

OFFENDERS WITH A MENTAL IMPAIRMENT UNDER A 'FUSION LAW': NON-DISCRIMINATION, TREATMENT, PUBLIC PROTECTION

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ABSTRACT

A common criticism of a 'fusion law' - a generic law covering all instances where a person's ability to make a treatment decision is impaired, regardless of the cause, and furthermore which only allows non-consensual treatment if it is in the person's 'best interests' – is that it fails to deal adequately with the protection of the public. This paper examines the implications of a 'fusion law' where a person with an 'impairment or disturbance of mental functioning' has committed an offence or where the person has been found 'unfit to plead' or 'not guilty by reason of insanity'. It is argued that within the parameters of a fusion law, unfair discrimination towards those with a mental impairment placed on treatment orders by a court - as exists presently in nearly all jurisdictions - can be avoided while at the same time providing satisfactory public protection. This can be achieved through hospital treatment, voluntary or involuntary depending on the person's decision-making ability and best interests (or best interpretation of 'will and preferences'), and a form of supervision order in the community that is supportively structured, but includes special conditions to ensure compliance.

I. INTRODUCTION

The aim of this paper is to examine the implications of a 'fusion law'¹ for the management of offenders with an 'impairment or disturbance of mental functioning', regardless of its cause. As the fusion law, a generic law applicable to all patients in all medical specialties, is based on a 'decision-making capacity' model, most of the discussion would apply also to a separate 'capacity'-based 'mental health' law.²

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¹ Dawson J, Szmukler G. Fusion of mental health and incapacity legislation. *Br J Psychiatry*. 2006;188:504-509; Szmukler G, Daw R, Dawson J. A model law fusing incapacity and mental health legislation & outline of the Model Law. *Journal of Mental Health Law*. 2010;Special Issue Ed 20:11-24; 101-128; Szmukler G, Kelly B. Debate: We should replace conventional mental health law with capacity-based law. *Br J Psychiatry*. 2016;209:449-453.

² The meanings of 'capacity' (and the related concept of 'best interests') have been contested and are still developing. I have argued for a concept of capacity or decision-making ability based on an analysis of the terms, 'will' and 'preferences', used in the UN Convention on the Rights of Persons with Disabilities (UN CRPD), but not further defined therein. [Szmukler G. The UN Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities. *Int J Law Psychiatry* 2017;54:90-97]. According to this account, decision-making may be undermined when there is a disjunction between a person's 'will' – that is, their, by and large stable, deeply held beliefs, values, commitments or conception

The arguments for a fusion law are readily available elsewhere. In essence, the fusion law aims to eliminate discrimination in the law against people with a diagnosis of a 'mental disorder' when it comes to non-consensual treatment. Under current legal arrangements, the autonomy or right to self-determination of those with a mental disorder is not accorded the same respect as it is for all other patients, when those with a mental disorder who retain the ability, or capacity, to make treatment decisions can nevertheless be treated involuntarily, while those with a physical disorder cannot. A second form of discrimination against persons with a mental disorder is their liability to preventive detention and treatment (albeit usually in a hospital) based solely on their purported risk of harm to others, and not, like the rest of the population, to their having committed an offence (or being strongly suspected of having done so). A fusion law, by applying the same justifications for involuntary treatment to all persons, regardless of medical specialty, eliminates these forms of discrimination.

A number of criticisms of the fusion law proposal have been raised, but the one probably generating most apprehension concerns the implications for the management of people with a mental disorder who present a significant risk of violence to others. Daw, for example, provides a good account of the prominence in the UK of public protection concerns during debates on reform of the Mental Health Act 1983 (MHA 1983) in response to proposals that some form of capacity-based criterion should be included in the justification for involuntary treatment.³ Inclusion of such a criterion was supported by the Richardson Expert Committee⁴ set up by the government to review the MHA 1983, by a number of stakeholders' (including the Royal College of Psychiatrists, the British Psychological Society, Mind) as well as in parliamentary recommendations from the Joint Scrutiny Committee, the House of Lords, and the Joint Committee on Human Rights.⁵

Governmental responses were strongly against this proposal. Rosie Winterton, Minister of State for Health Services stated: "every restriction was a patient not treated" and warned:

of the good – and a 'preference' – a wish, desire or intention expressed in the present. The greater the risk to the person's 'will' from acting on a 'preference' that contradicts that 'will' the stronger is the justification for an intervention. The object of the intervention is to support the person in giving effect to their 'will'. Such an intervention may, if all reasonable efforts at supported decision-making prove unsuccessful, lead to 'involuntary' treatment – in fact, supporting the 'will' (*voluntas*) rather against the 'will'. 'Best interests' in this sense is giving effect to the person's 'will'. The making of an advance directive is a good model – it asks that the 'will' of the maker should be respected if a situation should arise in the future where the person becomes unable to express that 'will' and instead may express a 'preference' inconsistent with that 'will'. The person asks that 'preference' not be respected. I will use the terms 'decision-making capacity' and 'best interests' in this paper but ask the reader to bear in mind how their interpretation may change. Alternative terms might be 'treatment decision-making ability' and 'will and preferences'.

