

**Interdepartmental Group to examine issues relating to  
people with mental illness who come in contact with the  
criminal justice system**

**First Interim Report**

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## Introduction

The Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the criminal justice system includes representatives of the Department of Justice and Equality, the Department of Health, the Health Service Executive, the National Forensic Mental Health Service, An Garda Síochána, the Office of the Director of Public Prosecutions and the Irish Prison Service.

The Interdepartmental Group originated from the Health/Justice Cross-Sectoral Team which was established in 2009 for the purpose of addressing issues arising from the interaction between the criminal justice system and mental health services.

The report of the Thornton Hall Project Review Group, published in 2011, recommended that an interdepartmental group be set up to examine the issue of people with mental illness coming into the criminal justice system. The Health/Justice Cross-Sectoral Team was charged by the then Ministers for Health and Justice and Equality with this task. Specific terms of reference for the Interdepartmental Group were agreed and published in March 2012. The terms of reference are set out in Appendix 1.

The Interdepartmental Group received submissions from a wide range of organisations and individuals. A list of organisations and individuals who made submissions is set out in Appendix 2.

Many submissions suggested the adoption of an “all stages” approach to diversion of people with mental illness from the criminal justice system. An “all stages” approach allows people with mental illness to be diverted into appropriate treatment and services at each stage of the criminal justice process. The Interdepartmental Group agreed that such an approach should be developed.

This interim report sets out the work of the Interdepartmental Group in relation to how diversion could be facilitated, where appropriate, at all stages of the criminal process up to the conclusion of a criminal trial. These stages include:

- Diversion following first contact with the Garda Síochána
- Diversion of persons remanded in custody
- Court diversion before trial: the fitness to be tried procedure
- Facilitating the psychiatric assessment of accused persons before trial
- The verdict of not guilty by reason of insanity
- Diversion of persons with mental illness who are convicted of offences.

Matters relating to mental health services for prisoners, matters relating to patients detained under the Criminal Law (Insanity) Act 2006 and post-release mental health services for former prisoners will be the subject of a further report of the Interdepartmental Group.

## Summary of Recommendations

1. The Interdepartmental Group recommends that An Garda Síochána implement a diversion policy as described in this Interim Report for use in suitable cases when they come in contact with adults with mental illness who may have committed a minor offence.
2. The Interdepartmental Group recommends that the Department of Health consider whether any amendments to sections 9 and 12 of the Mental Health Act 2001 are required to facilitate the operation of a Garda diversion policy.
3. The Interdepartmental Group recommends that the Department of Health consider the implications of any changes to the procedures for involuntary admission to approved centres under the Mental Health Act 2001 for the duration of detention in Garda stations of persons taken into custody under section 12 of the Act.
4. The Interdepartmental Group recommends that An Garda Síochána, the Office of the Director of Public Prosecutions and the HSE consider whether it will be necessary to develop protocols and/or guidelines for the operation of a Garda diversion policy.
5. The Interdepartmental Group recommends that the HSE and the Irish Prison Service make prison in-reach and court liaison services available to prisoners remanded in custody in Castlerea, Cork and Limerick Prisons.
6. The Interdepartmental Group recommends that prison in-reach, court liaison and diversion services should not be put on a formal statutory basis at this time.
7. The Interdepartmental Group recommends that the Department of Justice and Equality write to the Working Group on Efficiency Measures in the Criminal Justice System – Circuit and District Courts to bring their attention to the difficulties that the organisation of court sittings outside Dublin can cause for the attendance of medical personnel to give evidence in cases involving persons with mental illness who are charged with criminal offences.
8. The Interdepartmental Group recommends that the Department of Justice and Equality bring forward the following amendments to section 4 of the Criminal Law (Insanity) Act 2006:
  - (a) to require medical evidence to be considered by a court before a determination of unfitness to be tried is made;
  - (b) to provide for links between the criminal justice system and non-forensic mental health services so that persons found unfit to be tried by the District Court can be appropriately dealt with;
  - (c) to provide that a trial of the facts under section 4(8) will be mandatory where a court determines that a person is unfit to be tried and wishes to order in-patient care or treatment of the person;

(d) to address the issues raised by the judgment in *G. v. District Judge Murphy*.

9. The Interdepartmental Group recommends that the Department of Justice and Equality examine the possibility of:

(a) abolishing the option for out-patient examination or treatment under section 4 of the Criminal Law (Insanity) Act 2006, or

(b) amending the provisions relating to out-patient examination or treatment to provide for a more effective community order.

10. The Interdepartmental Group recommends that the Department of Justice and Equality bring forward a legislative provision:

(a) to enable medical staff of the Prison-In Reach and Court Liaison Service to notify the relevant court if they consider that a psychiatric assessment of a person remanded in custody would be appropriate, and

(b) to give the courts the power to order such an assessment.

11. The Interdepartmental Group recommends that the question of the test to be applied by a court in deciding whether to order the detention of a person found not guilty by reason of insanity should be pursued further by the Department of Justice and Equality in the context of the review of the Criminal Law (Insanity) Act 2006 and any proposals to change the criteria that must be satisfied before a person can be involuntarily admitted to an approved centre under the Mental Health Act 2001.

12. The Interdepartmental Group recommends that the Department of Justice and Equality, in consultation with the Department of Health, examine the question of amending section 5 of the Criminal Law (Insanity) Act 2006 to provide for options for courts to deal with persons found not guilty by reason of insanity who require in-patient treatment but do not require treatment under conditions of special security in the Central Mental Hospital.

13. The Interdepartmental Group recommends that the Department of Justice and Equality, in consultation with the Department of Health, bring forward legislation to provide for hospital orders for persons with mental disorders convicted of criminal offences.

14. The Interdepartmental Group recommends that the implications that ratification of the UN Convention on the Rights of Persons with Disabilities may have for the Criminal Law (Insanity) Act 2006 and the Mental Health Act 2001 be carefully considered by the Department of Justice and Equality and the Department of Health.

## Chapter 1: Diversion following first contact with the Garda Síochána

The usual first contact with the criminal justice system for a person with mental illness who may have committed an offence is with a member of the Garda Síochána.

The Interdepartmental Group examined the possibilities for providing avenues for the Garda Síochána to divert people with mental illness away from the criminal justice system and into appropriate care or treatment.

This section of the report outlines a diversion policy that could be employed by the Garda Síochána in suitable cases, when they come in contact with adult persons with a mental illness who may have committed a minor offence, to divert such people away from the criminal justice system and into more appropriate solutions in the public interest.

### **Initial contacts between Gardaí and persons with mental illness**

#### ***(i) Situations where Gardaí come into contact with a person with mental illness who presents a serious risk of immediate and serious harm to any person (whether or not the person may have committed an offence)***

As regards the level of interaction by An Garda Síochána with people with mental illness, the Interdepartmental Group was informed that in 2012, An Garda Síochána used their powers under the Mental Health Act 2001 in approximately 2,500 incidents, which involved about 2,000 individuals. Section 12 of the Act was applied in the vast majority of those incidents.

Section 12 of the Mental Health Act 2001, which provides for Garda powers to take persons believed to be suffering from a mental disorder into custody, may be invoked by the Gardaí where they come into contact with a mentally ill person in a crisis situation. In such situations, it may appear that the person is a danger to himself/herself or to others. Section 12 may be invoked to ensure that a medical assessment and admission to an approved centre and treatment in accordance with that Act are accessed.

Section 12(1) provides that where a member of the Garda Síochána has reasonable grounds for believing that a person is suffering from a mental disorder (as defined in section 3 of the Act) and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons, the member may take the person into custody.

Section 12(2) provides that where a member of the Garda Síochána takes a person into custody under section 12(1), he or she or any other member of the Garda Síochána must make an application forthwith to a medical practitioner for a recommendation that the person be admitted involuntarily to an approved centre.

Under section 12(3), the provisions of sections 10 and 11 apply to an application under section 12.

Section 12(4) provides that if an application for a recommendation under section 12 is refused by the medical practitioner, the person must be released from custody immediately.

Section 12(5) provides that where a recommendation is made following an application under section 12, the Garda Síochána must remove the person to the approved centre specified in the recommendation.

In the High Court judgment in *A.B. v. Commissioner of An Garda Síochána* [2013] IEHC 88, Mac Eochaidh J. noted that section 12 of the Mental Health Act 2001 “is expressed in terms which suggest that the powers (of civil detention) may not be exercised in respect of a person already in custody”.

The Interdepartmental Group noted the following issues regarding section 12:

- If a person taken into custody by the Gardaí under section 12 of the Mental Health Act is not involuntarily admitted to an approved centre, there should be the possibility of voluntary admission to an approved centre.
- If a person is taken into custody by Gardaí under section 12 of the Mental Health Act, this should not prevent the prosecution of the person where an offence is alleged to have been committed, if appropriate, whether or not the person is admitted to an approved centre.
- If a person taken into custody by the Gardaí under section 12 is admitted to an approved centre, it should be possible for the person to benefit from the Garda diversion policy, where appropriate, in relation to an offence alleged to have been committed by the person.

