ORIGINAL ARTICLE

THE MANDATORY TREATMENT ORDER – THE EXPERIENCE IN THE FIRST YEAR IN SINGAPORE

Kenneth GWW Koh*, Jimmy Lee**, Stephen Phang, Jerome Goh****

***Department of General and Forensic Psychiatry, Institute of Mental Health Health, Woodbridge Hospital 10 Buangkok View, Singapore 539747; **Department of General Psychiatry 1, Research Division, Institute of Mental Health, Woodbridge Hospital 10 Buangkok View, Singapore 539747; ***Department of General and Forensic Psychiatry, Mandatory Treatment Programme, Institute of Mental Health, Woodbridge Hospital 10 Buangkok View, Singapore 539747.**

Abstract

Objectives*: The Mandatory Treatment Order (MTO) became a sentencing option for select offenders with psychiatric illness in Singapore in 2011. This article aimed to study the psychiatric characteristics of the offenders in the first year of the MTO; *Methods*: A clinical audit was conducted on all the cases referred to the Institute of Mental Health for assessment as to their suitability to receive an MTO from January to December 2011. A psychiatrist went through all the case records. Data on the demographics, forensic history and psychiatric diagnoses were obtained from records; *Results*: There were differences seen between the genders in the likelihood of being granted an MTO. Gender also played a role in the length of MTOs granted and in the diagnoses of the individuals. The reasons for an MTO not being granted are presented. *Conclusion*: Some discussion is made regarding the availability of court diversion legislature in other countries for mentally ill offenders and the directions such diversion might take are highlighted. Potential areas for future research are pointed out. *ASEAN Journal of psychiatry, Vol. 14 (2): July – December 2013: XX XX.

Introduction

The Criminal Procedure Code (2010) was passed by the Parliament of Singapore on 19th May 2010 and assented to by the President on 10th June 2010. It was operationalised on 2 January 2011 and replaced the older Criminal Procedure Code (cap 68). A significant change to the new CPC (2010) was the inclusion of the Mandatory Treatment Order (MTO) as a sentencing option [1]. Court diversion treatment programmes such as this have been operational in countries such as the United States of America, Austria and Australia. To the authors' knowledge, there are no similar schemes for diverting mentally ill offenders from custodial sentences in the region.

Under section 339 of the act, offenders with treatable mental illnesses may now be ordered by the Court to receive compulsory psychiatric treatment instead of a custodial sentence when it is determined that their mental illness is amenable to treatment and has contributed significantly to their offending. Prior to the sentencing, the offender is assessed by a psychiatrist, who is appointed by the Director of Medical Services of Singapore under section 339 (13) of the CPC 2010. As of the end of the study period, there were 43 Appointed

Psychiatrists, all of whom practice at the Institute of Mental Health (IMH), Singapore.

For the purpose of obtaining the report from an Appointed Psychiatrist, the Court may order that an offender (a) be remanded for observation in a psychiatric institution for a period or periods, not exceeding 3 weeks in the case of any single period, or (b) attend at a psychiatric institution for assessment to enable the report to be submitted by the Appointed Psychiatrist.

Upon receipt of a request by the Court for such an assessment, the Appointed Psychiatrist, usually together with a medical social worker and a case manager, examines the accused person to determine if he has a mental illness and if this was significantly contributory to the offence(s). Where this has been satisfied, an assessment is then made as to the treatability of the illness, including the subject's likely compliance to treatment and how significant others may act to aid in adherence to treatment plans and in providing other forms of social support, as needed. When the Appointed Psychiatrist is satisfied that an MTO is viable, he makes a written report to the Court, outlining the management and recommending the duration of the MTO.

The MTO may only apply to certain offences. A court shall not make any MTO in respect of (a) an offence for which the sentence is fixed by law; (b) an offence for which a specified minimum sentence or mandatory minimum sentence of imprisonment or fine or caning is prescribed by law; (c) an offence which is specified in the Third Schedule to the Registration of Criminals Act (Cap. 268); (d) a person who had previously been detained or subject to police supervision under section 30 of the Criminal Law (Temporary Provisions) Act (Cap. 67); (e) an offence which is punishable with a fine only; or (f) an offence which is punishable with a term of imprisonment which exceeds 3 years.

The Court may then impose an MTO not exceeding 24 months. In addition, the Court may also make one or more other community orders, including a day reporting order; a community work order; a community service order; or a short detention order.

An offender in respect of whom a mandatory treatment order is in force shall be required to (a) attend the treatment sessions on such day and time and at such place as the Appointed Psychiatrist may require; (b) comply with such other conditions in connection with his treatment as the appointed psychiatrist may require; and (c) comply with such other conditions which a court may impose. In practice, this usually entails a combination of the adherence to medication (oral and/or depot), regular consultations with the psychiatrist, psychotherapy sessions, family or marital therapy and attendance at occupational rehabilitation. All offenders under the MTO will have a case manager assigned. This case manager tracks the patient by means of phone calls and, at times, house visits. Case managers build rapport with patients, seeking to aid not only in their compliance to appointments and medication, but also in negotiating rehabilitation in the community. Should the offender breach any of the conditions of the MTO, the Appointed Psychiatrist may report this to the Court and the order may be revoked, and a prison sentence imposed.

