



Criminal justice for the individual facing mental illness

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Abstract

A mental illness is a behavioural or mental pattern that causes significant distress or impairment of personal functioning. It is also called a mental or psychiatric disorder. These features may be persistent and remitting. There are many conflicts regarding the appropriateness of treatment and punishment for mentally ill persons who commit crimes. In general, population concern for public safety and usually finds it hard to accept that a mentally ill person who commits a crime can be hospitalized and discharged eventually, sometimes after a short time interval. In most countries the options of hospitalization are available in concert. In some, incarceration takes place before hospitalization. In some, hospitalization is first, which is followed by a prison term. Another option is "treatment years." The court would find out the number of years required for treatment, according to the crime. This dilemma has no common solution. The main aim is to maintain the balance between the rights of a patient to treatment and also the responsibility of the court to ensure the safety of public.

Keywords: mental illness, treatment years, criminal justice

Introduction

A mental illness is a behavioural or mental pattern that causes significant distress or impairment of personal functioning. It is also called a mental or psychiatric disorder. These features may be persistent, relapsing and remitting. Courts have the power in certain circumstances, to exempt an individual from criminal responsibility for actions performed while he or she was incapacitated by a mental disorder. That power rests on "the basic principle of criminal law that to be convicted of a crime, the state must prove not only a wrongful act, but also a guilty mind." Criminal Code has always provided that persons will not be held criminally liable for their actions if their mental state at the time rendered them "incapable of appreciating" the nature and quality of the act and knowing that it was wrong. In such a case, it becomes necessary for the state to exercise some level of control over those mentally disordered individuals who are believed to pose a threat to others. Thus, Parliament faces the challenge of achieving a balance between individual rights and public safety.

Laws and Policies

Three quarters of countries around the world have mental health legislation. Compulsory admission to mental health facilities is a topic of controversy. It carries the risk of abuse for socio-political and other reasons; yet it can potentially prevent harm to self and others, and assist some people in attaining their right to healthcare when they become unable to decide in their own interests.

All human rights containing mental health laws require proof of the presence of a mental disorder, but the type and severity of disorder that counts can vary in different jurisdictions. The two most commonly utilized grounds for involuntary admission are said to be serious likelihood of immediate or imminent danger to self or others, and the need for treatment.

Applications for someone to be involuntarily admitted generally come from a mental health practitioner. Human-rights-oriented laws may stipulate that independent medical practitioners or other accredited mental health practitioners must examine the patient separately and there should be regular, time-bound review by an independent review body. The individual should also have personal access to independent advocacy.

In order for involuntary treatment to be administered, it is shown that an individual lacks the mental capacity to understand treatment information and its implications, and thus become able to make an informed choice to either acceptance or refusal. Legal challenges have resulted in Supreme Court decisions that a person does not have to agree with a psychiatrist's characterization of the issues of "illness", nor agree with a psychiatrist's conviction in medication, but only recognize the issues and the information about treatment options.

Proxy consent or substituted decision-making are transferred to a personal representative, a family member or a guardian who is legally appointed. These patients may be able to make, when they are considered well, an advance directive stipulating how they wish to be treated should they be deemed to lack mental capacity in future. The right to supported decision-making, where a person is helped to understand and choose treatment options before they may be declared to lack capacity, may be included in legislation. There should be very least shared decision-making. Involuntary treatment laws are increasingly extended to those living in the community.

The World Health Organization reports that national mental health legislation takes away the rights of persons with mental disorders instead of protecting rights. In 1991, the UN adopted the Principles for the Protection of Persons with Mental Illness

and the Improvement of Mental Health Care, which established minimum human rights standards of practice in the mental health field. In 2006, the UN formally agreed the Convention on the Rights of Persons with Disabilities to protect and enhance the rights and opportunities of disabled people, along with those who possess psychosocial disabilities.

The term insanity is used as a synonym for mental illness, is often used technically as a legal term. The insanity defence may be used in a legal trial which is known as the mental disorder defence.

System in different countries for Mentally Ill Persons: The responsibility for forensic services is different in all countries. It is handled by the Justice Department in Greece, Italy, and Portugal, and is handled by the Health Department in England and Germany, or there may be joint responsibility for forensic services in Belgium. In all countries, there is a consensus that the law relates to mentally ill individuals who have psychotic disorders.

There are some countries that have a dichotomous view of criminal responsibility, e.g. Austria and Israel. However, most of the countries have a graduated view that leads to partial responsibility and reduced punishment or treatment.

Even if, the will of the accused and legal representation are contrary, the suspect has the right to an attorney. The courts are very careful for the prospect of the mentally ill representing themselves. In most countries, the cost of the attorney is covered by the department of justice, and there is no need of physical presence of the accused, though he must appear in court for the verdict.

In the case of incompetence to stand trial, most of the countries would suspend the trial. If the accused was ill when the crime was committed and is currently ill, then in all countries, the patient would be sent to the hospital for treatment. The danger to public safety and illness-related threats become important when the patient was ill when the crime was committed, but is not currently ill.