³ Daw R. The Mental Health Act 2007: the defeat of an ideal. *J Mental Health Law*. Nov 2007;131-148.

⁴ Expert Committee (1999) Review of the Mental Health Act 1983, Dept of Health, Nov. 1999.

⁵ *Supra* Note 3

"... if it cannot be shown that a patient's judgment is impaired, they cannot be detained – regardless of how much the patient needs treatment and however much they, and others, are at risk without it."⁶

In the Government's response to the Joint Scrutiny Committee it stated:

"... In the Government's opinion, it is not safe to assume that there is a link between the severity of a condition – and therefore the need for treatment – and the person's ability to make decisions. It is possible that people who are at very great risk to themselves or others would nonetheless retain the ability to make unimpaired decisions about their treatment."⁷

An echo of the same concerns is repeated in the 2018 Final Report of the Independent Review of the Mental Health Act 1983.⁸ Despite suggesting that a fusion law is currently the most promising direction of travel for the future, a number of 'tests' are proposed that such a law would need to pass. One is a 'public interest' test:

"The final confidence test is whether fusion law can take proper account of what is in the public interest, particularly when it comes to the risk of harm to others. We have considerable reservations as to whether the concept of 'best interests' can work in this respect. We think at this stage that necessity and proportionality are likely to be more appropriate assessments."⁹

II. ANOTHER FORM OF DISCRIMINATION

The discrimination against people with a mental disorder noted above concerns the failure to accord to them the same respect for autonomy as is accorded all other categories of patient. I propose there is a second form of discrimination, one that is evident in the forensic domain. Offenders with a diagnosis of a mental disorder may be subject to deprivations and restrictions of liberty for periods far in excess of those imposed on 'normal' (or 'non-disordered') offenders who have committed a similar offence with a similar level of seriousness.

In England and Wales, for example, under the Mental Health Act an offender with a mental disorder, following conviction, may be placed by the court on a hospital order (s.37) that, with renewals, is potentially indeterminate (though subject to appeal to a Mental Health Tribunal after 6 months, and once per year thereafter). In cases where it is deemed to be necessary for the protection of the public from serious harm, the hospital order may have a *restriction* order attached (s.37/41). This requires an authorisation by the Ministry of Justice for absolute discharge from hospital, which occurs rarely, or for a conditional

⁶ Rt. Hon Rosie Winterton MP Local Government Association Conference, Mental Health Bill, 1 March 2007.

⁷ Government response to the report of the Joint Committee on the draft Mental Health Bill 2004. Presented to Parliament by the Secretary of State for Health, July 2005.

⁸ Modernising the Mental Health Act. Final report of the Independent Review of the Mental Health Act 1983. GOV.UK, 2018

⁹ Ibid, page 227.

discharge to the community where the person is liable to recall if the person is thought again to pose a risk to themselves or others as a result of their mental disorder. An absolute discharge from conditional discharge again requires Ministry of Justice authorisation. Alternatively, discharge may occur via a Mental Health Tribunal. Again such a discharge is nearly always conditional; a later appeal may result in an absolute discharge.

III. VIOLENCE AND MENTAL DISORDER

Behind the concerns about whether a fusion law would fall short in protecting the public lies a stereotype that people with a mental disorder are intrinsically dangerous, especially those with a psychosis and thus apparently wildly irrational. This is presumably why mental health laws in the vast majority of jurisdictions couple the risk to others with the risk to the person themselves in the risk criterion supporting involuntary detention.

To what extent is that stereotype justified? Population studies show that people with a severe mental illness – a psychotic illness or an affective disorder, in the absence of drug or alcohol abuse or an antisocial personality disorder – are modestly, if at all, more likely to be violent than the rest of the population.¹⁰ Drugs or alcohol are especially associated with violent offences, whether with or without a mental illness. A meta-analysis of studies examining violence in schizophrenia found that those with this diagnosis were no more likely to commit a violent offence when abusing substances than those without a mental disorder who abused substances.¹¹

In England and Wales in 2004 1.6% of serious violent offences were perpetrated by persons known to have had contact with mental health services within the previous 12 months and who had a diagnosis of schizophrenia (or other delusional disorder) or an affective disorder. Eighty-five percent of those in this category, with schizophrenia, had also misused or were dependent on drugs or alcohol at the time.¹² The frequency of persons with such a mental illness among those who carried out a homicide was found to be higher, 3.5%. In 54% of these, drug or alcohol misuse was also present.

¹⁰ The risk of violence for those with a mental illness, in the absence of drug or alcohol misuse or antisocial personality, is only modestly, if at all higher than for the rest of the population. [Coid J, et al. Violence and psychiatric morbidity in a national household population--a report from the British Household Survey. *Am J Epidemiology*. 2006;164:1199-1208; Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives Gen Psychiat*. 2009;66:152-161; Fazel S, Lichtenstein P, Grann, et al. Bipolar disorder and violent crime: New evidence from population-based longitudinal studies and systematic review. *JAMA Psychiatry* 2010;67:931-938].