The Group noted that the Report of the Expert Group on the Review of the Mental Health Act 2001, published in March 2015, made a number of recommendations in relation to applications for involuntary admission to an approved centre and in relation to section 12 of the 2001 Act.

The Expert Group recommended that an Authorised Officer (a HSE official authorised to exercise the functions of an authorised officer) should be the person to sign all applications for involuntary admission to an approved centre (Recommendation 36). This would have the effect of reducing the involvement of Gardaí in the admission process.

It was also recommended that where a person is taken into custody by the Gardaí under section 12 of the 2001 Act, the initial assessment, whether that is by the Authorised Officer or the Registered Medical Practitioner, should take place as soon as possible after the person is taken into custody (Recommendation 41). The maximum period which the person can be held prior to being assessed by the Authorised Officer or Registered Medical Practitioner should be 24 hours. A second 24 hour timeframe in which both the Authorised Officer and the Registered Medical Practitioner must carry out their assessments commences once the first such assessment is initiated.

The Interdepartmental Group is of the view that the implications of these recommendations for the operation of section 12 of the 2001 Act by the Garda Síochána will need to be carefully considered. In particular, providing for two 24 hour periods for assessment by an Authorised Officer and a Registered Medical Practitioner could result in a person with a serious mental illness being detained in a Garda station for up to 48 hours. Serious issues arise as to the appropriateness of such a lengthy period of detention in what would be an unsuitable and stressful environment for a person with a mental illness.

***(ii) Situations where the Gardaí arrest a person for an offence and the person's mental illness becomes apparent after arrest***

*(a) Application under section 9 of the Mental Health Act 2001*

The Interdepartmental Group is of the view that if a person is arrested for a minor offence, it should be possible for the Gardaí to discontinue the criminal justice process and deal with the person under the Mental Health Act 2001 if it becomes obvious after the arrest that the person may meet the criteria for involuntary admission under that Act.

For example, where an intoxicated person is arrested for a public order offence, it may not become evident until he or she sobers up that he or she has a mental illness. Section 12 of the Mental Health Act would not have been used to take the person into custody as it would not have been apparent at the time of the arrest that the person had a mental illness.

Under current arrangements, the Gardaí can call a GP to a Garda station when a medical issue arises in relation to a person in Garda custody.

Section 9 of the Mental Health Act specifies who may apply to a medical practitioner for a recommendation that a person be admitted involuntarily to an approved centre. Members of the Garda Síochána are expressly included in the list of persons who may make such an application. Section 9(4) requires the applicant to have observed the person the subject of the application not more than 48 hours before the date of the making of the application.

Recent Annual Reports of the Mental Health Commission indicate that 331 involuntary admissions were made following applications under section 9 by An Garda Síochána in 2014 (20% of all admissions under section 9).

311 such involuntary admissions were made in 2013 (19% of admissions under section 9) and 336 in 2012 (22%).

Section 10 provides for the making by a medical practitioner of a recommendation for the involuntary admission of a person to an approved centre on foot of an application to the practitioner.

Section 11 provides that if an application for a recommendation for involuntary admission is refused and a further application is made in respect of the same person, the applicant must state the facts relating to the previous application and its refusal to the medical practitioner to whom the further application is made.



The Interdepartmental Group identified the following issues regarding section 9:

- It may be appropriate for the Gardaí to make an application under section 9 in respect of a person in Garda custody following an arrest where the person's mental disorder does not become apparent until after the arrest.
- Can the Garda Síochána make an application under section 9 in respect of a person arrested for an offence and who is in Garda custody under the law as it now stands, or should express provision be made for this in legislation?

The Group noted that the Report of the Expert Group on the Review of the Mental Health Act 2001, published in March 2015, made a number of recommendations in relation to applications for involuntary admission to an approved centre.

The Expert Group recommended that an Authorised Officer (a HSE official authorised to exercise the functions of an authorised officer) should be the person to sign all applications for involuntary admission to an approved centre (Recommendation 36).

A significant operational issue that will need to be addressed is the availability of Authorised Officers to sign applications for involuntary admission. If the Garda Síochána are no longer to be permitted to make applications for involuntary admission, it will be necessary for Authorised Officers to be available to Garda stations on a 24/7 basis.

*(b) Other situations where mental illness may be a factor*

A Garda diversion policy would also need to deal with people with mental illness who may have committed a minor offence but who do not meet the criteria for involuntary admission under the Mental Health Act.

Following a Garda encounter with a person suspected of committing an offence, a decision has to be made on how to proceed. The Gardaí have a number of options:

- No arrest, verify the person's name and address and issue a summons.
- Arrest the person, bring him or her to a Garda station, verify details and release the person, with no further action taken. An entry will be made in the custody record as to why the person was not charged.
- Arrest the person, bring him or her to a Garda station, release without charge and issue a summons at a later stage.
- An arrested person may be charged and brought before the court where there is enough evidence to do so.

A Garda diversion policy might apply in respect of persons with a mental illness, severe dementia or significant intellectual disability, as defined in section 3(2) of the Mental Health Act 2001, subject to the exclusions in section 8 of that Act, who are

alleged to have committed minor offences. A GP assessment would be sufficient to establish if a person has such a degree of mental illness, etc. Such a policy would involve the Gardaí exercising their discretion not to prosecute in such cases.

### **Issues arising in relation to Garda diversion**

The Interdepartmental Group examined a number of issues in relation to Garda diversion.

#### ***(a) What criteria should be applied to decide if diversion or a prosecution is the more suitable route?***

The Group considered that it would be appropriate to apply the following criteria:

- (i) The person is 18 years or older.
- (ii) Offence is a minor offence (as listed in the Schedule or by general agreement with the Director of Public Prosecutions or on a case-by-case basis with the consent of the DPP).
- (iii) Sufficient *prima facie* evidence for prosecution exists and there is no bar to prosecution, such as expiry of time limits or inadmissibility of evidence.
- (iv) The person has a mental illness, severe dementia or significant intellectual disability, as defined in section 3(2) of the Mental Health Act 2001, subject to the exclusions in section 8 of that Act.
- (v) The public interest does not require a prosecution.
- (vi) Offending pattern/risk of further offending.
- (vii) Treatment or care of the person may be more effective in preventing repeat offending than prosecution and punishment.
- (viii) The interests of the victim will need to be considered where an offence involving an individual victim is at issue.
- (ix) The person consents to assessment/treatment/care.

#### ***(b) To what offences could a diversion policy apply?***

There was consensus within the Interdepartmental Group that the diversion policy should apply to specified minor offences that could be tried summarily. It is suggested that a cautious approach be taken to the initial list of suitable offences. The list used for the Adult Cautioning Scheme would be appropriate. However, the Group is of the view that the offences under sections 17 and 18 of the Criminal Justice (Theft and Fraud Offences) Act 2001 (handling stolen property and possession of stolen property), which are included in the Adult Cautioning Scheme, should not be included in the list of specified offences for the purposes of a Garda diversion policy, because of the *mens rea* requirements of those offences.

The Group considers that there should, however, be flexibility to include other offences by general agreement with the Director of Public Prosecutions or on a case-by-case basis with the consent of the DPP.

***(c) What threshold of mental illness would warrant diversion rather than prosecution?***

The Group considers that the definitions of mental illness, severe dementia and significant intellectual disability in section 3(2) of the Mental Health Act 2001, subject to the exclusions in section 8 of that Act, should be used for the purposes of a Garda diversion policy.

Section 3(1) of the Mental Health Act defines “mental disorder”, for the purposes of the Act, as meaning mental illness, severe dementia or significant intellectual disability where—

- (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
- (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
- (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

Section 3(2) provides the following definitions of the terms “mental illness”, “severe dementia” and “significant intellectual disability” for the purposes of section 3(1):

“mental illness” means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;

“severe dementia” means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

“significant intellectual disability” means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

Section 8(2) of the Act provides that a person may not be involuntarily admitted to an approved centre by reason only of the fact that he or she is suffering from a personality disorder, is socially deviant, or is addicted to drugs or intoxicants.

The Group noted that the Report of the Expert Group on the Review of the Mental Health Act 2001, published in March 2015, made a number of recommendations in relation to the definition of mental illness and mental disorder in the 2001 Act. Further consideration of the implications of these recommendations will be required.

***(d) How will the person's mental health be assessed?***

Clearly, the Garda Síochána cannot make any determination in relation to a person's mental health. Medical assessment will be necessary. Under current arrangements, the Gardaí call a GP to a Garda station when a medical issue arises.

If the definitions of mental illness, severe dementia and significant intellectual disability for the purposes of Garda diversion are those provided for in section 3(2) of the Mental Health Act, then the necessary mental health assessments could be carried out by GPs.

***(e) Is the decision to divert rather than prosecute to be made at local or central level?***

The decision-maker in the Juvenile Diversion Programme is a Director (Superintendent) appointed by the Garda Commissioner. The Group noted that the advantage of a dedicated high-level decision-maker is that there is a consistent national approach to admission to the programme. There would be resource implications for the Garda Síochána if a similar approach was adopted for a scheme of diversion of persons with mental illness, as it would be necessary to dedicate a high-ranking officer to the scheme in the context of already heavy demands on Garda resources. The alternative approach is that decision-making is done locally by Superintendents. Such an approach leads to the possibility of less consistency in decision-making than if all diversion decisions were taken centrally.