Treatment and Punishment

There are many mentally ill persons in the crime raises the question of whether indeed it is a desirable situation. Today, there is more focus on the examination of the relationship between the crime and psychotic content. Automatic exemption from responsibility for a criminal, who has a chronic psychiatric illness such as schizophrenia, is no longer.

This approach does not mean that more patients will find themselves behind bars. In many countries, the options of incarceration and hospitalization are available in concert for mentally ill persons. In some countries, incarceration takes place before hospitalization. In others, hospitalization is first, followed by a prison term. This attitude describes a treatment or punishment ruling that integrates both concerns and contributes to public safety.

In the United States, the concept of guilty, but mentally ill gained the momentum. Many states added this option to the insanity defence and did not prohibit it. This verdict leads to a double stigma, and more prison time, because it indicates that the individual committed the crime, was aware of the act done by him, but had a mental disorder that interfered with compliance with the law. This course was intended to be

intermediary, but it did not reduce the number of rulings of not guilty by reason of insanity. A more severe course of punishment was created—one with no limitation on punishment, including the death penalty also. The main focus is on punishment and public safety is taken into account and not psychiatric treatment in prison. Guilty but mentally ill is not a defence; it is a court ruling that the individual is guilty and a candidate for punishment. The discussion focuses on the duration of hospitalization. The common denominator between the treatment model and the punitive model is the concern for public safety and to prevent from repeated endangerment. Repeat evaluations during hospitalization are necessary. The issue may be taken to the Supreme Court, though from a different perspective. It is the case in which the patient was hospitalized by court order for many years because his mental state did not improve, but the period of hospitalization was based on a non-serious crime e.g. theft of a bicycle, watch etc. The Honourable Judge ruled that the duration of hospitalization should not be longer than a prison sentence would have been for the identical crime. In such case, patient's condition would require additional treatment; he would be transferred to the civilian course of treatment. In this case, it seems that the intentions of the Court concerned allocation of responsibility, since the rules are meant for maximum, not the minimum, duration of treatment. From so many years, the pendulum has swung between punishment and treatment, between complete exemption from responsibility and limiting the insanity defence. For example, the insanity defence is partially abolished in Montana, Utah, Idaho, Kansas, and Nevada (US states); however, testimony regarding mental state is still permitted.

Combination of the Treatment and Punishment

It is needed to concern how treatment versus punishment can be settled—the right of the mentally ill patient to be treated versus the right of the public to be protected? Medically, there is a space for the narrow approach when it is clear that the crime is directly related to illness. Discharge should be determined by a legal committee or by the courts. According to the Mental Health Act, the patient under court order is discharged by the physician, unless there is a restriction order, which can be declared by the Court for a patient who has committed a serious crime. The Psychiatric Committee then handles the discharge, not the treating physician.

There may be some situation in which a person who is no longer psychotic would have to remain in the hospital because the legal committee did not release him. Now, the question arises regarding whether the hospital is the proper place for that person and whether public safety is the only question. The conflict arises- how to treat a patient who committed a crime and was found not responsible for his actions after his recovery from the psychotic state, to prevent mental relapse with danger to the public. In many countries, there is no such legal act for prevention, a subject that may need legislation. If the individual is no longer ill, but is still dangerous, should he remain in the hospital or be transferred to a nonmedical incarceration facility? The opinions are divided, although many believe hospitalization is most appropriate, since the core of the problem is the illness.

There is an option for compulsory conditional discharge and

ambulatory care following every court-ordered hospitalization. It allows closer follow-up and enables the rehospitalisation in the event of disturbed mental state that creates a risk based on prior proven dangerousness. Discharge and transfer to the community should be gradual. After a long hospitalization in a closed ward, the patient needs to be assisted and close supervision for some period. The aim is to assist the patient when necessary and to protect the public. In Germany and The Netherlands, discharge from hospital is always conditional, and hence appropriate community outpatient facilities are required that is not available in all countries.

Another option could be "treatment years." The court would compute the number of years of treatment required, according to the severity of the crime and the risk to public safety. The treatment setting would be determined by medical professionals in accordance with the decision of a psychiatric committee, under court supervision when necessary, with the option to appeal. When in a psychotic state, the patient would be hospitalized but would later become the candidate for a rehabilitation program, as his condition started improving. He would then be eligible to transfer to ambulatory care, with the approval of the psychiatric committee. Ambulatory care would be compulsory after discharge, and the frequent visits and treatment would be fixed by the physician. Follow-up visits would be required at least monthly for major crimes. Along with the regular medical follow-up, legislation is necessary to enable supervision by a parole officer who would be responsible for enforcing compulsory ambulatory treatment. If the patient's condition were to deteriorate, he would be readmitted on the basis of original treatment year's order, until stabilized. This is the low cost solution, considering that it makes use of existing treatment facilities, along with parole officer who would have the authority to enlist the help of the police to enforce compulsory treatment whenever necessary. Guaranteed ongoing treatment is economical and could help avoid exacerbation of the patient's condition and hence reduce the risk of recidivism.