¹¹ Fazel S, Gulati G, Linsell L, et al. Schizophrenia and violence: systematic review and meta-analysis. *Plos Medicine*. 2009; <https://doi.org/10.1371/journal.pmed.1000120>

¹² Flynn S, Rodway C, Appleby L, Shaw J. Serious violence by people with mental illness: national clinical survey. *J Interpersonal Violence* 2014;29:1438-1458

A report on mental illness and homicide in England covering 2005 to 2015 found 6% of perpetrators (an average of 32 per year) had a diagnosis of schizophrenia. Of these, 61% were known to mental health services, while 88% also had a history of alcohol or drug misuse. Thirty-six percent with this diagnosis had an abnormal mental state at the time of the offence; 34% were convicted of murder; and 41% received a custodial sentence.¹³

A rarely cited Home Office Statistical Bulletin in 2006 reported on the experiences of victims of violent crime who were interviewed as part of the British Crime Survey. Three years, between 2002 and 2005, were covered. Victims who had experienced a violent incident were asked why they thought the incident happened. 'The offender was suffering from a mental illness' was given as the reason in 1%, 2% and 1%, of all violent incidents, per respective year.¹⁴

These data indicate that fears of violence caused by people with a severe mental illness are grossly unrealistic and are underlined by a seductive prejudicial stereotype of dangerousness.

IV. FORENSIC IMPLICATIONS OF A FUSION LAW - PRINCIPLES

Central to a fusion law is the principle that involuntary detention or treatment is only justified when a person with an impairment or disturbance in the functioning of mind lacks treatment decision-making capacity *and* the intervention is in the person's best interests.¹⁵ I am using the terms 'impairment or disturbance in the functioning of mind' and not 'mental disorder' to make it

¹³ National Confidential Inquiry into Suicide and Homicide. Annual Report 2017. <https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-homicide-annual-report-2017/>

¹⁴ Coleman K, Hird C, Povey D. Violent crime overview, Homicide and Gun Crime 2004/2005. 2nd Edition (Supplementary Volume to Crime in England and Wales 2004/2005), Home Office Statistical Bulletin 2006

¹⁵ An assessment of the 'best interests' of a person does not mean that the well-being of third parties is necessarily excluded. For example, if violence against another person is threatened by a person who is currently mentally ill and lacking decision-making capacity, this might be inconsistent with the best interests of the ill person. An example would be where the ill person, when well, deeply values their relationship with the threatened person (for example, a close relative or friend). Causing serious physical or psychological harm would be contrary to the ill person's normal commitments to the victim. Following recovery, such harms are likely to be regretted by the ill person and seen by that person as having been caused when not 'really being himself or herself', or as being opposed to the person's deeply held values. Acting to prevent a risk of violence to unspecified persons, if inconsistent with the person's deeply held beliefs and values, such as the unacceptability of violence, would again be in the subjective 'best interests' of the person. (A consistency of values, on the other hand, would in these terms suggest antisocial behaviour without an impairment of decision-making capacity). Another example would be a person admitted to hospital involuntarily for treatment in their best interests who becomes violent to other patients. Proportionate measures taken to prevent such violence would be justified as cessation of treatment would not be in the person's best interests. In a similar vein, violent acts that are radically contrary to a person's deep beliefs, values or commitments are proposed by Tadros to best define an attribution of 'not guilty by reason of insanity' (Tadros V. *Criminal Responsibility* Oxford, Oxford University Press. 2005)

clear that in a fusion law the impairment is not restricted to those who have a diagnosis of a psychiatric or 'mental disorder'; it can result from any disease or disorder. As a shorthand I will use the term 'impairment of mind'. The interpretations of decision-making capacity and best interests are evolving, with a growing regard, at least in some jurisdictions, being given to a respect for the person's beliefs and values (or 'will and preferences'). Details will not be discussed here; they are readily available elsewhere.¹⁶ The essential principle I am advocating is that a hospital order made by a court should not authorise involuntary treatment if an offender retains decision-making capacity. Voluntary treatment would be the only option for such a person.

A second principle follows from the need to eliminate discrimination against offenders with an impairment of mind when compared to non-disordered offenders convicted of a similar offence with a similar level of seriousness (based, for example, on the degrees of harm and culpability). The management of those with a mental impairment should be, as far as possible, on an equal basis with other offenders. Most importantly, the total duration of a deprivation of liberty (in hospital or prison) or a restriction of liberty (following discharge to the community) imposed by a sentence or court order for an offender with an impairment of mind should be no longer than that imposed on a non-disordered offender. Depending on the response to treatment, where provided, it may indeed be shorter.

