Submission to NSW Law Reform Commission

Regarding Consultation Papers 5 & 6

'People with cognitive and mental health impairments in the criminal justice system: an overview'

Submission based on findings of the "People with Mental Health Disorders and Cognitive Disability (MHDCD) in the Criminal Justice System in NSW", an ARC Linkage grant (2007-2009), Chief Investigators A/Professor Eileen Baldry, Dr Leanne Dowse, Emeritus Professor Ian Webster, PhD scholar Phillip Snoyman

Contact: Eileen Baldry: 93851878; e.baldry@unsw.edu.au

One matter not covered by this legislation is that of complex needs: those people who have both MD and ID who come into contact with the CJS. The MHDCD project is analysing detailed data on the pathways of a large number of people who have been in prison, drawn from the 2001 inmate health survey and the DCS statewide disability services database. The project has gathered information on these 2,731 persons from every criminal justice agency and most human service agencies to allow the creation of pathways into and through the criminal justice system for persons with these disabilities.

Analysis has revealed that of those in the cohort with intellectual disability (below 70 IQ) and borderline ID (70-80 IQ), all in all 1600 / 2731 two thirds have multiple diagnoses. See attached background paper.

Acronyms
PWMD – People with mental disorder
PWID – People with Intellectual Disability
PWCD – People with Cognitive Disability

Issue 5.1 – Should a broad umbrella definition of mental health impairment, incorporating mental illness and cognitive impairment, be included in the MHFPA? What practical impact would this have?
The project research indicates that there is not a direct fit between mental health and cognitive and DSM IV diagnoses. The situation is more complex, both in terms of the individual diagnoses themselves and in the instances where they co-occur. In particular dual diagnoses or comorbid diagnoses are not simply the presence of two conditions, but rather their combination creates an additional level of complexity that requires attention in its own right. Reducing the categories either separately or in combination to a broad definition of mental health impairment will potentially conflate further obscure both the obvious and subtleties of the different groupings and their cumulative and complex interactions. The adoption of an umbrella definition runs the risk of returning to conceptualisations abandoned in Australia in the 1920s, when the first distinctions were drawn between mental illness and intellectual

disability. Since that time service systems and interventions for disability and mental health have developed along very different trajectories. Returning to an umbrella category is likely to have its most significant practical impact in the area of development and delivery of options for intervention and management. Reducing to a single category implies at least some homogeneity in the group, which would appear to directly counter the findings of the MHCDC study and to the broader literature in the field. Even at the most basic level people with intellectual disability (PWID) are recognised to have a developmental disorder which affects areas of learning and adaptive functioning. Service responses generally consider the range of supports, potentially including skills training, the provision of accessible information to support cognitive access to information and external supports to promote adaptive functioning. People with mental disorder (PWMD) are very different, with service responses including pharmacotherapies, psychological and other external supports. In addition to these two broad categorical differences there exists a range of other impairment types that would potentially also be subsumed into an umbrella category including borderline intellectual disability, Acquired Brain Injury, dementias, autism spectrum disorders, borderline personality disorder etc – all of which have unique presenting profiles, support needs and intervention strategies. Conflating all very these different presentations potentially obscures the need for specific and tailored service and support options. A multi-axial consideration of different "groups" is preferable, with consideration of the medical, psychological and social aspects of each.

Issue 5.2 – If an umbrella definition were to be adopted, would it be appropriate to state that mental impairment includes a mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired?

The implication that the full range of mental health and cognitive disabilities be included is welcome but as noted above, the suggestion of using one term would be confusing and detrimental. An Intellectual disability is not a mental impairment. And the negative synergistic effects of having both mental health disorder and cognitive disability would not be well addressed were they to be subsumed in a broad definition.

Issue 5.3 – Should the term "mental illness" as used in part 4 of the MHFPA be replaced with the term "mental impairment"?

No

The focus would then be on the impairment only, and the context in which the impairment manifests is ignored. This locates the problem within the individual only, and removes any responsibility from the broader society. The "disabling" context is removed.

Issue 5.4 – Should the MHFPA continue to refer to the terms "mental condition" and "developmentally disabled"? If so, in what way could the terms be recast?