***(f) What procedure should be put in place to facilitate diversion rather than a prosecution?***

The following procedure presumes an assessment by a medical practitioner of whether the person has a mental illness, severe dementia or significant intellectual disability, as defined in section 3(2) of the Mental Health Act, subject to the exclusions in section 8 of the Act.

1. A person is arrested by a Garda and it is apparent on arrest or later that the person has a mental illness, severe dementia or significant intellectual disability.
2. A GP is called to the Garda station, or the person is brought to hospital for treatment of physical injuries, and the person is examined.
3. Following examination of the person by a medical practitioner:

- (a) If the medical practitioner considers that the person has a mental disorder that would warrant a recommendation for involuntary admission to an approved centre, the procedure under section 9 of the Mental Health Act should be invoked. The Gardaí should also consider whether the person should be dealt with under the Garda diversion scheme.
- (b) If the medical practitioner considers that the person has a mental illness, severe dementia or significant intellectual disability, as defined in section 3(2) of the Mental Health Act, subject to the exclusions in section 8 of that Act, but is not so unwell as to require involuntary admission, the Gardaí should consider whether the person should be dealt with under the Garda diversion scheme. Consideration should be given to arranging for voluntary admission of the person to an approved centre in appropriate cases.
- (c) If the medical practitioner finds that the person does not have a mental illness, severe dementia or significant intellectual disability, as defined in section 3(2) of the Mental Health Act, subject to the exclusions in section 8 of that Act, the Garda Síochána may proceed with a criminal prosecution in the usual manner by way of summons or otherwise.

4. Where paragraph 3(a) or 3(b) applies, or if the person has been the subject of an application under section 12 of the Mental Health Act, the Gardaí will assess whether the criteria for diversion appear to be met.

5. The person is released and an entry made in the deferred charges book. Consideration should be given to facilitating the voluntary admission of the person to an approved centre in appropriate cases.

6. A report is made to the Garda decision-maker.

7. Garda decision-maker agrees to diversion. If the decision-maker does not agree to diversion, a prosecution will proceed.

8. Person informed and no further action taken in relation to prosecution.

The Group notes that further consideration will need to be given to the question of what arrangements could be put in place to prevent over-use of diversion, as are in place for the Adult Cautioning Scheme and the Juvenile Diversion Programme.

***(g) What protocols/guidelines or legislative change may be necessary to facilitate a Garda diversion policy?***

The Interdepartmental Group notes that further consideration will need to be given to whether it will be necessary to develop protocols and/or guidelines between the HSE and An Garda Síochána and between the Office of the Director of Public Prosecutions and An Garda Síochána for the operation of a Garda diversion policy as described above.

It will also be necessary to consider whether any amendment of sections 9 and 12 of the Mental Health Act 2001 may be required to facilitate the operation of a Garda diversion policy.

**Recommendations:**

1. The Interdepartmental Group recommends that An Garda Síochána implement a diversion policy as described in this Interim Report for use in suitable cases when they come in contact with adults with mental illness who may have committed a minor offence.
2. The Interdepartmental Group recommends that the Department of Health consider whether any amendments to sections 9 and 12 of the Mental Health Act 2001 are required to facilitate the operation of a Garda diversion policy.
3. The Interdepartmental Group recommends that the Department of Health consider the implications of any changes to the procedures for involuntary admission to approved centres under the Mental Health Act 2001 for the duration of detention in Garda stations of persons taken into custody under section 12 of the Act.
4. The Interdepartmental Group recommends that An Garda Síochána, the Office of the Director of Public Prosecutions and the HSE consider whether it will be necessary to develop protocols and/or guidelines for the operation of a Garda diversion policy.

Schedule of offences to which a Garda diversion policy could apply

***Criminal Justice (Public Order) Act 1994***

Section 4: Intoxication in a public place  
Section 5: Disorderly conduct in a public place  
Section 6: Threatening, abusive or insulting behaviour in a public place  
Section 8: Failure to comply with direction of a member of An Garda Síochána  
Section 9: Wilful obstruction  
Section 11: Entering building etc with intent to commit an offence  
Section 22: Surrender and seizure of intoxicating liquor

***Criminal Justice (Theft and Fraud Offences) Act 2001***

Section 4: Theft (where the value of the property concerned is less than €1,000)  
Section 8: Making off without payment (where the value of the payment is less than €1,000)

***Intoxicating Liquor Act 2003***

Section 6: Offences by a drunken person  
Section 8: Disorderly conduct

***Non-Fatal Offences Against the Person Act 1997***

Section 2: Assault (Assaults on a member of An Garda Síochána shall be forwarded to the Director of Public Prosecutions)

***Criminal Damage Act 1991***

Section 2: Damaging property (where the value of the property damaged is less than €1,000)  
Section 3: Threat to damage property.

***Dublin Police Act 1842***

Section 14(12): Nuisances in public thoroughfares (applies to Dublin Metropolitan (Court) District Only)

***Intoxicating Liquor Act 1927***

Section 17: Persons on licensed premises during prohibited hours

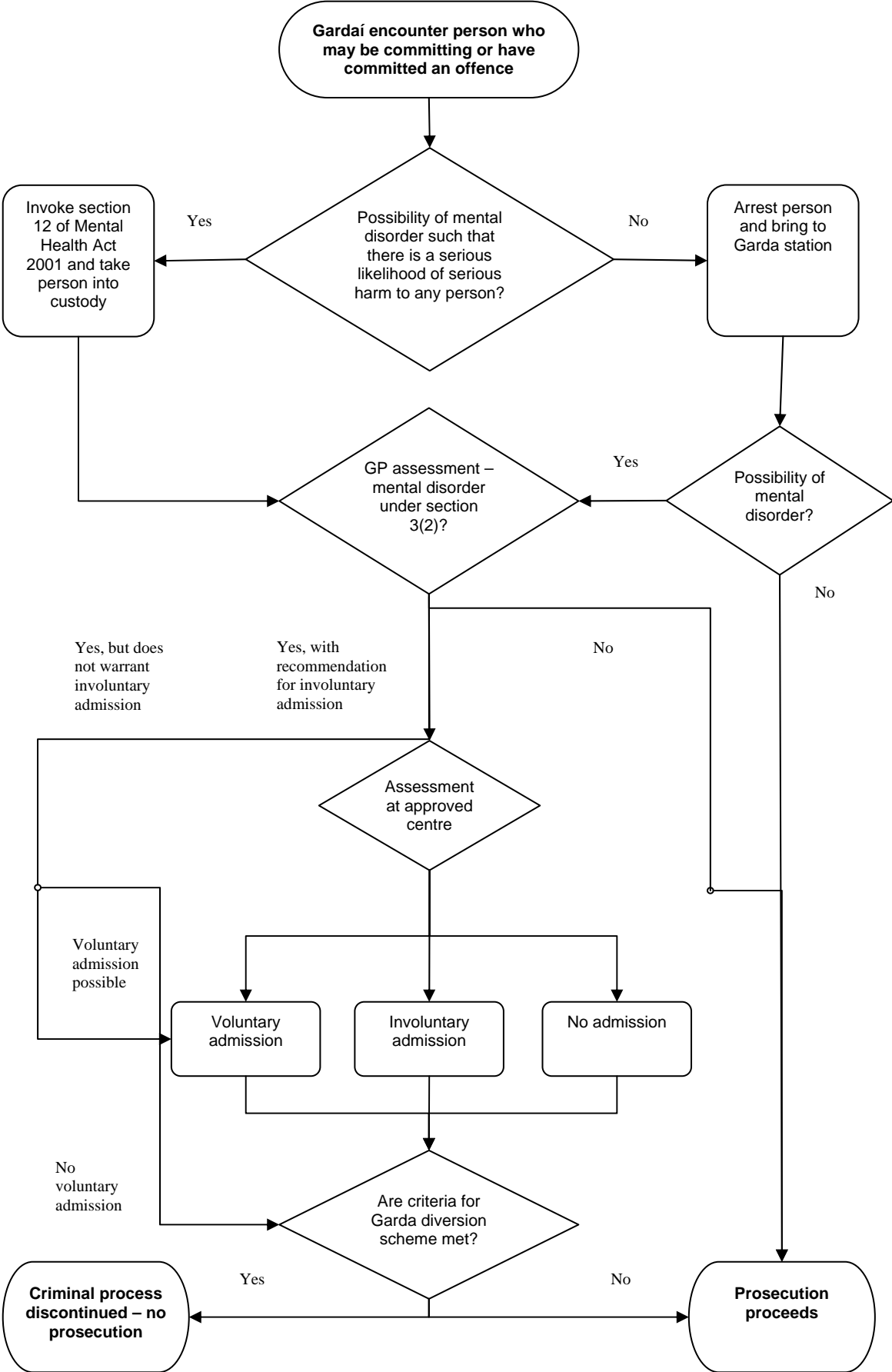
***Licensing Act 1872***

Section 12: Public drunkenness

***Summary Jurisdiction (Ireland) Amendment Act 1871***

Section 8: Offensive or riotous conduct in a theatre or other place of public amusement (applies to Dublin Metropolitan (Court) District only)

# Garda Diversion Flowchart





## Chapter 2: Diversion of persons remanded in custody

Prior to 2006, there were no full-time arrangements for mental health screening of persons remanded in custody. In 2006, the Prison In-reach and Court Liaison Service (PICLS) was established in Cloverhill Prison, Ireland's main remand prison. The service provides a full-time mental health team to co-ordinate screening for major mental health problems and to facilitate diversion to mental health treatment for persons requiring such care.