In this audit, we aimed to study the criminological and psychiatric characteristics of those referred by the Courts for an MTO suitability assessment and those who eventually went on to receive such an order.

Methods

A clinical audit was conducted on all the cases referred to IMH for assessment as to their suitability to receive an MTO in the first year from January to December 2011. A psychiatrist went through all the case records. Data on the demographics, forensic history and psychiatric diagnoses were obtained from records.

Results

One hundred and fourteen cases were referred for assessment in the first year, with 72 (63.2 %) being granted MTOs. The mean age of all cases referred was 40.9 (SD 12.1) years old. There

were no significant differences in the age or ethnic distribution between the group granted and the group denied the MTO. However, there was a significant difference (P = 0.006) in preference of females being granted MTOs. 82.4% of females and 55.0% of males were granted the MTOs. Most MTO cases were dealt with expediently, with the median time from the referral by the Court, to the psychiatrist's assessment, to the decision on the MTO being 28 days (with a range of 6-56 days).

Table 1. Characteristics of offenders granted MTO

	MTO Granted n=72
Age in years	39.7 (9.9)
Gender, n(%)	
Male	44 (61.1)
Female	28 (38.9)
Ethnicity, n(%)	
Chinese	56 (77.8)
Malay	8 (11.1)
Indian	8 (11.1)
Duration of MTO in months, n(%)	
6	2 (2.8)
9	3 (4.2)
12	12 (16.7)
18	2 (2.8)
24	53 (73.6)
Type of current offence, n(%)	
Theft	32 (44.4)
Minor sexual	12 (16.7)
Miscellaneous	22 (30.6)
Violence against persons	11 (15.3)
History of previous convictions, n(%)	42 (58.3)
Contributing Psychiatric Diagnosis, n(%)	
Psychotic illness	30 (41.7)
Depression	23 (31.9)
Bipolar disorder	3 (4.2)
Paraphilia	11 (15.3)
Others*	8 (11.1)
Treatment modalities, n(%)	
Medication	67 (93.1)
Individual Psychotherapy	19 (26.4)
Marital/Family therapy	4 (5.6)
Residential stay	2 (2.8)
Occupational therapy	3 (4.2)

*Three offenders had additional contributing psychiatric diagnoses

Table 1 displays the characteristics of the group granted MTOs. MTOs granted ranged from 6 months to the maximum allowable duration of 24 months. Fifty-three (73.6%) subjects received the maximal duration (see table 1). Eleven (15.3%) of the 72 granted MTOs had never seen a psychiatrist before. Thirteen (18.1%) of the group granted MTOs had a co-morbid psychiatric diagnosis.

There were gender differences observed in MTOs granted (Table 2). Males were significantly more likely to receive a MTO with a longer duration (p = 0.029). Minor sexual offences were only committed by males. Twenty-one (75.0%) out of the 28 females committed theft. Most of the females granted MTO (60.7%) suffered from depression, whilst the commonest psychiatric diagnosis in the male group was psychotic illnesses (52.3%). Medication was the mainstay of treatment for most of the MTO recipients, with 93.1% (n = 67) being on pharmacotherapy. Nineteen patients were also referred for psychotherapy.

Table 2. Gender differences amongst offenders granted the MTO

	Male N=44	Female N=28	*p*- value
Duration of MTO in months, n(%)			0.029
6	2 (4.5)	0	
9	0	3 (10.7)	
12	6 (13.6)	6 (21.4)	
18	0	2 (7.1)	
24	36 (81.8)	17 (60.7)	
Type of offence, n(%)			
Theft	11 (25)	21 (75)	<0.001
Minor sexual offences	12 (27.3)	0	0.002
Violent offences against persons	9 (20.5)	2 (7.1)	0.182
Miscellaneous minor offences	16 (36.4)	6 (21.4)	0.202
Offenders with previous convictions, n(%)	26 (59.1)	16 (57.1)	0.870
Contributing psychiatric diagnosis, n(%)			< 0.001
Psychotic illness	23 (52.3)	7 (25.0)	
Depression	6 (13.6)	17 (60.7)	
Bipolar disorder	3 (6.8)	0	
Paraphilia	11 (25.0)	0	
Others	1 (2.3)	4 (14.3)	

The reasons for the 42 not granted MTO were noted. Five (11.9%) did not suffer from a mental illness. Twelve (28.6%) had a mental illness that was assessed to be not linked to the offence. Sixteen (38.1%) had a mental illness that was assessed to be untreatable. Sixteen (38.1%) had inadequate social support, and 16 (38.1%) were assessed to be unlikely to comply with the requirements of the MTO. Some offenders had multiple reasons for their being found unsuitable.