No

The term "developmentally disabled" is largely used in the North American context to denote an impairment which occurs before the age of 18 years and

which includes both physical (eg. cerebral palsy) and/or cognitive impairment. In this sense it denotes a broader group than is of interest to MHFPA. Usage in Australia also varies widely across jurisdictions and institutions and as such it is a contested and multi-variate term that introduces additional and unwarranted confusion. The term 'mental condition' is also rather indeterminate however the inclusion of 'mental' in broad usage generally denotes psychiatric or psychological involvement rather than a 'cognitive' focus. The delineation of mental/psychiatric/psychological from cognitive/intellectual is in practice (see above) likely to more clearly reflect the differing impairment groups which are the focus of the legislation. It is suggested that referring to "people with intellectual/cognitive disability", or "PWMD" is more in keeping with contemporary social norms as it shifts the emphasis to the whole person and the social context rather than just the impairment.

Issue 5.5 – Alternatively, should the MHFPA include a definition of cognitive impairment or disability? If so, should that definition be 'a significant disability in comprehension, reason, judgment, learning or memory, that is the result of any damage to, or disorder, developmental delay, impairment or deterioration of, the brain or mind'?

The problem with any of the 'new' definitions is in operationalising the concepts – how are they going to be uniformly defined, measured and applied. The use of the term 'cognitive' is broadly encompassing of intellectual and other functions as outlined in the proposed definition above. Regarding the use of the terms 'impairment' and 'disability', in contemporary disability studies the now widely accepted 'social model of disability' delineates between the bodily 'impairment' and the social consequence/experience of that impairment referred to as the 'disability'. In keeping with this it is suggested that 'cognitive impairment' be the preferred usage and the word disability reserved for usage in "person with a cognitive disability".

Issue 5.6 – Should the MHFPA be amended to create a general power of the court to order an assessment of an offender at any stage during proceedings? If so:
(a) Who should conduct the assessment?
(b) What should an assessment report contain?
(c) Should any restrictions be placed on how the information contained in an assessment report should be used?

a) While not specifically examined by the MHDCD project to date, the issue of assessment appears very complex.
For PWCD the Dept of Corrective Services Statewide Disability Service database indicates that assessment results can vary significantly over time, likely as a result of being under stress or not motivated, or where there are secondary gains for low scores). Therefore scores can vary quite substantially on different testings. The type of assessment also varies and impacts results. Nevertheless the assessments should be conducted by psychologists with experience with PWCD including dual and comorbid issues.
For PWMD, the disorder may be present at some times, but not others. A

psychiatrist is the best person to make a diagnosis, although people familiar with instruments such as CIDI could be used.
b) The assessment report should not be only based on an assessment done around the time of contact with the CJS. It should contain historical information that confirms (or contradicts) the assessment. For PWCD, school records containing psychological assessments can confirm that the level of functioning has always been low (i.e. they fit with age of onset prior to age 18). For ABI, medical and hospital records can confirm onset and impact. Some sort of functional assessment is also required. Social information about the use of illicit substances and their impact on the individual would also be useful. All these are time consuming – this may impact on length of the court proceedings unless data linkage occurs across agencies. Pathways and trajectories through the CJS are important aspects of the report.
c) Information should be used to make decisions about best management of the individual – access to services, treatments and history are used by the Court to make these decisions.

Submission regarding NSW Law Reform Commission – Consultation Paper 6

'People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences'

Issue 6.1 – Should the MHFPA expressly require the court to consider the issue of fitness whenever it appears that the accused person may be unfit to be tried?
Research from the project indicates that PWCD and MD cycle through the system often and rapidly. The type of offence contributes to their presence in the CJS. Fitness should not be considered in all cases – rather the historical pathways the person has followed through the CJS should inform the Courts. The research shows S32 is underused, and this should be considered rather than fitness on more occasions.
Issue 6.30 – Should a defendant's self-induced intoxication or withdrawal from an intoxicant be able to form a basis for claiming that the defendant is not guilty of a charge by reason of mental illness and, if so, in what circumstances?
The project has shown that people with complex needs and comorbidity have more contact with the CJS. The effect of the self-induced intoxication needs to be considered in terms of Court options –i.e. mandatory or voluntary treatment for substance use as part of a pathway out of offending. It should not form a basis for claiming that the defendant is not guilty of a charge by reason of mental illness.
Issue 6.34 – Should the court have the power to order an assessment of the defendant for the purposes of determining whether he or she is

entitled to a defence of mental illness?
Yes – but in a holistic manner as described above.