PICLS consists of medical and nursing staff who attend Cloverhill Prison on a daily basis. The service is provided by the National Forensic Mental Health Service. The service screens all new remands for the presence of major mental illness and performs comprehensive assessments for persons thus identified, or following referral.

Psychiatric reports may be provided for the courts regarding issues such as fitness to be tried, the presence or otherwise of mental illness, and treatment arrangements in the event of the imposition of a custodial or non-custodial sanction. Such reports can, in particular, aid the courts in diverting people with mental illness away from prison by ensuring that such persons can access appropriate treatment following the imposition of a non-custodial sanction.

It should be noted that the great majority of these diversions (about 80%) involve voluntary attendance at non-hospital settings, such as out-patient treatment settings. In these voluntary cases the court adjourns to allow the person to access such treatment and bail may be granted on this basis.

In other cases, a person may be sent to a local approved centre for assessment and possible admission. In such cases, the person may be granted bail or given a non-custodial sanction by the court in order that they may access mental health care in an approved centre.

An in-reach service for women detained in the Dóchas Centre is led by a consultant forensic psychiatrist from the Central Mental Hospital.

PICLS supplied detailed statistics to the Interdepartmental Group in relation to services provided at Cloverhill Prison.

Between 2006 and 2011, PICLS screened all 20,084 remands to Cloverhill Prison. The service conducted comprehensive assessments of 3,195 committals and arranged diversions for 572 of these (89 to the Central Mental Hospital, 164 to community inpatient settings and 319 to community outpatient settings), during these six years.

All 6,177 remand committals of 5,472 individuals were screened by PICLS in the years 2012 to 2014. This represents 61% of all remand committals nationally during this period. There were also 2,197 sentenced committals to Cloverhill during this period, mainly following periods on remand and serving short sentences from the District Court (i.e. already screened as above). Thus there was a total of 8,374 remand and sentenced committals to Cloverhill from 2012 to 2014.

1,205 of these 8,374 committals were identified as requiring mental health assessment and received comprehensive mental health assessment. 281 committals (3.36%) had active psychotic symptoms (the most severe form of mental illness) during their committals. This is in keeping with expected rates based on national and international epidemiological research.

The following table sets out the diagnostic breakdown for the 1,205 committals assessed by the PICLS at Cloverhill Prison during the years 2012 to 2014. It should be noted that the table refers to primary clinical diagnosis. Patients may have had multiple diagnoses.

<b>International Classification of Diseases (ICD) Code</b>	<b>Diagnostic Group (Primary Diagnosis)</b>	<b>Number</b>	<b>%</b>
<b>F0-9</b>	Organic Mental Disorders	21	1.7%
<b>F10-19</b>	Substance Use Disorders	460	38.3%
<b>F20-29</b>	Schizophrenia, Schizotypal and Delusional Disorders	279	23.2%
<b>F31</b>	Bipolar Affective Disorder	49	4.1%
<b>F32-39</b>	Other mood disorders	74	6.1%
<b>F40-49</b>	Neurotic Disorders	6	0.5%
<b>F60-69</b>	Personality Disorders	222	18.4%
<b>F70-79</b>	Intellectual Disability	15	1.2%
<b>F80-99</b>	Childhood and Developmental Disorders	9	0.8%
<b>No Mental Illness</b>	No Mental Illness or Adjustment Reaction only	70	5.8%
<b>Total</b>		<b>1,205</b>	<b>100%</b>

Of the 1,205 patients receiving comprehensive assessment based on screening and referral, 25% had a history of personality disorder, 3% had a history of definite intellectual disability diagnosis, 86% had a history of substance misuse disorders and 64% had a history of deliberate self harm. 35% were homeless.

There were 68 admissions from Cloverhill to the Central Mental Hospital during 2012 to 2014. 13 of the 68 admissions were voluntary under section 15(1) of the Criminal Law (Insanity) Act 2006, while 55 were involuntary under section 15(2) of the Act. As at April 2015, 16 of these remained as inpatients at the CMH, 14 were admitted to Community General Psychiatric Hospitals after discharge from the CMH, 7 had community outpatient treatment arrangement arranged, with the remainder returned to prison.

82 were diverted at first instance to community general psychiatric hospitals. Of these, 66 were admitted following application under the Mental Health Act 2001. 16 were admitted as voluntary patients. 220 were diverted to community outpatient treatment settings.

There is a consensus in the Interdepartmental Group that the existing Prison In-reach and Court Liaison Service works very well and that an extended or similar

service should be made available to prisoners remanded in custody in Castlerea, Cork and Limerick Prisons. The Group notes that the HSE and the Irish Prison Service are currently developing arrangements for the provision of forensic mental health in-reach services in those prisons.

The Interdepartmental Group considers that there would be no advantage to putting prison in-reach, court liaison and diversion services on a formal statutory basis and is concerned that a statutory basis might adversely affect the flexibility, accessibility and responsiveness of the service.

The Interdepartmental Group is aware that there are difficulties regarding the availability of medical staff from PICLS and community mental health services to give evidence in courts outside the Dublin area in the context of court diversion of remand prisoners to psychiatric settings. These issues arise mainly from the organisation of court sittings, particularly where medical staff may have to spend a long time in court waiting for a case to be heard.

The Interdepartmental Group is of the view that it would be worth exploring whether arrangements could be put in place to address the difficulties that the organisation of court sittings outside Dublin can cause for the attendance of medical personnel to give evidence in cases involving persons with mental illness who are charged with criminal offences.

The Group is of the view that while this could be done by the Department of Justice and Equality bringing the issue to the attention of the President of the District Court and the Director of Public Prosecutions, it would be more appropriate for that Department to write to the Working Group on Efficiency Measures in the Criminal Justice System – Circuit and District Courts to bring the issue to the attention of that Group.

**Recommendations:**

5. The Interdepartmental Group recommends that the HSE and the Irish Prison Service make prison in-reach and court liaison services available to prisoners remanded in custody in Castlerea, Cork and Limerick Prisons.

6. The Interdepartmental Group recommends that prison in-reach, court liaison and diversion services should not be put on a formal statutory basis at this time.

7. The Interdepartmental Group recommends that the Department of Justice and Equality write to the Working Group on Efficiency Measures in the Criminal Justice System - Circuit and District Courts to bring their attention to the difficulties that the organisation of court sittings outside Dublin can cause for the attendance of medical personnel to give evidence in cases involving persons with mental illness who are charged with criminal offences.

## Chapter 3: Court diversion before trial: The fitness to be tried procedure

Section 4 of the Criminal Law (Insanity) Act 2006 sets out the procedure to be followed when there is an issue about the fitness to be tried of a person charged with a criminal offence. The defence, the prosecution or the court may raise an issue as to whether an accused person is fit to be tried. Such an issue can arise at any stage of criminal proceedings but usually emerges before the trial commences.

The test for establishing whether a person is unfit to be tried is a functional test based on the capacity of the person to participate in his or her trial. The test is set out in section 4(2) of the 2006 Act. A person will be deemed unfit to be tried if, because of a mental disorder, he or she is unable to understand the nature or course of the proceedings so as to plead to the charge, instruct a legal representative, elect for trial by jury in a case involving an indictable offence, make a proper defence, challenge a juror to whom he or she may wish to object or understand the evidence. "Mental disorder" in this context, as defined in section 1 of the 2006 Act, includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication.

If the charge relates to a summary offence or an indictable offence being tried summarily, any question as to whether or not the accused person is fit to be tried will be determined by the District Court. If the charge relates to an indictable offence not being tried summarily, the District Court must send the person forward to the court of trial for determination of the person's fitness to be tried.

Where an issue arises about a person's fitness to be tried, the court may request evidence from a consultant psychiatrist for the purposes of deciding whether to adjourn the proceedings to facilitate the accused person in accessing any care or treatment necessary for his or her welfare, deciding whether or not the accused person is fit to be tried, or committing a person who has been found unfit to be tried to a designated centre for examination. These provisions, which were added by section 4 of the Criminal Law (Insanity) Act 2010, were intended to reduce unnecessary referrals for assessment in the Central Mental Hospital and to allow for more informal diversion arrangements (such as those operated by the Prison In-reach and Court Liaison Service) to be applied in suitable cases.