Northern Ireland is the first country to pass a form of fusion law (Mental Capacity Act, 2016).¹⁷ It accords with the first principle cited above in that involuntary treatment is restricted to offenders who lack decision-making capacity and it must be in the person's best interests. The second principle, however, is not fully recognised. An offender (or person found 'unfit to plead' or 'not guilty by reason of insanity') may be detained in a hospital or care home against their capacitous wishes, even though they cannot be treated if they have decision-making capacity and refuse the treatment. Detention may occur for an indeterminate period. For example, under a *Public Protection Order* (PPO) (s. 168) the person can be detained in an 'appropriate establishment' (a hospital or care home) if they have committed an imprisonable offence (other than those for which the sentence is fixed by law, i.e. murder) and if: they have an impairment of, or a disturbance in, the functioning of the mind or brain; appropriate care and treatment is available; releasing the person would create a risk, linked to the impairment of mind, of serious physical or psychological harm to others; and, depriving the person of their liberty is proportionate to the likelihood and seriousness of the risk. A 'restriction condition' may also be imposed with the PPO if the court is satisfied, having regard to all of the

¹⁶ Szmukler G. The UN Convention on the Rights of Persons with Disabilities: 'Rights, will and preferences' in relation to mental health disabilities. *Int J Law Psychiatry* 2017;54:90-97; Szmukler G. "Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities. *World Psychiatry* 2019;18:34-41

¹⁷ Mental Capacity Act (Northern Ireland) 2016
<http://www.legislation.gov.uk/niu/2016/18/contents/enacted>

circumstances, and particularly the nature of the offence, the history of the offender and the risk of physical or psychological harm to the public, that restrictions are necessary for the protection of the public from serious physical or psychological harm. A PPO is of indeterminate duration; a restriction condition may be for a specified or unlimited period (until terminated when considered no longer necessary by the Department of Justice).¹⁸

There are three countries that limit the length of a hospital order to no longer than a prison sentence for a similar offence – Italy, Croatia and Portugal, though in the case of the first, a conditional discharge may continue long beyond the custodial phase, and in the case of the last, the order may be extended by 2 years on multiple occasions. However, decision-making capacity is not a pre-requisite for involuntary treatment in any of those jurisdictions.

What would be the implications for forensic practice if both anti-discrimination principles – first, equal respect for the autonomy of persons with a mental disorder compared to other patients, and second, management of offenders with a mental disorder on an equal basis with non-disordered offenders – were to be implemented?

I shall restrict the discussion mainly to people who have committed a serious offence (or if not convicted because of a 'mental condition' defence, have nevertheless done an act or omission that would normally constitute a serious offence). Of greatest concern are serious violent or sexual offences.

I shall first consider offenders with an impairment of mind who lack decision-making capacity and those who retain decision-making capacity. I will then consider persons who are judged to be 'unfit to plead' (or to stand trial) and those judged 'not guilty by reason of insanity'; in most jurisdictions imprisonment is ruled out in these situations since the person has not received a conviction.

A further option that should be available for the court in all cases involving a person with a mental impairment is diversion to mental health services, under a civil involuntary treatment order. In such cases, the patient would fall outside the criminal justice system, with treatment and discharge decisions resting entirely with the clinician (or a civil mental health tribunal). This would be an option under a fusion law, but the criteria for an involuntary treatment order would now be based on decision-making capacity and best interests. Where a serious offence has been committed, however, the court is unlikely to adopt such a civil law disposal.

¹⁸ Campbell P, Rix K. Fusion legislation and forensic psychiatry: the criminal justice provisions of the Mental Capacity Act (Northern Ireland) 2016. *Br J Psychiatry Advances* 2018;24:195-203.

V. OFFENDERS WITH AN IMPAIRMENT OF MIND WHO LACK DECISION-MAKING CAPACITY

Consider the case where a court has found the person guilty of the offence. It accepts further the evidence that the offender has an impairment or disturbance in the functioning of mind, that he or she lacks treatment decision-making capacity, and that treatment would be in the person's best interests. Under a fusion law the person would thus meet the criteria for *involuntary treatment*. Transfer to a psychiatric hospital would thus be appropriate.

However, I suggest that a number of other conditions should also apply to such a disposition. An order by the court could not impose a deprivation of liberty (or post-release restriction of liberty) that would last longer than that imposed by a sentence on a non-disordered offender convicted of a similar offence with a similar level of seriousness. An indeterminate hospital order would not be possible (unless, of course, the usual sentence was life imprisonment).

Furthermore, if or when the person on an involuntary hospital order recovers decision-making capacity with an adequate degree of stability following treatment, the person would now be able to choose to continue with, or reject, further treatment. Continuing with treatment in hospital – if this were recommended by the clinician – would be as a *voluntary* patient. Treatment on this basis could be terminated by the patient at any time as long as they had decision-making capacity. If the patient, now with decision-making capacity, were to refuse treatment on a voluntary basis, there would be two management options. The first would be transfer to *prison* (this person having been convicted of the offence) until release was determined to be appropriate. The second would be *discharge* directly to the community under a form of *supervision order*. The decision to discharge the person to the community, whether from hospital or prison, would fall to a parole board (or other form of review board) that would have the necessary expert psychiatric membership. The aim would be, wherever possible, for the total duration of incarceration to be no longer than the usual custodial part of the sentence imposed on the non-disordered offender.

What if the offender were to remain ill and still meet the criteria – decision-making incapacity and best interests – for involuntary hospitalisation (or for a community treatment order) at the end of the court order related to their offence? At this point, the person would be managed under a *civil* order, and would now be outside the criminal justice system.

