**Consultation Paper 5**

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

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**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?**

CSNSW supports this proposition for the reasons set out in paragraph 4.45 of the paper. Such a definition would cover a range of conditions that in the experience of CSNSW affect the nature and degree of criminal responsibility and is not limited by reference to how and when the impairment was caused.

CSNSW notes however that an unintended consequence of this might be to compound the already persistent confusion regarding the differences between these types of disabilities and the appropriate intervention and support required for each condition.

CSNSW also notes that availability of supports, responses and treatments across the range of impairments varies greatly. This variation could result in problematical and inequitable options in terms of criminal justice and health and community responses to people falling under the definitions.

CSNSW notes also that it may be difficult to apply an objective definition to the term 'impairment'. Whereas a condition or a might be diagnosed and defined, the subjective nature of impairment does not provide for this as "impairment related experiences are unique to the individual; often people with very similar conditions experience them in very different ways"[1]. It may be then that the level of impairment experienced by the individual will also be of relevance.

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[1] Deal M *Attitudes of Disabled People Toward Other Disabled People* (Enham Research Project) http://www.enham.org.uk/data/files/05_chapter_2.doc

**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?**

CSNSW supports this definition. A limitation of the Act in its current form is the use of the term "developmentally disabled". This term essentially limits the use of the provisions of the Act to those individuals who have a disability that was evident prior to the age of eighteen years. The restrictive nature of this term excludes individuals with a brain injury that was acquired in adulthood or low cognitive functioning that did not present until after the developmental period. The age of onset in these cases is not indicative of the impact the condition has on the individual and therefore should not be a cause to deny an individual access to diversionary measures where there is clearly a need for an alternative method of disposal of a matter that will more appropriately address the needs of the individual.

A further problem with the developmental disability concept is that it is often difficult and time consuming to seek historical evidence of the onset of the disability in persons who are often living chaotic lifestyles with limited contact with families of origin and whose personal records are often sparse.

The inclusion of personality disorder in the definition could also be problematical due to the number of different types of personality disorder and the frequency with which such a diagnosis might be made in an offending population – especially if anti-social personality disorder was included. However CSNSW is of the view that inclusion of Personality Disorder is appropriate with some provisos. According to the *Diagnostic and Statistical Manual of Mental Disorders* Fourth Edition (DSMIV) an essential feature of a Personality Disorder is "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of an individual's culture and is manifested in at least two of the following areas: cognition, affectivity; interpersonal functioning, or impulse control". As such the diagnosis could well include a class of people with a disorder that affects the nature and degree of criminal responsibility. However due to the range of manifestations of such a disorder CSNSW recommends that where personality disorder is included in the definition it is with the proviso that discretion is available as to its relevance and the appropriateness of it providing a reason for an alternative course of action (as in s.32(b) MHFPA). This latter consideration is particularly relevant in the case of anti-social personality disorder which frequently manifests in criminal behaviour.

**Issue 5.3**

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

CSNSW supports the use of the term mental impairment in Part 4 of the MHFPA for the reason discussed in paragraphs 4.50 and 4.51 of Paper 5.

However, as discussed in respect of issue 5.1, there are difficulties in using the term impairment in reference to a range of clinical diagnoses due to the subjective nature of impairment.

**Issue 5.4**

**Should the MHFPA continue to use the terms "mental condition" and "developmentally disabled"? If so, in what way could the terms be recast?**

CSNSW does not support the continued use of the terms 'mental condition' or developmentally disabled within the *Mental Health (Forensic Provisions) Act* for the reasons stated in paragraphs 4.53.

In addition the term "developmentally disabled" is an outdated term that does not reflect appropriate terminology to be employed when speaking about people with a disability. The correct practice is to place emphasis on the person rather than the disability, which is secondary. As such, while the term "developmental disability" can be used to describe a condition pertaining to a diagnosis such as Down's syndrome or cerebral palsy, stating that a person with one of those conditions is "developmentally disabled" could cause offence.

However, it is not simply the manner in which the term is presented that makes its inclusion in the Act inappropriate. Even if the term were to be recast as "developmental disability", as stated earlier that term has a specific meaning and would restrict access to people who were not identified as having a recognised disability during the developmental period.