Submission regarding NSW Law Reform Commission – Consultation Paper 7

'People with cognitive and mental health impairments in the criminal justice system: diversion'

Issue 7.1 – **(1) Should a legislative scheme be established for police to deal with offenders with a cognitive impairment or mental illness by way of a caution or a warning in certain circumstances?** **(2) If so, what circumstances should attract the application of a scheme like this? For example, should the scheme only apply to certain types of offences or only to offenders with certain defined forms or mental illness of cognitive impairment?**
We need more information about the pathways to answer this question. The police are the gatekeepers – they at present treat all people who offend in the same ways (Snoyman's PhD thesis provides evidence of this). If this was to occur, this would require a whole new approach to policing, and would need to consider public and police safety as well as impact on the person with ID &/or MD. It would need new police policy and procedures in addition to legislative changes. Placing responsibility on police is not sufficient – it would require interagency co-operation in that Health would need to create 'beds' for PWMD, and ADHC would need services and supports for PWCD. Systemic change is required in addition to legislative change.
Issue 7.2 – Could a formalised scheme for cautions and warnings to deal with offenders with a cognitive impairment or mental illness operate effectively in practice? For example, how would the police identify whether an offender was eligible for the scheme?
As the research show that PWMDCD cycle through the system frequently, much of the information about their MD or CD is known. One solution is to require this information to appear on COPS database (that person has ID or history of MD) and this plays a role in Police identification.
Issue 7.4 – Should the police have an express, legislative power to take a person to hospital and/or an appropriate social service if that person appears to have a cognitive impairment, just as they can refer a mentally ill or mentally disturbed person to a mental health facility according to s22 of the MHA?
Yes, but see 7.1 above
Issue 7.5 – Do the existing practices and policies of the Police and the DPP give enough emphasis to the importance of diverting people with a mental illness or cognitive impairment away from the criminal justice system when exercising discretion to prosecute or charge an alleged offender?
No. The police practices focus on public safety and equitable treatment for all

offenders, and not on the offender or disabilities. This would need systemic changes (see 7.1 above)
Issue 7.6 – Do provisions in the Bail Act 1978 (NSW) setting out the conditions for the grant of bail make it harder for a person with a mental illness or cognitive impairment to be granted bail than other alleged offenders?
Yes. The project shows that people with comorbid/multiple diagnoses are significantly more likely to be remanded in custody than those with single or without a diagnosis. People with these disabilities find it much harder to meet bail conditions, have far fewer options for support and accommodation and are more likely to have a history of incarceration and breaching, often because they are unable to meet the conditions due to their disability. The impact of remand for PWCD and MD is to add to their already chaotic lives. They do not appear to receive services whilst on remand or when released so remand has a negative impact cementing them further into a criminal justice culture and living space.
Issue 7.8 – What education and training would assist police in using their powers to divert offenders with a mental illness or cognitive impairment away from the criminal justice system?
This would require new policy and procedures and changes on the level of attitude rather than skills training for identification of PWID and PWCD (Snoyman PhD thesis).
Issue 7.9 – **(1) Should the term "developmentally disabled" in s32(1)(a)(i) of the MHFPA be defined?** **(2) Should "developmentally disabled" include people with an intellectual disability, as well as people with a cognitive impairment acquired in adulthood and people with disabilities affecting behaviour, such as autism and ADHD? Should the legislation use distinct terms to refer to these groups separately?**
PW Borderline cognitive functioning should be included in the definition – referred to as having cognitive impairment. The complex needs and presentation should also be included under S32
Issue 7.10 – Is it preferable for s32 of the MHFPA to refer to a defendant "with a developmental disability" rather than to a defendant who is "developmentally disabled"?
Person with a cognitive impairment
Issue 7.11 – Should the term "mental illness" in s32(1)(a)(ii) of the NHFPA be defined in the legislation?
Yes
Issue 7.13 –