If the court decides that the accused person is unfit to be tried, it must adjourn the proceedings. Section 4(6) provides that the court, having first heard evidence from an approved medical officer (a consultant psychiatrist), may commit the person to a designated centre for examination for a period of up to 14 days. The court may, as an alternative, order that the person be examined at a designated centre as an out-patient.

If the court is satisfied, having considered the evidence from the approved medical officer who examined the accused person, that the person is suffering from a mental disorder, as defined in the Mental Health Act 2001, and in need of in-patient care or treatment in a designated centre, the court may commit the person to the centre until an order is made by the Mental Health (Criminal Law) Review Board to conditionally

or unconditionally discharge the person. The court also has the option of ordering that the person receive out-patient treatment at a designated centre.

Statistics published by the Mental Health (Criminal Law) Review Board in its Annual Reports indicate that the number of people found unfit to be tried who are detained in the Central Mental Hospital and whose detention falls to be reviewed by the Review Board is relatively small. The Review Board held 15 review hearings in relation to persons detained under section 4 in 2014 (9% of the total number of reviews) and 16 such reviews in 2013 (10% of the total).

Section 4(8) provides for an optional trial of the facts in a case where a person is found unfit to be tried. The court may allow evidence to be adduced as to whether the accused person did the act alleged. If the court is satisfied that there is a reasonable doubt as to whether the person did the act alleged, it must order that the person be discharged.

The Interdepartmental Group examined a number of issues that have emerged regarding the operation of the fitness to be tried procedure in section 4 of the Criminal Law (Insanity) Act 2006 and considered possible actions to address these issues.

***a. Requirement for medical evidence before determining fitness to be tried***

Section 4 of the 2006 Act does not require a court to consider medical evidence before determining that an accused person is unfit to be tried.

The Interdepartmental Group is of the view that while the question of a person's fitness to be tried is a matter for the court to determine, no determination of unfitness to be tried should be made without medical evidence having been considered by the court. Section 4 of the 2006 Act could be amended to require medical evidence to be considered by a court before a determination of unfitness to be tried is made.

The Group is of the view that if an issue arises as to a person's fitness to be tried for a minor offence being dealt with by the District Court, the court should be able to seek an opinion from the HSE catchment area consultant psychiatrist in a case where it would be appropriate to admit the accused person to the local approved centre if he or she is found unfit to be tried. In a more serious case before the District Court, the catchment area psychiatrist could request the court to obtain evidence from the National Forensic Mental Health Service. It would be necessary for evidence to be given by a consultant psychiatrist from the NFMHS in more serious cases being dealt with by the Circuit Court, the Central Criminal Court or the Special Criminal Court.

The Group recognises that the introduction of a requirement for medical evidence in every case where fitness to be tried is at issue is likely to have resource implications for community mental health services and the NFMHS.

The Group also considers that provision could be made to require the medical evidence under section 4(3)(aa)(iii) or section 4(5)(bb)(iii) that is necessary before an accused person can be committed to a designated centre for examination to be

given by an approved medical officer in a designated centre, rather than any consultant psychiatrist, as is the case at present. This would ensure that accused persons could be committed to a designated centre for examination under section 4 only on the basis of a report from an approved officer in that centre.

***b. Options for dealing with persons found unfit to be tried***

The Interdepartmental Group considers that the possibility of indefinite detention in the Central Mental Hospital for a person found unfit to be tried for a minor offence is disproportionate both in terms of the possible length of detention and the level of security involved. The Group favours widening the disposal options available to the District Court to enable persons found unfit to be tried to access local mental health services.

Legislative provision could be made for links between the criminal justice system and local mental health services in fitness to be tried cases in the District Court. The legislation could distinguish between the District Court and other courts. The Group noted that such legislative changes would have potentially significant resource and operational implications for the HSE and mental health service providers. These implications will need further consideration.

An issue that will require further examination is whether any power to commit a person who has been found unfit to be tried to a designated centre or an approved centre for in-patient care or treatment should be stated in the legislation to be exercisable only following consultation with the centre concerned regarding suitability and availability. A difficulty with such a provision would be that if medical evidence has been given that a person who is unfit to be tried requires in-patient care or treatment, but no appropriate place for the person is available, the courts will have to order the release of the person as there will be no other place in which he or she can be lawfully detained.

***c. Trial of the facts after a person is found unfit to be tried***

Section 4(8) provides for an optional trial of the facts in a case where a person is found unfit to be tried. A person who is unfit to be tried could be detained for in-patient care or treatment for a long duration without a determination having been made as to whether he or she committed the alleged offence.

There is agreement within the Interdepartmental Group that nobody found unfit to be tried should be detained in a designated centre without a trial of the facts. Section 4(8) of the 2006 Act should be amended to provide that a trial of the facts will be mandatory where a court determines that a person is unfit to be tried and wishes to order in-patient care or treatment of the person. However, care will need to be taken to ensure that the trial of the facts only relates to the *actus reus* of the alleged offence, in order to avoid the difficulties that emerged with the operation of the corresponding legislation in England.

***d. Out-patient assessment or treatment under section 4 of the 2006 Act***

The option to order out-patient examination or treatment under section 4 of the 2006 Act is seldom, if ever, used because there is no means of enforcing an order for examination or treatment if the person does not comply with the order.

The Interdepartmental Group agrees that the Department of Justice and Equality should examine the possibility of (a) abolishing the option for out-patient examination or treatment under section 4 of the 2006 Act or (b) amending the provisions relating to out-patient examination or treatment to provide for a more effective community order.

### ***e. Implications of the High Court judgment in G. v. District Judge Murphy***

In *G. v District Judge Murphy* [2011] IEHC 445, the High Court ruled that section 4 of the Criminal Law (Insanity) Act 2006 provided for unconstitutional discrimination against a person charged with an offence whose fitness to be tried is in question.

The facts of the case were that the Director of Public Prosecutions consented to a charge of sexual assault being dealt with summarily by the District Court if the accused person pleaded guilty, as provided for by section 13 of the Criminal Procedure Act 1967. However, when the accused person appeared before the District Court, the issue of his fitness to be tried was raised. The effect of raising the fitness issue was that there could not be a guilty plea and the District Court was required to send the case forward to the Circuit Criminal Court for the matter to be dealt with as an indictable offence.

The accused person submitted that section 4 of the 2006 Act gave rise to an unconstitutional lacuna in that if he was sent forward to the Circuit Court and was determined to be fit to be tried, he could not avail of the opportunity to plead guilty before the District Court and being subject to a lower maximum sentence.

The High Court (Hogan J.) found that the Oireachtas failed to provide a mechanism whereby persons charged with indictable offences whose fitness to be tried is later established can obtain the benefit of a guilty plea before the District Court. In making rules which permit accused persons to avail of the option of summary disposal before the District Court, the Oireachtas cannot place certain categories of accused persons (such as those whose mental capacity is in doubt) at a real disadvantage as compared with other similarly situated accused persons, without objective justification. The Court found that this happened in this case by reason of the drafting of the relevant provisions of section 4 of the 2006 Act. It followed, accordingly, that the requirement of equality before the law under Article 40.1 of the Constitution had been violated.

The Court did not strike down section 4 of the 2006 Act, on the basis that it contained important safeguards for persons with mental illness. Instead, the Court issued a declaration to the effect that it would be unconstitutional in the case concerned if in the event that the person was found fit to be tried and pleaded guilty to the offence charged, the Circuit Court were to impose a sentence higher than he would have received in such circumstances in the District Court.

The Interdepartmental Group agrees that section 4 of the 2006 Act will need to be amended to address the issues raised by the judgment in *G. v. District Judge Murphy*.

Recommendations:

8. The Interdepartmental Group recommends that the Department of Justice and Equality bring forward the following amendments to section 4 of the Criminal Law (Insanity) Act 2006:

(a) to require medical evidence to be considered by a court before a determination of unfitness to be tried is made;

(b) to provide for links between the criminal justice system and non-forensic mental health services so that persons found unfit to be tried by the District Court can be appropriately dealt with;

(c) to provide that a trial of the facts under section 4(8) will be mandatory where a court determines that a person is unfit to be tried and wishes to order in-patient care or treatment of the person;

(d) to address the issues raised by the judgment in *G. v. District Judge Murphy*.

9. The Interdepartmental Group recommends that the Department of Justice and Equality examine the possibility of:

(a) abolishing the option for out-patient examination or treatment under section 4 of the Criminal Law (Insanity) Act 2006, or

(b) amending the provisions relating to out-patient examination or treatment to provide for a more effective community order.



## Chapter 4: Facilitating the psychiatric assessment of accused persons before trial

Accused persons with mental illness tend to be sent straight into the fitness to be tried procedure because section 4 of the Criminal Law (Insanity) Act 2006 requires the issue of fitness to be raised before the provisions of that section can be applied by a court.

In the Implementation Plan for the recommendations of the Report of the Commission of Investigation into the death of Gary Douch, the Interdepartmental Group recommended that the courts should be given a statutory power to adjourn proceedings when an issue arises as to the mental health of an accused person to facilitate psychiatric assessment and treatment of the person before the trial without using the fitness to be tried procedure under section 4 of the 2006 Act. This may be of particular benefit in cases involving minor offences where the accused person is less likely to be remanded in custody.