Thus the total duration of the court order related to the offence - including the hospital, custodial and community supervision components - would be no longer than that imposed by the usual sentence on the non-disordered offender for a similar offence. For the person with a mental impairment who might make a rapid recovery in hospital, the deprivation of liberty element (in hospital or prison) might be substantially less than the usual custodial element in the case of the normal offender. The duration of the supervision order might also be

shorter. The parole board or tribunal would decide, having taken into account the risk of further violence.

The nature of the *supervision order* that would apply following the person's release from confinement under this proposed regime needs particular attention if it is to satisfy concerns about public protection. It must have adequate 'teeth'. I propose that the supervision order will mandate *regular reviews* (probably with a social worker or probation officer with special expertise in mental health matters) and mandate a *mental health assessment* from an expert if the reviewing officer detects signs of relapse or indicators of a significant risk of reoffending. Other conditions may be imposed as occurs for non-disordered offenders on parole (e.g. prohibiting the individual from attending at a specified place; a restraining order where the necessary criteria are met). Supervision, however, should involve more than monitoring; it should be constructive, offering support, and help for engaging in health care, rehabilitation, education, training or employment programmes. Where appropriate, assistance could be offered with access to specialised supported accommodation (particularly helpful for some offenders with intellectual disabilities). Involuntary treatment would not be possible unless the person were to relapse, and again lose decision-making capacity, and treatment would be in their best interests. Otherwise treatment could only occur on a voluntary basis.

A *breach of the conditions* of the supervision order in the absence of reasonable mitigation could result in recall to the court. If the person retains decision-making capacity and refuses voluntary treatment, the court could impose a range of penalties, including a curfew, with or without an electronic tag, and up to a custodial disposal. The processes would be similar to those for a breach of parole conditions or could mirror existing penalties for breaches of protective orders, as exist, for example, with regard to breach of a restraining order under the Protection from Harassment Act 1997 or a Sexual Harm Prevention Order under the Sexual Offences Act 2003. A supervision order could not extend in the context considered here beyond the period stipulated in the court order made at sentencing (or longer than the sentence for a comparator non-disordered offender).

It would be necessary that the offender have the capacity to understand the terms of the supervision order for it to be an option. The proposal has much in common with the Law Commission's proposed supervision orders for those found 'unfit to plead' and supported by Justice in its report 'Mental health and fair trial'.¹⁹

¹⁹ Law Commission. Unfitness to Plead. Volume 1: Report. 2016 Law Com No 364. <http://www.lawcom.gov.uk>; Mental health and fair trial: A report by JUSTICE. 2017. www.justice.org.uk

What if the offender were assessed by the court to present a serious risk to others that would be likely to outlast the usual term of a sentence for the offence? A restriction order of indeterminate duration specifically for offenders with a mental disorder would be discriminatory and thus no longer available. However, a non-discriminatory solution exists. In England, for example, '*extended sentences*' are available for non-disordered offenders who are assessed as presenting a risk to others that is likely to persist beyond the term of a usual sentence. Depending on the nature of the index offence and specified previous offences as set out in a schedule to the Criminal Justice Act 2003, the extension may be for up to 5 years or 8 years depending on the index offence. A *discretionary life sentence* may also be imposed by the court where the offender is assessed as dangerous and the offence itself justifies a life sentence, or where the defendant is convicted of a serious specified offence and has a previous conviction for such an offence. An extended court order could be imposed on an offender with an impairment of mind based on the same criteria. This form of preventive detention is established at the sentencing stage. Attention would need to be given to the possible intrusion here of a form of *indirect discrimination*. Persons with a mental illness may be more likely judged to pose an ongoing risk, simply because they have such an illness. Evidence would thus be required concerning the precise nature of the risk, its relationship to the mental illness, how exactly the risk might unfold and how the sentence is proportionate to the risk.

VI. OFFENDERS WITH AN IMPAIRMENT OF MIND WHO RETAIN DECISION-MAKING CAPACITY

What if the court has found the person guilty of the offence, it accepts the evidence that the offender has an impairment or disturbance in the functioning of mind but finds that he or she *retains* treatment decision-making capacity? Under a fusion law the person would not meet the criteria for involuntary treatment. Transfer to a psychiatric hospital would then only be possible if the offender accepted treatment on a *voluntary* basis. If such treatment were refused, or having commenced the patient decided no longer to continue, then the person would go to prison. If there is a treatment that would benefit the person, the option of treatment should be retained so that the person could be transferred to a hospital as a voluntary patient if they were to change their mind.

Discharge from voluntary hospitalisation to the community or release from prison to the community would be with the authorisation of the parole or review board as for offenders who have a period of involuntary treatment in hospital. *Supervision orders* would involve the same range of conditions as described above. Again, the total duration of the deprivation of liberty (in custody or hospital or both) plus restriction of liberty in the community (on a supervision order) must be no longer than the sentence incurred by a non-disordered offender who has committed a similar offence with a similar degree of seriousness. *Extended sentences* would be available as described above.

Engagement in treatment on a voluntary basis may increase the likelihood of an earlier release or discharge into the community. If this were being cynically used by an offender with the aim of obtaining earlier release from detention, one hopes that this would become evident in the way the person engages, or fails to engage, in the treatment. In any case the person would still be under a supervision order in the community for the remainder of the sentence and be required to have a mental health assessment if there were indications of increasing risk.