**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"?**

CSNSW agrees that the terms "cognitive impairment" or "cognitive disability" are preferable and agrees with the stated definition, whilst having some concerns about the broadness of this definition. This is particularly because, as noted in relation to Issue 5.1, the availability of supports, responses and

treatments across the range of impairments varies greatly. This variation could result in problematical and inequitable options in terms of criminal justice and health and community responses to people falling under the definition.

**Issue 5.6**

**Should the MHFPS 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 be used?**

CSNSW believes that there is a strong need for the court to be able to order a diagnostic assessment during proceedings and supports the proposal to vest a specific power in the court to do so in relation to matters under the *Mental Health (Forensic Provisions) Act*.

In ordering such assessments, the following must be taken into account:

(a) In respect of cognitive impairments other than a mental illness, the assessment must be conducted by a qualified psychologist. Assessment of possible brain injury falls most appropriately within the expertise of a neuropsychologist. Assessment of an intellectual disability and brain injury does not come within the expertise of psychiatrists.

(b) The information contained within the report should be that information that is generally considered appropriate to include in any such report detailing diagnostic assessment, including the elements of clinical diagnosis, level of functioning and relevant historical background. In addition, if the court wishes the assessment to cover the risk of reoffending and associated clinical recommendations, this information should also be addressed within the report.

(c) With specific reference to intellectual disability, any assessment should include not only testing of intellectual functioning, but adaptive functioning (where possible). All reasonable steps should be taken to ascertain whether the offender has been tested within the previous two years. If they have been tested, the 'practice effect' could result in any testing for court purposes may be invalid and therefore may not provide accurate information regarding the offender's level of functioning. Furthermore, historical reports should be obtained to determine the age of onset for adult offenders, or history of functioning for juvenile offenders. The inclusion of this information would enable an accurate diagnosis of intellectual disability to be made and where the clinical criteria cannot be met, to indicate whether the offender is functioning in

the range of intellectual disability. Although the diagnosis of intellectual disability may not be required to utilise the provisions within the *Act*, it does impact on the type of services that can be accessed by the offender e.g. Ageing Disability and Home Care (ADHC) or Non Government Agencies, and will assist in better management of the offender by criminal justice agencies.

(d) Any assessment ordered by the court should be specifically requested for the purpose of the matter before the court. However, the information contained in the assessment report needs to be shared with other agencies as required to ensure that current and accurate information is available.

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**Consultation Paper 6**

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

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**Issue 6.2**

**Do the *Presser* standards remain relevant and sufficient criteria for determining a defendant's fitness for trail?**

Issues relating to fitness for trial are outside the expertise of CSNSW. However as the employer of large number of psychologists working with offenders it is relevant to note that assessment of the extent to which a cognitive impairment would prevent person from meeting the *Presser* standard would normally be considered the role of a psychologist, not a psychiatrist as mentioned in paragraph 1.10.

**Issue 6.21**

**Should legislation expressly recognise cognitive impairment as a basis for acquitting a defendant in criminal proceedings?**

**If yes, should the legislation expressly include cognitive impairment as a condition coming within the scope of the defence of mental illness, or is it preferable that a separate defence of cognitive impairment be formulated as a ground for acquittal?**

CSNSW supports the recognition of severe and profound cognitive impairment as a basis for acquitting a defendant in criminal proceedings.

If the LRC were to recommend such a defence applying to "cognitive impairment", CSNSW believes that the defence should be separate from the

defence of mental illness in recognition of the differences between psychiatric disorders and other cognitive impairments.

CSNSW notes however that because cognitive impairments such as senility, acquired brain injury and developmental delay are not liable to remediation by treatment, the disposition of a matter in which the accused is acquitted due to such impairment presents difficulties that are not encountered in the case of treatable mental illnesses.

**Issue 6.22**

**Should the defence of mental illness be available to defendants with a personality disorder, in particular those demonstrating an inability to feel empathy with others?**

As noted in response to Issue 5.2 above, whilst the inclusion of Personality Disorder as a category of mental illness is warranted the range of severity and manifestation of the illness does raise issues about the appropriateness of it providing for a course of action that is different from that pertaining to crime generally. This is particularly the case with anti-social personality disorders a symptom of which is often an inability to feel empathy with others. CSNSW does not support this being available as other than a threshold test that would be subject to testing of its extent ant the appropriateness of an alternative disposition. .