Having given the matter further consideration, the Interdepartmental Group is of the view that a wide-ranging provision for psychiatric assessment of accused persons before trial may give rise to difficulties in practice and would add an extra layer to criminal proceedings involving accused persons whose fitness to be tried is not at issue.

However, as regards persons remanded in custody who may have a mental illness, the Group considers that provision should be made to enable PICLS medical staff to notify the relevant court if they consider that the psychiatric assessment of a person remanded in custody would be appropriate and that the courts should have a power to order such an assessment.

PICLS prepared over 250 District Court reports during the years 2012 to 2014, each of which dealt with both fitness to be tried and the insanity defence.

### Recommendation:

10. The Interdepartmental Group recommends that the Department of Justice and Equality bring forward a legislative provision:

(a) to enable medical staff of the Prison-In Reach and Court Liaison Service to notify the relevant court if they consider that a psychiatric assessment of a person remanded in custody would be appropriate, and

(b) to give the courts the power to order such an assessment.

## Chapter 5: The verdict of not guilty by reason of insanity

An accused person's mental disorder may have been a factor in the alleged offence. If it was such as to absolve the person of criminal responsibility, it is open to the accused person to plead insanity as a defence.

The special verdict of "not guilty by reason of insanity" is provided for by section 5 of the Criminal Law (Insanity) Act 2006. This replaced the verdict of "guilty but insane" under section 2 of the Trial of Lunatics Act 1883.

Section 5(1) sets out in statutory form the parameters of the defence of insanity which is based on the common law as it was before the enactment of the 2006 Act. The test to be applied relates to the mental condition of the person at the time the act was committed and not at the time of the trial.

Where the court (or the jury, in a case being tried by the Circuit Court or Central Criminal Court) finds that the accused person committed the act alleged and, having heard evidence from a consultant psychiatrist, finds that the person was suffering at the time from a mental disorder such that he or she ought not to be held responsible for the act because he or she:

- (i) did not know the nature and quality of the act,
- (ii) did not know that what he or she was doing was wrong, or
- (iii) was unable to refrain from committing the act,

a special verdict of not guilty by reason of insanity will be returned.

A person found not guilty by reason of insanity may be subject to detention for the purpose of in-patient care or treatment if the court is satisfied that it is necessary. The court will consider the mental condition of the person to determine whether he or she should be released or detained in a designated centre for in-patient care or treatment. The decision as to how the person should be dealt with is made not by reference to the criminal law definition of insanity, but by reference to the civil law definition of "mental disorder" in the Mental Health Act 2001.

For the purpose of determining whether or not a person found not guilty by reason of insanity is suffering from a mental disorder within the meaning of the 2001 Act and is in need of in-patient care or treatment in a designated centre, section 5(3) of the 2006 Act permits the court to commit the person to a designated centre for up to 14 days for examination by an approved medical officer (a consultant psychiatrist). This period may be extended by the court, following consultation with an approved medical officer, to up to 6 months in total.

Section 5(2) provides that having heard evidence from the approved medical officer, the court must commit the person to a designated centre if it is satisfied that the person has a mental disorder within the meaning of the Mental Health Act 2001 and is in need of in-patient care or treatment in a designated centre. The person's detention is subject to ongoing review by the Mental Health (Criminal Law) Review

Board which decides if and when the person should be conditionally or unconditionally discharged from the designated centre having “regard to the welfare and safety of the person ... and to the public interest” (section 11).

Statistics published by the Mental Health (Criminal Law) Review Board in its Annual Reports indicate that the Review Board held 106 review hearings in relation to persons detained under section 5(2) in 2014 (64% of the total number of reviews) and also 106 such reviews in 2013 (67% of the total).

The Interdepartmental Group examined a number of issues that have emerged regarding the operation of section 5 of the Criminal Law (Insanity) Act 2006 and considered possible actions to address these issues.

***a. A defence of insanity cannot be put to the jury by the court if the accused person pleads guilty to the offence.***

The Supreme Court has held that a court of trial is not permitted to put the option of a verdict of not guilty by reason of insanity before a jury if the accused person pleads guilty and does not raise insanity as a defence. This matter was at issue in *DPP v. Redmond* [2006] IESC 25, which involved a case stated from the Circuit Court to the Supreme Court. In that case, it was clear that the accused person, who was fit to plead, pleaded guilty because he preferred to be subject to a definite sentence of imprisonment rather than indefinite detention in the Central Mental Hospital.

The question stated to the Supreme Court was whether a court has the power or duty to decline to act on a plea of guilty if, on the evidence before it, it is satisfied that it has substantial grounds for believing that the accused person was insane at the time he or she committed the acts alleged to constitute the offence. Should the court in those circumstances decline to accept a plea of guilty, enter a plea of not guilty on behalf of the accused person and seek to ensure that the issue of his or her insanity is fully investigated in the course of the trial?

The majority of the Supreme Court did not consider that it was open to the trial judge in that case to decline to accept the plea of guilty even if the judge believed that the accused person was insane.

Geoghegan J noted that on the facts of the case, it was not certain that an insanity verdict would have been returned if the defence had been put to the jury. He said that if there was a case where on a reading of the book of evidence, it seemed certain that there would have to be a verdict of insanity, it may well be that a judge could force a change of plea. However, he left that issue open because it did not arise in this case. He said that an accused person is entitled to have tactical reasons as to whether he pleads guilty rather than not guilty and he did not think an accused person's motive for pleading guilty should be examined.

He considered that the answer to be given to the case stated by the Circuit Court was that the particular grounds for leading the trial judge to believe that the accused person was insane at the time he committed the acts alleged to constitute the offence did not empower the judge to decline to accept the plea of guilty. Fennelly J, Kearns J and Macken J agreed that the question raised in the case stated should be answered in that manner.

Fennelly J did not think that it would be consistent with the onus of proof of insanity being on the defence for a judge to be permitted to substitute a plea of not guilty by reason of insanity for a guilty plea. He noted the practical difficulties that would arise if this were permitted and pointed out that if the accused person appeared unfit to be tried, that issue could be raised by the prosecution and the person could be detained in the Central Mental Hospital if found unfit to be tried.

Kearns J said that an intervention by a trial judge to set aside a guilty plea would run counter to the accused person's right to select his preferred line of defence, which is an integral part of the right to a fair trial guaranteed by Article 38 of the Constitution. In his view, a judge would require to be satisfied that very exceptional circumstances are demonstrated and a very high threshold met before intervening to set aside a guilty plea.

Denham J's dissenting judgment was to the effect that a judge has inherent jurisdiction to intervene in a guilty plea to ensure the due process of law, that this jurisdiction should only be exercised in exceptional circumstances and exceptional circumstances existed in this case because the accused person pleaded guilty to avoid indefinite detention and had made this known to the trial judge.

The Interdepartmental Group noted that the current legal position on this issue can lead to difficulties in cases where persons with mental illness who are fit to be tried refuse to plead not guilty by reason of insanity even though they may meet the test for the verdict. This can lead to persons with serious mental illness being convicted of offences and receiving long sentences of imprisonment.

However, in view of the difficulties identified by the Supreme Court in relation to permitting the substitution by a judge of a plea of not guilty by reason of insanity for a plea of guilty, the Interdepartmental Group does not recommend any change to the law on this matter at this time.

#### ***b. Operation of the two-stage procedure under sections 5(2) and 5(3) of the 2006 Act***

The Interdepartmental Group examined the operation of the procedure required before a person found not guilty by reason of insanity can be detained in a designated centre under section 5(2) of the 2006 Act.

A verdict of not guilty by reason of insanity is based on the person's mental disorder at the time the act was committed. Under section 5 of the 2006 Act, after a person has been found not guilty by reason of insanity, the court must then consider the current mental condition of the person to determine whether he or she needs to be detained in a designated centre (Central Mental Hospital). This decision is made not by reference to the criminal law definition of insanity or mental disorder, but by reference to the civil law relating to mental health, as contained in the Mental Health Act 2001.

If the person's condition has improved to the extent that he or she does not require in-patient treatment, the court should not order the person to be detained. If the

person remains unwell, the court can order that he or she be detained in a designated centre.

Section 9 of the 2006 Act permits the Director of Public Prosecutions to appeal a decision of a court not to commit a person found not guilty by reason of insanity to a designated centre under section 5(2). There is the possibility of judicial review if there was no evidence before the court to support a finding that the person was not in need of in-patient treatment in a designated centre.

The approach in section 5 of the 2006 Act is in accordance with obligations arising under the European Convention on Human Rights. Article 5(1) (Right to liberty and security) of the ECHR provides that no one shall be deprived of his liberty save in accordance with a procedure prescribed by law, except in a limited number of specified cases, including the lawful detention of persons of unsound mind (paragraph (e)).

ECHR case-law would not permit the automatic detention of a person found not guilty by reason of insanity without evidence that he or she currently had a mental disorder and needed in-patient treatment.