VII. THE 'MENTAL CONDITION' OR 'SPECIAL' DEFENCES

A. The problem

Persons judged to be 'unfit to plead' (or unfit to stand trial) or 'not guilty by reason of insanity' (or another form of insanity defence) may present special problems in respect of their disposal by the court. As culpability is absent in the case of the person not guilty by reason of insanity, or not able to be fully established in the case of unfitness to plead, a conviction is excluded, and a custodial sentence is ruled out. Currently, the usual disposal when the options of a discharge or supervision order are regarded as inadequate is a hospital order that may be of indeterminate duration. The purpose of the hospital order is to provide treatment, but equally, though arguably less explicitly, to protect the public. The two elements are somewhat obscured in the hospital order. Whether the person has or does not have treatment decision-making capacity at the time of the court hearing is immaterial as to whether a hospital order can be made.

Under a fusion law, involuntary treatment would only be possible for a person with a mental impairment if the decision-making capacity and best interests criteria were met. While this would be the case in many - perhaps the majority of cases - where a mental condition defence were accepted, it is likely there will be cases where the person has decision-making capacity at the time of the hearing and would thus not be eligible for an involuntary treatment order. For example, sufficient time may have elapsed between the act or omission and the court hearing for a defendant judged not guilty by reason of insanity to have regained decision-making capacity, perhaps following treatment during the period on remand. Or in the case of unfitness to plead, the criteria for unfitness may not map well on to those determining an impaired decision-making capacity for treatment. Colleagues suggest that such cases are likely to be rare; there is a commonly held view that the threshold for unfitness to plead is higher than the civil threshold for decision-making incapacity

Thus, where the defendant is judged to be unfit to plead or not guilty by reason of insanity and i. has been found to have done the act or omission, and ii. he or she lacks decision-making capacity and treatment for a mental impairment is in the person's best interests, an involuntary treatment order would be justified under a fusion law. Such treatment would need to be continued on a voluntary basis following a recovery of decision-making capacity, or if refused,

treatment would end. But what would be the options available to the court when the defendant is judged to be unfit to plead or not guilty by reason of insanity, *has* decision-making capacity but *rejects* the offer of treatment, yet is assessed as presenting a substantial *risk* to others? Or what if on a stable recovery of decision-making capacity, when involuntary treatment must cease, the person subject to such an order rejects further treatment on a voluntary basis yet is assessed as presenting a continuing substantial risk to others?

If there were some form of *generic dangerousness legislation* that allowed the preventive detention of any person - irrespective of whether they had a 'mental disorder' or not - assessed by a court as presenting an unacceptable risk to others, even if not convicted of an offence, the problem could be solved. (As would the discrimination against persons with a mental disorder who are singularly liable under current mental health laws to be detained if deemed to present a risk to others, even if they have not committed an offence). Such legislation is unlikely to be adopted. It would also probably be in breach of the European Convention on Human Rights.

Another argument might be founded on the *exceptional position* of those judged to be unfit to plead or not guilty by reason of insanity. Despite having perhaps done an act of great seriousness, such as a homicide, they are not held culpable, and thus cannot be detained even if assessed as presenting a substantial risk to others (unless, for a period at least, they meet the criteria for involuntary treatment). One could claim that this exceptional group of persons merits exceptional measures. In the absence of any acceptable alternative, it could be argued that they might be detained on a hospital order on the basis of the risk they are deemed to pose. Further conditions might be attached: that the risk to others is serious, there is a causal nexus with an impairment of mind, and that there is a treatment for the condition that will significantly reduce the likelihood of future violence. The question of a time limit on the order would need to be addressed.

Or one might *do away with* the 'mental condition' defences altogether. Zero culpability on the basis of a mental impairment, as in the case of a person deemed 'not guilty by reason of insanity', might be regarded as a fiction. After all, the vast majority of persons with a serious mental illness, especially in the absence of drug or alcohol misuse, do not commit serious acts of violence. If there always remained an element of culpability, even if low, a conviction would then be possible, especially if another element in determining the seriousness of an offence - the harm caused - were high. Detention in an appropriate establishment - not necessarily a prison but a place more supportive for a person with a mental impairment - would then be possible. Treatment would need to be on a voluntary basis for the person with decision-making capacity. The maximum duration of the detention would be commensurate with the sentence imposed on a non-disordered offender who has committed a similar offence of a similar degree of seriousness. The low culpability might be taken to mean that the major contribution to the level of seriousness would be the harm entailed in the index offence.

There are indeed a few jurisdictions where the insanity defence has been abolished. Sweden is a notable example. However, the court can sentence the offender with a 'severe mental disorder' to indefinite detention in a forensic facility and allow compulsory treatment. The deprivation of liberty of the person detained in a forensic unit may, as elsewhere, far exceed in its duration the sentence that would be imposed on a non-disordered offender for the same offence. There is at present a strong movement for reform; criticisms surround the way in which various interests are blurred: the need for treatment, principles of criminal responsibility and public protection.²⁰ A recent governmental committee has proposed the reintroduction of a criminal responsibility element with an acquittal if the person is found unaccountable. However, it is proposed that a form of declaratory judgment would be made, and this could entail a number of 'public protection measures', including incarceration, involuntary treatment, restraint orders, residency requirements, or prohibitions on drug or alcohol use. These measures would be reviewed six-monthly and with no fixed term overall. While the criminal responsibility element has received support, the 'protective measures' have been the subject of criticism. Proportionality is again an issue here: those with a mental impairment may suffer longer restrictions on their liberty than other offenders.

