compared them to a similarly sized sample of non-mentally ill offenders made subject to good behaviour bonds (Douglas et al 2006). The study, which examined criminal recidivism and a range of socio-economic variables, demonstrated positive effects on treatment compliance, symptom severity and socio-vocational functioning and, although not statistically significant, a positive trend towards less reoffending amongst clients made subject to s32 orders.

Background to the *Mental Health (Criminal Procedure) Act* 1990

The MHCP Act was introduced in the NSW Parliament in 1989, at the same time as the new *Mental Health Act* 1990 (NSW) (MHA). The provisions relating to mentally ill offenders now contained in the MHCP Act had been originally in Parts 11A and 11B of the *Crimes Act* 1900 (NSW) but, with the enacting of the new MHA, it was considered that the 'provisions should more appropriately be placed in a new principal piece of legislation'.[4] Part 3 of the MHCP Act concerns summary proceedings before a magistrate and gives magistrates broad powers regarding the disposition of defendants who appeared to be mentally disordered[5] or developmentally disabled. In essence, s32 gives a magistrate the power to divert a defendant into mental health treatment in the community and s33 enables a defendant to be diverted into involuntary treatment in a psychiatric hospital, instead of dealing with the person by way of criminal law.

However, the MHCP Act, as made, did not contain provisions whereby a person who was made subject to a s32 order could be recalled by the court if the order was breached, thus making the order somewhat 'toothless'. An Interdepartmental Committee came to the view that the lack of 'ramifications for non-compliance' (Spiers 2004:9) led to an escalation of offending behaviour and ultimately to the imposition of severe sanctions including custodial sentences. The Committee also believed that magistrates had become reluctant to make s32 orders as a result of the lack of enforceability. Amendments to the MHCP Act, that allowed an offender to be brought back before the court if the person breached the terms of a s32 order, commenced on 14 February 2004.

Eligibility

Section 32 is contained within Part 3 of the MHCP Act and applies to persons charged with summary offences or offences triable summarily. Persons charged with strictly indictable offences are not eligible for diversion through these provisions; instead Part 2 of the MHCP Act applies to those offences triable on indictment only.

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2 Also known as 'involuntary outpatient commitment' (IOC) or 'community treatment orders' (CTOs).

3 The Statewide Community and Court Liaison Service (hereafter SCCLS) provides a mental health court liaison service to the NSW Local Court. SCCLS is operated by Justice Health which is a statutory corporation constituted by s41 of the *Health Services Act* 1997 (NSW).

4 Peter Collins, New South Wales, Legislative Assembly, *Parliamentary Debates (Hansard)*. 22 March 1990 at 892.

5 The term 'mentally disordered' is used here in its broadest sense and includes. mentally ill; mentally disordered and persons suffering from a 'mental condition'.

Section 32 may apply to a person who at the time of appearing before a magistrate or at the time of the alleged offence is either:

(i) developmentally disabled, or

(ii) suffering from mental illness, or

(iii) suffering from a mental condition for which treatment is available in a hospital, but is not a mentally ill person within the meaning of Chapter 3 of the *Mental Health Act* 2007.

Section 32 is a discretionary power of the magistrate, that is, the magistrate must decide whether it is more appropriate to deal with the person under s32 or under the otherwise applicable law.

'Court Diversion'

Section 32 is a form of 'pre-trial' diversion that allows a magistrate to divert a mentally ill offender out the criminal justice system at an early stage in the process and before the lengthy and expensive process of a full hearing. Court diversion is not unique to mental health and nor is it a new phenomena (see James 2006 for description of a 1914 US programme; see also the MERIT programme in NSW: Linden 2003:33). There is some disagreement as to whether diversion is a complete alternative to or diversion out of the normal criminal justice process or whether prosecution should continue after the person has been successfully treated (see Hartford et al 2004; Greenberg & Nielsen 2002; O'Neill 2006; Birmingham 2001).