In *Winterwerp v. The Netherlands* [1979] ECHR 4, the leading case on Article 5(1)(e), the European Court of Human Rights stated that an individual cannot be deprived of his liberty as being of “unsound mind” unless the following three minimum conditions are satisfied:

- firstly, he must reliably be shown to be of unsound mind, that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise;
- secondly, the mental disorder must be of a kind or degree warranting compulsory confinement;
- thirdly, the validity of continued confinement depends upon the persistence of such a disorder.

In *Witold Litwa v. Poland* [2000] ECHR 141, the European Court of Human Rights reiterated that a necessary element of the “lawfulness” of the detention within the meaning of Article 5(1)(e) is the absence of arbitrariness. The detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. It does not suffice that the deprivation of liberty is executed in conformity with national law but it must also be necessary in the circumstances.

In *Shtukaturov v. Russia* [2010] ECHR 292, the European Court of Human Rights considered that no deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with Article 5(1)(e) of the Convention if it has been ordered without seeking the opinion of a medical expert. Any other approach falls short of the required protection against arbitrariness inherent in Article 5 of the Convention. The court also took the view that the medical assessment must be based

on the actual state of mental health of the person concerned and not solely on past events. A medical opinion cannot be seen as sufficient to justify deprivation of liberty if a significant period of time has elapsed.

In *O.H. v. Germany* [2011] ECHR 1975, the European Court of Human Rights held that the relevant time at which a person must be reliably established to be of unsound mind, for the requirements of Article 5(1)(e), is the date of the adoption of the measure depriving that person of his liberty as a result of that condition.

The two-stage procedure under section 4 of the 2006 Act (which is similar to that provided for in section 5) was considered by the High Court and Supreme Court in *F.X. v. Clinical Director of the Central Mental Hospital* [2012] IEHC 271, [2014] IESC 1. In that case, the Supreme Court affirmed the judgment of the High Court that the two-stage procedure was a layer of protection added by the Oireachtas for the benefit of an accused person found unfit to be tried and established core protections for vulnerable persons.

The Interdepartmental Group, having considered the matter, does not recommend any change to the two-stage procedure required under section 5 of the 2006 Act before a person found not guilty by reason of insanity can be detained in a designated centre.

***c. The test to be applied by a court in deciding whether to order the detention of a person found not guilty by reason of insanity***

Another issue that has emerged in relation to section 5 of the 2006 Act is whether the references to the Mental Health Act 2001 should be removed from section 5 and that a welfare and safety of the person and public interest test should apply, as provided by section 11 of the 2006 Act in relation to decisions of the Mental Health (Criminal Law) Review Board.

The Interdepartmental Group noted that in determining whether a person is in need of in-patient care or treatment in a designated centre, the likelihood of the person causing serious harm to himself/herself or other persons will be at issue in many cases.

As regards the review of detention under the 2006 Act by the Mental Health (Criminal Law) Review Board, section 11(2) of the Act provides that the Review Board shall “have regard to the welfare and safety of the person whose detention or conditions of discharge it reviews or whose application for unconditional discharge it determines under the Act and to the public interest”.

The Interdepartmental Group is of the view that the question of the test to be applied by a court in deciding whether to order the detention of a person found not guilty by reason of insanity should be pursued further by the Department of Justice and Equality in the context of the review of the Criminal Law (Insanity) Act 2006.

The Group noted that the Report of the Expert Group on the Review of the Mental Health Act 2001, published in March 2015, made a number of recommendations in relation to the definition of mental illness and mental disorder in the 2001 Act and

the criteria that must be satisfied before a person can be involuntarily admitted to an approved centre under that Act.

***d. Options in cases where a person found not guilty by reason of insanity is found not to need in-patient care or treatment in a designated centre***

The Interdepartmental Group noted that section 5 of the 2006 Act does not make any provision to deal with persons found not guilty by reason of insanity who do not require in-patient treatment in a designated centre (the Central Mental Hospital). A court is required to release such a person, even though he or she may have a mental illness that, while not requiring treatment under conditions of special security in a designated centre, could benefit from treatment in a community mental health service. Section 5 does not provide for court powers to order any form of care or treatment other than detention in a designated centre.

Further consideration will need to be given to the question of whether section 5 of the 2006 Act should provide for other options for courts in dealing with persons found not guilty by reason of insanity who may require in-patient psychiatric treatment.

**Recommendations:**

11. The Interdepartmental Group recommends that the question of the test to be applied by a court in deciding whether to order the detention of a person found not guilty by reason of insanity should be pursued further by the Department of Justice and Equality in the context of the review of the Criminal Law (Insanity) Act 2006 and any proposals to change the criteria that must be satisfied before a person can be involuntarily admitted to an approved centre under the Mental Health Act 2001.

12. The Interdepartmental Group recommends that the Department of Justice and Equality, in consultation with the Department of Health, examine the question of amending section 5 of the Criminal Law (Insanity) Act 2006 to provide for options for courts to deal with persons found not guilty by reason of insanity who require in-patient treatment but do not require treatment under conditions of special security in the Central Mental Hospital.

## Chapter 6: Diversion of persons with mental illness who are convicted of offences

There are a number of circumstances where a person with a mental illness may be properly convicted of an offence:

- (a) The person may decide not to enter a plea of not guilty by reason of insanity;
- (b) The person's mental disorder may have been a factor in the alleged crime but was not such to justify a verdict of not guilty by reason of insanity. Section 6 of the 2006 Act provides for a finding of diminished responsibility but only in the case of a charge of murder where it allows for a finding of guilty of manslaughter on the grounds of diminished responsibility.
- (c) The person may have a mental disorder that had nothing to do with the commission of the crime and which may even have arisen after the event.

In cases other than murder, where there is a mandatory sentence of life imprisonment, the courts may take the mental disorder of the offender into account at sentencing as a mitigating factor, but there are no mental disorder specific options open to the courts. In the absence of specific provisions to deal with persons with mental disorders who are convicted of offences, the courts may try to arrange treatment or care using suspended sentences, probation orders or postponement of sentencing or they may impose a prison sentence with a recommendation that the person receives treatment, but these options are basically aspirational.

There may be cases where a person with a mental disorder is properly convicted of a crime and it is not appropriate that the person be at liberty, but imprisonment is not in the best interests of either the individual concerned or society.

While a prisoner can be transferred to the Central Mental Hospital from prison for treatment, there can be difficulties:

- (a) There may be a delay because of lack of space in the Central Mental Hospital (no other psychiatric hospitals are designated to receive prisoners);
- (b) The prisoner may still be in need of in-patient treatment when his or her sentence expires, but must be released from the Central Mental Hospital even though this may not be in the interest of the individual concerned or society;
- (c) If the sentence has not expired, the prisoner has to be returned to prison when his or her mental health improves. Prison is not a therapeutic environment and this can lead to unnecessary relapses;
- (d) The prisoner may have an intellectual disability and require some supervision, but not at the level of security of a prison. Prison may not provide an appropriate environment for such a person.

### **Hospital Orders**



Legislation providing for hospital orders in other common law jurisdictions gives the criminal courts discretion to deal with certain offenders with mental illness by ordering their admission to hospital, rather than sentencing them to imprisonment.

In England and Wales, in addition to the insanity verdict and diminished responsibility, the courts have the following powers in cases where a person is convicted of an offence not carrying a mandatory sentence but punishable by imprisonment:

- the court may order his or her admission to and detention in a hospital. Such an order cannot be made without the prior involvement of the hospital concerned (**section 37** of the Mental Health Act 1983, as amended). The person then effectively becomes a patient under civil law.
- if the court considers it necessary to protect the public from serious harm, it may in addition impose a restriction order (**section 41** of the Mental Health Act 1983, as amended) which makes discharge subject to special provisions. There is no time limit on the length of detention.
- alternatively, the higher courts may order the person's admission to and detention in a hospital with the prior involvement of the hospital concerned and also pass a prison sentence (**section 45A** of the Mental Health Act 1983, as inserted in 1997). If the person recovers, he or she may have to serve the remainder of the prison sentence.

Before any of the above orders can be made, the court must be satisfied, on the evidence of two registered medical practitioners, that the convicted person is suffering from a mental disorder that warrants detention and that treatment is available.

The Commission of Investigation into the death of Gary Douch in its final report in 2014 recommended that consideration be given to the introduction of hospital orders in Ireland, stating that such orders are an important feature of the England and Wales Mental Health Act 1983 and are "universally regarded as a useful and humane option for the courts in dealing with mentally disordered offenders" (recommendation 5.5).

As part of the assessment of the Commission's recommendations, the Interdepartmental Group agreed that the introduction of hospital orders should be given further consideration. The potential advantages of hospital orders include:

- (i) persons who clearly have a mental disorder would not be sent to prison and this would reduce the numbers of persons with mental illness in prison over time;
- (ii) hospital orders would allow for the possible involvement of psychiatric centres other than the Central Mental Hospital on a case-by-case basis with their agreement;
- (iii) hospital orders might reduce the use of the verdict of not guilty by reason of insanity.