(1) Should the requirement in s32(1)(a)(iii) of the MHFPA for a mental condition "for which treatment is available in a mental health facility" be changed to "for which treatment is available"? **(2) Should the legislation make is clear that treatment is not limited to services aimed at curing a condition but can include social services programs aimed at providing various life skills and support?**
1. Yes. Service provision should not be limited to mental health facility
Issue 7.15 – What would be a suitable general term to determine eligibility for a s32 order under the MHFPA? For example, should s32 apply to a person who suffers from a "mental impairment"? How would a term such as "mental impairment" be defined? For example, should it be defined according to an inclusive or exhaustive list of conditions?
Broader definition including PWBID, ID, MD, ABI, and comorbid and dual diagnoses (discussed above)
Issue 7.16 – Are there specific condition that should be expressly excluded from the definition "mental impairment", or any other term that is preferred as a general term to determine eligibility under s32 of the MHFPA? For example, should conditions related to drug or alcohol use or abuse be excluded? Should personality disorders be excluded?
Personality disorder should be excluded. ADHD excluded as it is not defined for adults.
Issue 7.17 – Should a magistrate take account of the seriousness of the offence when deciding whether or not to divert a defendant according to s32 of the MHFPA? Why or why not?
Pathway through CJS should be considered, including frequency of contact, supports available in the community, and whether the offending is escalating in terms of seriousness or the same offence is repeated. S32 should be used more extensively and community and human service agencies obliged to provide services and supports for those with complex needs.
Issue 7.18 – Should the decision to divert a defendant according to s32 of the MHFPA depend upon a direct causal connection between the offence and the defendant's developmental disability, mental illness, or mental condition?
Not only the individual, but the broader disabling impacts too
Issue 7.19 – Should the decision whether or not to divert a defendant according to s32 of the MHFPA take into account the sentence that is likely to be imposed on the defendant is he or she is convicted?
Project is showing that much offending behaviour is criminalising for PWMDCD. For example Justice offences are creating a cycle of contact with CJS, motor traffic offences could be dealt with differently – evidence from the MHDCD project indicates a prison sentence does nothing to change this behaviour. In fact a time spent in prison whether sentenced or unsentenced, does the opposite for persons with MHDCD – they become set in a criminal justice cycle from an early age.

Issue 7.25 – Should s23(3) of the MHFPA include a requirement for the court to consider the person or agency that is to implement the proposed order and whether that person or agency is capable of implementing it? Should the legislation provide for any means of compelling a person or agency to implement an order that it has committed to implementing?
Yes and yes
Issue 7.28 – Should there be provision in s32 of the MHFPA for the Local Court or the Mental Health Review Tribunal to adjust conditions attached to a s32(3) order if a defendant has failed to comply with the order?
Yes but recognising that in many such cases the disability / support service / case manager will be the key to the client complying
Issue 7.30 – Should the MHFPA clarify the role and obligations of the Probation and Parole Service with respect to supervising compliance with/an reporting on breaches of orders made under s32(3)? What should these obligations be?
The obligation should be to assist the client to meet the terms of the S32 order given that the client will inevitably have difficulty with some aspects of reporting and compliance by virtue of their disability.
Issue 7.33 – (1) Should the MHFPA expressly require the submission of certain reports, such as a psychological or psychiatric report and a case plan to support an application for an order under s32? (2) Should the Act spell out the information that should be included within these reports? If so, what are the key types of information that they should contain?
It is clear from the MHDCD research that pathways and context need to be included in submissions along with psychological or psychiatric reports
Issue 7.35 – (1) Should there be alternative ways of hearing s32 applications under the MHFPA rather than through the traditional adversarial court procedures? For example, should there be opportunity to use a conferencing-based system either to replace or enhance the current court procedures? (2) If so, should these alternative models be provided for in the legislation or should they be left to administrative arrangement?
No need include in the legislation A number of different ways of arranging S32 hearings should be trialled and evaluation in a number of different court settings – conferencing, use of special list days etc. Courts administration should be advised of what approaches worked well and what didn't and those that worked in particular settings could be instituted.

Issue 7.36 – Should s33 of the MHFPA require a causal connection between the defendant's mental illness and the alleged commission of the offence?

No.

Issue 7.42 –

(1) Should there be a statement of principles included in legislation to assist in the interpretation and application of diversionary powers concerning offenders with a mental illness or cognitive impairment?

(2) If so, what should this statement of principles include?

Yes

Amongst other things the principle that human and social services be obliged to provide appropriate disability services and supports for those diverted.

If this not ensured diversion is no more than a delay for imprisonment as evidenced in many evaluations of diversion programs.