Another form of diversion for mentally ill offenders that operates in NSW is 'police diversion' or diversion at the time of arrest. Section 22 of the MHA gives a police officer a discretionary power to apprehend a person who is suspected of having committed an offence, or who has attempted suicide, or is at risk of attempting suicide, or is a serious risk of harm to others and take that person to a psychiatric hospital for an assessment.

Why Divert Mentally Ill Offenders?

There are a variety of reasons to justify diverting mentally ill persons away from the criminal justice system. Those reasons could be summarised as health reasons, reducing recidivism, human rights reasons and economic reasons. Although it is in the interests of the wider community that mentally ill offenders are appropriately treated, that interest must be balanced against the community interest in punishing and deterring offending. The study of the role of the law in acting as a therapeutic agent in this process is known as therapeutic jurisprudence (Wexler 1992:27). The role of the magistrate in diversion becomes one of balancing the interests of the welfare of the person against the interests of the wider community in preventing offending through the mechanisms of imprisonment and deterrence.

Health Reasons

The World Health Organisation states unequivocally that '[p]risons are bad for mental health':

> There are factors in many prisons that have negative effects on mental health, including: overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services, especially mental

> health services, in prisons. The increased risk of suicide in prisons (often related to depression) is, unfortunately, one common manifestation of the cumulative effects of these factors (WHO 2007).

O'Neill (2006:87), in discussing the situation in the Republic of Ireland, states '[p]risons are toxic and inappropriate environments in which to manage people with major mental illnesses. The mentally ill are vulnerable in such settings. Where involuntary treatment is required, this is not permissible in a prison setting'. A similar restriction exists in NSW, where the MHA and MHCP Act only permit involuntary treatment for a mental illness in a hospital (or 'mental health facility' in the language of the new *Mental Health Act* 2007) not within the general prison setting.

There is now extensive research which indicates that mentally ill persons are over-represented in the prison population as compared to the general population. Fazel and Danesh (2002:545) conducted a meta-analysis of 62 international surveys and found a mean prevalence for psychosis in prisons of 3.7 per cent. Butler and Allnutt (2003) in their extensive survey of mental illness amongst NSW prisoners estimated that between 4 and 7 per cent of reception inmates had a functional psychotic mental illness and 9 per cent had at least some form of psychotic disorder. This was statistically significantly higher than the findings of a similar survey of the general community where the prevalence of any psychosis was 0.42 per cent (Butler & Allnutt 2003:48).

The over-representation of mentally ill persons in prisons may be explained only partly by the higher risk of a mentally ill person committing an offence (Mullen 2001:44). Other factors cited include difficulty in meeting bail requirements (O'Neill 2006), the overall reduction in the numbers of psychiatric beds, and failure to develop adequate community mental health services, particularly services for marginalised clients, such as the homeless or those with co-occurring mental illness and substance misuse disorders (Birmingham 2001:199).

Put together, the over-representation of mentally ill persons within prisons, the negative effects of prison on mental health and the difficulties of properly treating severely mentally ill persons in a prison setting, make a compelling case for diverting mentally ill offenders out of the criminal justice system and into appropriate mental health facilities.

Reducing Recidivism

There has been surprisingly little research into the effect of court diversion on recidivism. Hartford et al (2004) in their extensive review of the literature regarding several different types of mental health diversion in Canada found that the evidence was not sufficient to make definitive conclusions about such areas as 'policy, planning, evaluation, funding, training, staffing levels and clinical interventions'. Many of the published reports are descriptive studies that do not examine recidivism as an outcome (Sharples et al 2003:300).

Hough and O'Brien (2005:411) examined the effect of CTOs on offending in a large sample of 553 CTOs in Western Australia. They found a significant reduction in offending and violent offending during the CTO and for a period of a year following the end of the year. They suggest that the reduction in offending is due to improved compliance with medication but their research does not demonstrate this as a causative factor in the reduction.

The study by Cosden et al (2005:199) is significant as it is one of the few randomised trials in an area where it is often ethically and legally impossible to randomly assign patients to different treatment groups. The study examined clients randomly allocated to either a 'Mental Health Treatment Court (MHTC) with diversion to treatment supported by an

assertive community treatment (ACT) model of case management' or 'treatment as usual'. They found that both groups had reduced jail days and improved psychosocial function but the MHTC group showed a greater improvement overall.