Discussion

Some interesting trends were seen in this audit. Males were more likely to get longer MTOs than females. When we explored the duration of MTOs by psychiatric diagnoses, we found that 27 out of 30 (90%) with psychotic illnesses, and all of those with bipolar disorders received the maximum 24 months MTO duration. Three in four with a diagnosis of psychotic illness, and all patients with bipolar disorder in this sample were males. Therefore, it would not be surprising to find that males had longer MTO durations. Psychotic illnesses and bipolar disorders tend to be more chronic and debilitating than depressive disorders and generally require lifelong treatment [2]. The assessing psychiatrists are therefore more likely to recommend the maximal MTO duration for cases with psychotic and bipolar disorders so that these receive the longest possible period of compelled treatment, without which compulsion they would be more prone to default, relapse and then potentially offend again.

When we further explored the duration of MTO by type of offence, we found that almost all convicted of violent offences against persons and the majority of sexual offenders were also given the maximum MTO duration. Table 2 revealed that males formed the majority of violent offenders and all sexual offences were committed by males. Therefore, we posit that males received longer MTOs based on their psychiatric diagnoses and offences committed.

Although we found that females were more likely to be granted MTOs compared to males, the small sample of 6 females limited our ability to draw properly meaningful conclusions. This finding therefore should be interpreted with caution. Literature has shown, however, that females with psychotic illnesses are less likely to deteriorate socially as much as males, as they more frequently continue to reside with their families of origin and therefore have more social support [2,3]. Female psychotic patients are therefore more likely to receive an MTO as they would be less likely to be found to be lacking in social support or be deemed unlikely to comply with MTO requirements.

The law in Singapore has long recognized that prison sentences are not always the most appropriate means of dealing with certain groups of offenders. Youth offenders, for instance, have long had access to probation as a form of alternate sentencing. The past few years have seen an even greater awareness of the necessity to establish specialist courts to deal with special groups of offenders, including mentally ill individuals. To that effect, the Community Court was established in 2006 to manage (a) youthful offenders (aged 16 to 18); (b) offenders with mental disabilities; (c) neighborhood disputes; (d) attempted suicide cases; (e) family violence cases; (f) carnal connection offences committed by youthful offenders; (g) abuse and cruelty to animals; and (h) cases which impact on race relations issues [4].

In Singapore, The Honorable the Chief Justice Chan Sek Keong, in his keynote address at the 2011 Subordinate Courts Workplan, announced new directions in the treatment of certain categories of offenders. Mandatory Treatment Orders, among other community sentences were means to calibrate the punishments to fit the crime and the offender. These took into account the nature and gravity of the offence, and the character of the offender, having regard to his age and/or mental capacity. In the Chief Justice's words, "this gave life to a principle of criminal justice that is more humane, therapeutic, beneficial, humanistic, healing, restorative, curative, collaborative and comprehensive [5]."

Special legal regulation governing mentally disordered prisoners is not a new phenomenon, having been the practice in many countries for decades in some instances [6]. Mental Health Courts are now widespread across the United States as a form of diversion for justice-involved individuals with mental illness [7]. In Australia, methods of diversion include magistrates courts diversion programmes, psychiatric court liaison services and legislative powers of diversion [8].

Ongoing research into the efficacy of court diversion programmes is crucial. Knowing the profiles of offenders who are most likely to comply with court directives can aid assessors in making more informed recommendations regarding court diversion and thereby allow for resources to be most appropriately allocated.

At the moment, in Singapore, court diversion in the form of an MTO, only takes place after there has been a conviction. In other countries, where court diversion is more established, pre-trial diversion is sometimes employed. Some jurisdictions in the United States train Specialty Police Units to channel persons with mental illness out of the criminal justice system and into mental health treatment [9]. In Canada, prosecutors may use their discretion to drop criminal proceedings against mentally disordered persons on the condition that such persons be certified and detained for treatment in a hospital setting [10]. As Singapore evolves and improves its legislature, such pre-trial diversion may become a viable alternative too.

Conclusion

The present audit looked at the characteristics of those who received MTOs in Singapore in the

first year since its inception. A more thorough evaluation of the success of the programme is not fully possible yet, given its early days. Nonetheless, certain patterns in those who were recommended MTOs are already emerging, for instance in terms of their gender, psychiatric diagnoses and durations of MTOs. This information may help subsequent assessors in their determination as to the suitability of persons to receive an MTO and how long to recommend that the MTO should run. Subsequent audits should look at relapse and recidivism rates of individuals on a longer term during and after completion of their MTOs and also at the characteristics of those who breach their orders.

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Correspondence author: ***Dr Kenneth GWW Koh, Institute of Mental Health, Woodbridge Hospital 10 Buangkok View, Singapore 539747.***

Email: kenneth_koh@imh.com.sg

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