The abolition of the mental state defences is also claimed to be necessary for compliance with the UN Convention on the Rights of Persons with Disabilities (UN CRPD).²¹ Such defences are deemed to be discriminatory as they limit persons with disabilities' legal capacity on the basis of their having a disability. Instead it is claimed that support measures or special accommodations are required to make the normal procedures of law accessible to those with disabilities on an equal basis with others. It is further argued by the UN CRPD Committee that an impairment of 'mental capacity' is not a justification for an interference with legal capacity. Despite statements such as the following from the Office of the High Commissioner for Human Rights:²² '... disability-neutral doctrines on the subjective element of the crime should be applied, which take into consideration the situation of the individual defendant' - a detailed account of how accommodations to legal procedures would operate were these changes to be introduced has yet to be provided, certainly one that has attracted a reasonable degree of wider support.²³

²⁰ Gooding P, Bennet T. The Abolition of the Insanity Defence in Sweden and the United Nations Convention on the Rights of Persons with Disabilities: Human Rights Brinkmanship or Evidence It Won't Work? *New Criminal Law Rev* 2018;21:141-169

²¹ Committee on the Rights of Persons with Disabilities. Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities. Adopted during the Committee's 14th session, held in September 2015. <https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc>

²² Annual report of the High Commissioner for Human Rights to the General Assembly. A/HRC/10/49, presented 26 January 2009, para 48-9.

²³ Peay J. Mental incapacity and criminal liability: redrawing the fault lines? *Int J Law Psychiatry* 2015;40:25-35; Gooding P, O'Mahoney C. Laws on unfitness to stand trial and the UN Convention on the Rights of Persons with Disabilities: Comparing reform in England, Wales, Northern Ireland and Australia. *Int J Law, Crime and Justice* 2016;44:122-145

The fullest schema thus far is probably that suggested by Slobogin.²⁴ He proposes that the mental condition defences be dropped, and that culpability on conviction be determined by the court on the basis of the *subjective mental state* of the mentally ill defendant, in the same way as it is for other defendants. The degree of mitigation would depend, for example, on whether the person believed circumstances existed, that if true, would have justified the offending act, for example, by amounting to duress. However, he also supports a *preventive detention* measure, though strictly limited to persons who pose a significant risk of unjustifiable serious bodily harm to another, but who are presently, like those not guilty by reason of insanity, not subject to criminal jurisdiction. This would require proof, he proposes, that such a person: (a) believes such harm is not criminal (for some with serious mental illness or enemy combatants); or (b) is powerless to prevent the harm (as with 'automatists' or with contagious diseases) or (c) is willing to cause such harm even if punishment, death or serious bodily injury to the actor is highly likely (as with some terrorists). So far, the schema, if applied generically to all in a 'disability-neutral' fashion, might be seen as compliant with the CRPD. However, the third element in the schema, 'protective' of the person's *competence* to make decisions or autonomous choices, might be seen as not. Competence is to be determined by a 'basic rationality and basic self-regard' test. This would require the person to have a 'minimal' understanding of the risks and benefits of the choice to be made, an ability to give reasons not based on demonstrably erroneous facts, and an effort to consider these and other reasons for self-preservation. Peay²⁵ discusses the 'esoteric' questions that may arise in attempts to apply the 'subjective element' in a criminal act to people with a serious mental illness, such as one involving delusional ideas. For example, what is to be the definition of, or weight to be attached to, a perpetrator's 'reasonable' or 'honest' belief concerning the circumstances of an offending act if the act is based on an 'irrational' delusional belief?

However, a powerful argument against an abolition of the not guilty by reason of insanity verdict is the centuries-old moral principle in the law that a person who is not criminally responsible for an act should not be punished for it.

B. Management under a fusion law

Returning to, and accepting the conventional current situation where a verdict of not guilty by reason of insanity or unfit to plead is adopted, how would a fusion law, strictly observed, play out?

Let us first consider a *not guilty by reason of insanity* verdict. A trial has shown that the act or omission was done. A prison sentence is not possible as there is

²⁴ Slobogin C. Eliminating mental disability as a legal criterion in deprivation of liberty cases: the impact of the Convention on the Rights of Persons with Disability on the insanity defense, civil commitment, and competency law. *Int J Law Psychiatry* 2015;40:36-42.

²⁵ *Supra* Note 20

no conviction. The options would be: i. acquittal and discharge; ii. a supervision order; iii. treatment on a voluntary basis if the person has decision-making capacity; iv. involuntary treatment on a hospital order if the person lacks decision-making capacity and treatment is in his or her best interests. When decision-making capacity is regained, treatment could only be continued on a voluntary basis, otherwise the person would be discharged from hospital. Some options may be combined sequentially, for example, voluntary treatment and a supervision order.