Human Rights Approach

The Standard Minimum Rules for the Treatment of Prisoners, adopted by the United Nations states at Rule 82(2) that '[p]risoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management'.

And Principle 1(1) of the Principles for the protection of persons with mental illness and the improvement of mental health care states that '[a]ll persons have the right to the best available mental health care, which shall be part of the health and social care system'.

Principle 20 provides that Principle 1 shall apply to criminal offenders in the following way:

> All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.

While the above rules and principle have not yet crystallised into rules of international law with the same status as the major human rights instruments, they add to the weight of arguments for not sending mentally ill persons to prison.

Efficacy of Section 32

There have been no published studies of the efficacy of s32 per se. The publicly presented case-control study of Douglas et al is, as yet, the only available quantitative study of the effects of s32. The study demonstrated statistically significant improvements in certain health and social-vocational outcomes but only showed a non-significant trend towards reduced reoffending. The study cohort needs to be followed for a longer period of time to demonstrate whether the trend in re-offending is truly positive.

In the absence of specific research on s32, and with the similarity of s32 orders to CTOs made under the MHA, it may be useful to examine whether evidence for or against the efficacy of mandatory out-patient treatment can illuminate the question of efficacy of s32 orders.

Randomised controlled trials are the 'gold standard' in evaluating the efficacy of health interventions but it is legally impossible to randomly allocate patients to orders such as s32. Kisely et al (2007:3) performed a meta-analysis of five, systematically selected studies with a total number of 1108 subjects. The analysis found there was very little evidence for CTOs reducing either the number of admissions or total number of bed-days. They concluded, given the lack of evidence of efficacy of CTOs, it could not be said that CTOs were necessarily a less restrictive alternative to admission. The study was not looking at a criminal sample, so it did not examine recidivism.

Bonta and colleagues (1998:123) did not look at any one particular intervention but conducted a meta-analysis to identify the factors that statistically predicted recidivism among mentally disordered offenders. The study found that the predictors of re-offending were similar for mentally ill and non-mentally ill offenders. That is, factors such as

'[c]riminal history, antisocial personality, substance abuse, and family dysfunction' are the most important correlates of crime and '[c]linical or psychopathological variables were either unrelated to recidivism or negatively related' (1998:139). In fact, the 'presence of a mental disorder was associated with less recidivism'. This last finding is in contradiction to the view taken by Mullen (2001) and Torrey (1994:653) who suggest that many studies now indicate a small but raised risk of violent offending by the mentally ill.

In view of the result above that non-clinical factors are more important correlates of crime, it might be reasonable to surmise that treatment programmes that only seek to influence clinical variables, for example reducing symptom severity and bed use by improving medication compliance, will not necessarily reduce re-offending.

Concluding Remarks

Does the research on CTOs answer the question of whether s32 is effective at reducing recidivism and improving clinical outcomes? The largest research studies published on CTOs seem to indicate that they do not have the desired effect of producing less restrictive treatment alternatives to in-patient admissions. There is one large study from WA that demonstrated a significant positive effect of CTOs on reduction in reoffending. The only study so far conducted on s32 by Douglas and colleagues showed s32 orders had a positive effect on clinical and socio-vocational variables and at the very least did not make offenders more likely to re-offend. With further follow-up the results from Tamworth may demonstrate a positive effect on recidivism. For the present it would be safe to conclude that s32 orders do some good and certainly have been demonstrated to do no harm, in that they do not increase re-offending.

Section 32 orders are an example of the law acting as a 'therapeutic agent' by diverting mentally ill offenders into appropriate treatment facilities. But like any other therapeutic intervention, s32 orders must be used on the basis of good evidence, preferably in the form of 'gold standard' evidence from meta-analyses of randomised controlled trials conducted with large numbers of subjects. The difficulties of obtaining such evidence may mean that other types of studies, such as case-control and comparisons with international best practice may be the only practical way to proceed.

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