If introduced, it would be envisaged that both the convicted person and the Director of Public Prosecutions could avail of appropriate appeal mechanisms where a hospital order is made. A decision would have to be made as whether the power to make hospital orders would be restricted by court type or category of offence.

The Interdepartmental Group is supportive of the introduction of hospital orders, as they would reduce the number of persons with serious mental illness being committed to prison.

However, the Group recognises that the introduction of hospital orders may have potentially significant resource implications and operational issues for the HSE and mental health service providers, and these will need further consideration. However, if hospital orders could only be made by a court following consultation on suitability and availability with the receiving centre, this would mean that demand would be regulated to a large degree.

### **Community Sanctions**

In early 2014, the Government approved the drafting of a Criminal Justice (Community Sanctions) Bill to replace the Probation of Offenders Act 1907 with modern provisions dealing with community sanctions and the role of the Probation Service in the criminal justice system.

The General Scheme of this Bill proposed that in order to facilitate the diversion of persons with mental illness who have committed very minor offences, the courts would be permitted to set conditions relating to psychiatric treatment when making a binding over order (which will replace the conditional discharge provided for in section 1(1)(ii) of the 1907 Act). This would be subject to a requirement for the court to be satisfied on the basis of medical evidence that the offender is in need of psychiatric treatment.

The Interdepartmental Group notes that this proposal will be examined further by the Department of Justice and Equality during the drafting of the Bill in consultation with the Department of Health and the Office of the Attorney General.

#### **Recommendation:**

13. The Interdepartmental Group recommends that the Department of Justice and Equality, in consultation with the Department of Health, bring forward legislation to provide for hospital orders for persons with mental disorders convicted of criminal offences.

## Chapter 7: Issues arising from the UN Convention on the Rights of Persons with Disabilities

The purpose of the United Nations Convention on the Rights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 12.2 (Equal recognition before the law) of the Convention provides that States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

Article 14.1 (Liberty and security of the person) provides that States Parties shall ensure that persons with disabilities, on an equal basis with others:

- a. Enjoy the right to liberty and security of person;
- b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

An important issue raised in a number of submissions received by the Interdepartmental Group was a possible conflict between Irish law and the Convention resulting from the interpretation given to the Convention by the Office of the UN High Commissioner for Human Rights (UNHCHR) in its 2009 Thematic Study on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities.

The UNHCHR Thematic Study suggested that Article 12 of the Convention requires the defence of insanity to be abolished and that the detention of persons without their consent on the grounds that they have a mental disorder is not permissible under Article 14 of the Convention, even if combined with grounds that the person poses a danger to themselves or others or is in need of care or treatment.

Such an interpretation of the Convention would have very significant implications for the powers under the Criminal Law (Insanity) Act 2006 to deal with persons with mental disorders who have or are alleged to have committed criminal offences and, in particular, with the power to involuntarily detain such persons for care and treatment. There would also be significant implications for the involuntary admission provisions of the Mental Health Act 2001.

It was therefore necessary to clarify the position regarding the Convention before the work of the Interdepartmental Group could proceed. Following the receipt of advice from the Attorney General which clarified the legal issues involved in relation to the Convention, the Interdepartmental Group resumed its work in October 2013.

While the OHCHR interpretation has no formal status in relation to the Convention, it appears to have influenced the views of the UN Committee on the Rights of Persons with Disabilities, which is the body of independent experts which monitors implementation of the Convention by the States Parties.

In its General Comment No. 1 (April 2014), the Committee on the Rights of Persons with Disabilities stated that:

“The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention. States parties must refrain from such practices and establish a mechanism to review cases whereby persons with disabilities have been placed in a residential setting without their specific consent.” (paragraph 40)

In a Statement on Article 14 of the Convention on the Rights of Persons with Disabilities (September 2014), the Committee on the Rights of Persons with Disabilities stated the following:

*“1. The absolute prohibition of detention on the basis of disability.* There are still practices in which state parties allow for the deprivation of liberty on the grounds of actual or perceived disability. In this regard the Committee has established that Article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived disability. However, legislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. This practice is incompatible with Article 14 as interpreted by the jurisprudence of the CRPD committee.

*2. Mental health laws that authorize detention of persons with disabilities based on the alleged danger of persons for themselves or for others.* Through all the reviews of state party reports the Committee has established that it is contrary to Article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness tied to disability labels is contrary to the right to liberty. For example, it is wrong to detain someone just because they are diagnosed with paranoid schizophrenia.

*3. Detention of persons unfit to plead in criminal justice systems.* The committee has established that declarations of unfitness to stand trial and the detention of persons based on that declaration is contrary to article 14 of the convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant.”

The Interdepartmental Group considers that the interpretation being given to Articles 12 and 14 of the Convention by the Committee on the Rights of Persons with

Disabilities could cause significant difficulties for the operation of the Criminal Law (Insanity) Act 2006 and the Mental Health Act 2001.

The provisions of the Convention apply to persons with mental illnesses as well as those with intellectual disabilities.

With the exception of pre-trial remand in custody, the Constitution of Ireland does not allow the preventative detention of a person under the criminal law. Other jurisdictions do make provision for such preventative detention in certain circumstances.

If the special verdict of not guilty by reason of insanity was abolished, a person with mental illness who killed another person would either be:

- (a) found guilty of murder or manslaughter, or
- (b) acquitted on the basis that he or she did not have the necessary *mens rea* for the offence.

Neither scenario would be acceptable if the person was not responsible for his or her actions because of the mental illness. Under (a), a person with mental illness would be treated as a criminal, not a patient, and would be subject to a criminal sanction where punishment rather than treatment would be the primary purpose. Under (b), a person who has killed someone and who may pose an immediate threat to the life of others would have to be released with no provision for detention or treatment. Furthermore, the interpretation put on the Convention by the OHCHR and the UN Committee on the Rights of Persons with Disabilities suggests that such persons could not be detained under civil law.

Neither the OHCHR nor the UN Committee on the Rights of Persons with Disabilities has jurisdiction under international law to make definite interpretations of the Convention. If Ireland is to proceed to ratify the Convention, it would have to be made clear that it was being done on the basis of an interpretation of the relevant articles that recognises that a person could not be detained solely because of a mental disorder but would allow that a person could be detained if he or she had a mental disorder and, arising from that mental disorder, the person posed a serious danger to himself/herself or others. This would have to be done in the knowledge that this interpretation may conflict with that of the OHCHR or the UN Committee on the Rights of Persons with Disabilities but on the basis that it is a valid interpretation of the Convention under international law.

**Recommendation:**

14. The Interdepartmental Group recommends that the implications that ratification of the UN Convention on the Rights of Persons with Disabilities may have for the Criminal Law (Insanity) Act 2006 and the Mental Health Act 2001 be carefully considered by the Department of Justice and Equality and the Department of Health.

## APPENDIX 1: Terms of reference of the Interdepartmental Group

Pursuant to the recommendation of the Report of the Thornton Hall Project Group (July 2011) the Cross Sectoral Health/Justice Team is charged by the Minister for Health and the Minister for Justice and Equality with examining issues relating to people with mental illness or a mental disorder interacting with the criminal justice system and its agencies and having regard to Government policy in relation to the delivery and future development of the Forensic Mental Health Services, including the principles which should underpin the delivery of such services as set out in *A Vision for Change* shall endeavour in particular:

(1) to identify the circumstances where such interactions take place, the agencies and services potentially involved and the issues that arise (including interaction with the Gardaí, decisions to prosecute or not to pursue criminal charges, diversion, persons in custody including imprisonment and post custodial arrangements);

(2) to establish if practicable an indication of the annual number of incidents or individuals involved in the different circumstances;

(3) to set out existing practices, background and developments;

(4) to take into account evidence of good practice in other jurisdictions;

(5) to take into account relevant reports and recommendations;

(6) to consult as appropriate;

(7) to consider the circumstances where it might be appropriate to divert people suffering from a mental illness or mental disorder away from the criminal justice system to more appropriate services, how best to achieve this and whether guidelines, principles or statutory provisions should be introduced to facilitate or inform such diversion;

(8) taking into account the resources available and international evidence as to good practice in the field, to consider how best to deliver mental health services to persons properly in the criminal justice system, to facilitate their return in due course to the community and to ensure necessary treatment continues after release

and

(9) to report to and make recommendations to the Minister for Justice and Equality and Minister for Health for consideration by the Government by mid 2012.

## APPENDIX 2: List of organisations and individuals who made submissions to the Interdepartmental Group

Amnesty International

Association for Criminal Justice, Research & Development

Children's Mental Health Coalition

Clinical Nurse Specialist, Prison In-reach/Liaison, North Lee Mental Health Services, HSE South

Human Rights Commission

Irish Advocacy Network

Irish Penal Reform Trust

Irish Youth Justice Service

Jesuit Centre for Faith and Justice

Mental Health Commission

Mental Health (Criminal Law) Review Board

Mental Health Ireland

Mental Health Reform

Dr Eugene Morgan

National Disability Authority

Probation Service