Pros of Treatment

1. Reduces recidivism rates: Because mental health court is designed to target the needs of offenders, individuals will get much more help and assistance while in the program compared to being incarcerated. If an offender can find housing, employment, and get financial assistance then they are less likely to return to a life of crime.
2. Improves the lives of offenders: Treatment is typically mandatory for mental health court. Offenders participating in counselling and getting the required help will improve their lives.
3. Reduces incarceration costs: One of the main reasons mental health court was created was to cut costs. Sending an offender to prison costs taxpayers tens of thousands of dollars per year. Keeping offenders out of prison and in community-based programs drastically cuts costs.

Cons of Treatment

While mental health court has many beneficial aspects to it, there are some drawbacks and even ethical issues.

1. Mandatory treatment/medication: Treatment and/or

medication are typically mandated by mental health court. Many people feel that it is unethical to force a person into being on medication. It is explained to the offender though that if they do not comply with the conditions of mental health court then they will be incarcerated. It almost leaves the offender with no choice.

2. Waiting lists: With the increase in mental health disorders and substance abuse issues, treatment centres are overcrowded. There are waiting lists and it can sometimes take months for an offender to begin treatment. This causes an issue for the offender and the court system as well, since there is a mentally-ill offender left untreated for a significant amount of time.
3. Longer sentencing requirements: Since there are waiting lists and treatment standards, an offender may be in mental health court much longer than if they just went to jail. This keeps offenders in the system longer, which is never a good thing.

Eliminating Discriminatory Practices and Punishments:

Individuals with mental health conditions mostly face abuse and unfair treatment at every stage of involvement with the criminal justice systems. There are many circumstances where practices in the criminal justice systems can cause serious harm. The issues faced by mentally ill persons are particularly profound in terms of variations of the insanity defence and the use of the death penalty for those with serious mental illnesses. In order to ensure that the criminal justice system really aims justice, we must consider cases in the way in which legal practices disproportionately impact individuals with mental disorder at each stage in involvement.

Changes required in Criminal law

- People should work to appeal laws in those states which permit a sentence of life without parole and to eliminate sentences of life imprisonment for extremely lengthy sentence which fails to recognize that juvenile offenders differ from adults.
- States should provide a full insanity defence. When defendants' mental health prevents them from understanding the wrongfulness of the act and controlling their behaviour, they should be acquitted by reasons of insanity. Criminal liability in such cases is neither appropriate nor effective.
- Our current criminal justice system inadequately addresses the complexity of cases involving criminal defendants with mental illness. Thus, mental health law calls upon states to suspend using the death penalty in accurate, and systematic ways of determining guilt and considering a defendant's mental status are developed.

Conclusion

Mental disorder is the criteria for special treatment of offenders at every stage in the criminal process, from investigation to punishment. The confusion of either to treat or to punish has no particular solution. Both the cases have benefits and drawbacks as well. These alternatives contribute to the public security and peace of mind and to the patient's welfare. At the end, the patient must return to the community. The goal is to reach a balance between the rights of the patient

to treatment and the responsibility to ensure the safety of the public. The balance between the rights of a patient, the right to treatment, and public safety is considered with the “treatment years” approach.

References

1. Christodoulou G. Psychiatric reform revisited. *World Psychiatry*. 2009; 8:121-2.
2. Melamed Y, Ganot N, Mester R, *et al*: The civil liability for damages of the criminally insane. *Isr J Psychiatry Relat Sci*. 2008; 45:285-90.
3. Kalian M, Witztum E. The Israeli model of the “district psychiatrist—a fifty-year perspective. *Isr J Psychiatry Relat Sci*. 2006; 43:181-97.
4. Salize HJ, Dreissing H. Placement and treatment of mentally ill offenders: legislation and practice in EU member states. Final report, 2005- 2009, Available at http://ec.europa.eu/health/ph_information/implement/wp/mental/docs/ev_20050530_co04_en.pdf. Accessed.
5. Baillargeon J, Binswanger IA, Penn JV, *et al*. Psychiatric disorders and repeat incarcerations: the revolving prison door. *Am J Psychiatry*. 2009; 166:103-9.
6. Zemishlany Z, Melamed Y. The impossible dialogue between psychiatry and the judicial system: a language problem. *Isr J Psychiatry Relat Sci* 43:150–4; discussion, 2002, 155-8.
7. Toib JA. Civil commitment and the criminal insanity plea in Israeli law. *Int J Law Psychiatry*. 2008; 31:308-18.
8. Hathaway M. The moral significance of the insanity defence. *J Crim Law*. 2009; 72:310-17.
9. Hughes Rosallie, Hayward Mark, Finlay WML. Patients’ Perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health*. 2009; 18:152-160.
10. Katsakou Christina, Priebe Stefean. Patient’s experiences of involuntary hospital admission and treatment; A review of qualitative studies. *Epidemiologia e Psichiatria Sociale*. 2007; 16:172-178.