As noted earlier for those with a mental impairment who have been convicted, the *supervision order* must have 'teeth'. Such an order would only be imposed where the person was assessed on the best available evidence as presenting a substantial risk of serious harm to others. Mandatory reviews would be required, as well as a mandatory mental health assessment if there were evidence of relapse of an illness that has been associated previously with serious harm to others. Other conditions could also be imposed as described earlier for supervision orders (e.g. a restraining order). Again, supervision should be constructive, offering support, and help for accessing suitable programmes, and where it might be helpful, specialised supported accommodation. Involuntary treatment would not be possible unless the person were to relapse, again associated with a loss of decision-making capacity and with the treatment being in the person's best interests. Otherwise treatment could only occur on a voluntary basis. A breach of the supervision order would be reported to the court and might, depending on the circumstances, constitute a separate *offence*. If so, punishment would include a possible custodial sentence. As noted above, a breach of a supervision order under the *Protection from Harassment Act 1997*, an order that can be made even if the person is not convicted, carries a range of penalties up to a custodial sentence of 5 years. The Law Commission examined the arguments concerning the moral case for and against creating a related offence for persons found not guilty of the index offence.²⁶ It concluded that where a person poses a significant risk of harm, having no sanction to ensure compliance with a supervision order would undermine public confidence in the court system. As stated earlier, the assessment of risk would need to be as transparent and objective as possible.

The total duration of an order could be no longer than the sentence passed on a non-disordered offender who had committed a similar offence, of a similar degree of seriousness. At the end of this period, if the criteria for involuntary treatment were still met, only a civil order could be imposed. As in the case of convicted mentally impaired persons, an *extended order* could be imposed by the court according to the same criteria as apply to non-disordered offenders. The only difference would be the absence of a conviction for the index act or omission, but commission of the act has nevertheless been established by trial. The history of prior offences (including acts or omissions where the person was found not guilty by reason of insanity) would parallel those of the non-

²⁶ Law Commission. Unfitness to Plead. Volume 1: Report. 2016 Law Com No 364. <http://www.lawcom.gov.uk>

disordered offender subject to an extended sentence. The key issue here is one of risk, not culpability.

In the case of a ruling that the person is '*unfit to plead*', the same options as for not guilty by reason of insanity would apply. The court, however, could stipulate a period within which a restoration of the capacity to stand trial would result in a full trial.

VIII. CONCLUSIONS

Concerns about the adequacy of measures to protect the public from offenders with a mental disorder have been frequently raised as an argument against the feasibility of a fusion law (and in key respects, of a 'capacity-based' mental health law). I have sketched out the possible implications of such law for forensic provisions. Two key forms of discrimination against persons with a mental impairment (including, but not restricted to, so-called 'mentally disordered' offenders) need to be avoided. The first is that arising from the treatment of persons with a mental illness when compared to all other patient groups; the second is that arising from the treatment of an offender with a mental impairment when compared with non-disordered offenders. Eliminating the first form requires that patients' autonomy is equally respected. Eliminating the second form of discrimination requires that the total period of a deprivation of liberty and restriction of liberty must not exceed in duration that entailed in the sentence imposed on a non-disordered offender convicted of a similar crime having a similar level of seriousness.

The management of convicted offenders with a mental impairment or disturbance in the functioning of mind would in some respects parallel that imposed on non-disordered offenders, especially in terms of comparable periods of deprivation and restriction of liberty. The differences would be in periods of inpatient treatment, voluntary or involuntary, and a form of post-discharge supervision which, despite resembling probation, would however have a stronger therapeutic and supportive emphasis. Extended sentences would be available on the same basis as for non-disordered offenders.

Some colleagues voice concerns about the unsuitability of a prison environment for people with a mental disorder, even if they have decision-making capacity yet refuse hospital treatment. This view should be taken seriously and presents a strong argument for making 'reasonable accommodations' in prison for people with disabilities, including mental health disabilities, especially as their numbers would likely increase with a concomitant decrease of those in secure hospitals.

The 'mental condition' defences, the insanity defence and unfitness to plead, present a special problem in terms of management. Imprisonment is ruled out since the person is not convicted. The difficulty arises when the person has done an act - and perhaps previous acts - that suggest the person poses a substantial risk to others. Under a fusion law, the conventional recourse to a hospital order would only be available if the person lacked decision-making

capacity and treatment was in their best interests. For the person with decision-making capacity, treatment if considered appropriate, could only occur on a voluntary basis.

One possible solution to the problem posed by a person who presents a serious risk, retains decision-making capacity, and refuses treatment is to see the position of such a person - in a kind of 'no-man's land' between the criminal justice system and the healthcare system - as exceptional. One might then argue that a hospital treatment order might be made even if capacity is preserved. The avoidance of discrimination would require at least that the maximum term of such an order should be no longer than the sentence normally imposed for a similar offence with a similar level of seriousness. However, satisfactory public protection may be achieved in a non-discriminatory manner within the parameters of a fusion law by making use of hospital treatment, voluntary or involuntary depending on the person's decision-making capacity, and a form of supervision order in the community that is supportively structured, but includes conditions to ensure compliance.