**Issue 6.37**
**If the umbrella definition of cognitive and mental impairment suggested in Consultation 5, Issue 5.2, were to be adopted, should it also apply to the partial defence of substantial impairment.**

CSNSW supports the application of the umbrella definition to the partial defence of substantial impairment and notes that as stated in paragraph 4.34 such a test is a threshold test only. A defendant would still need to demonstrate that the impairment was such that it diminished criminal responsibility.

**Issue 6.52**

**What orders should result in a person becoming a "forensic patient"?**

CSNSW does not have any views regarding what orders should result in a person becoming a "forensic patient", but requests that the LRC consider recommending alternative terminology to denote people with a cognitive impairment who are deemed to be UNA, or deemed not guilty due to cognitive impairment if such a defence is introduced, to clearly distinguish between the different diagnoses.

Whilst as indicated in paragraphs 6.46 and 6.47 there are benefits for people who are UNA being classified as "forensic patients" and thereby being accorded access to the current procedures available for those patients CSNSW is concerned that it would amplify the current misperception that all such patients have a mental illness. The use of the term "forensic patient" for all offenders who fall under the relevant provisions of the *Act* often causes confusion, as the predominant view is that all "forensic patients" are people with a diagnosed psychiatric disorder. The practical result of this is that in considering what treatment, resources and services should be available for this group there is a focus on those that are suitable for people with mental illness and a lack of focus on what is required for people with cognitive impairment.

**Issue 6.53**

**To what extent (if any) should the court take into account a risk of harm to the person him – or her – self, as distinct from the risk (if any) to other members of the community?**

CSNSW notes that whilst paragraph 6.58 states that "forensic patients in NSW are generally detained in prison" this situation is being remedied to some extent through the operation of the Forensic Hospital. Nevertheless, CSNSW submits that the risk of harm an offender poses to other members of the community should be distinct from the risk of self harm. The criminal justice system is not designed to address the latter circumstance.

Where the risk of harm to the person is a consequence of a severe or profound intellectual impairment[2], such issues should never result in a criminal sanction as a method of addressing this risk.

**Issue 6.54**

**Should a court be provided with a power to refer a person to the civil jurisdiction of the MHRT, or to another appropriate agency, if the person poses a risk of harm to no-one but him or her self?**

This provision provides a 'safety net' if the self harm reference were removed from s.39 (2) MHFPA. As such CSNSW supports the provision which appears to be consistent with the developing 'therapeutic jurisprudence' remit of courts in NSW.

[2] A severe or profound intellectual disability is diagnosed where a person's intellectual functioning is scored at below 35-40 on a recognised psychometric test.

**Issue 6.55**

**What kind of possible "harm" should be relevant to decisions by the court to detain or release persons who are UNA or NGMI?**

CSNSW believes that the types of "harm" that should be relevant to decisions by the court to detain or release persons who are UNA or NGMI should focus on risk to the community and include:

- Risk of physical harm to a member or members of the community
- Risk of severe psychological harm to a member or members of the community

This limited focus is further justified by reference to s. 39 MHFPA which as outlined in paragraph 6.71 requires a court to order the detention of a person who is NGMI unless it is positively established that it is sate to release the person.

**Issue 6.65**

**What powers or procedures (if any) should be provided to assist the court in determining the appropriate order in cases where the person is UNA or NGMI? and:**

**Issue 6.66**

**Should legislation provide a mechanism for the court to notify the MHRT of its final order in cases where the person UNA or NGMI?**

CSNSW has no comment to make in relation to these questions with respect to non custodial orders. However where the court makes a custodial order CSNSW is of the view that the provisions of s.77 MHFPA need to remain in force to ensure that the Commissioner of Corrective Services is able to detain a person in any correctional centre even if a court designates a particular correctional centre. This remains necessary for matters of safety and good order of correctional centres.

**Issue 6.77**

**Should legislation provide specific roles for an agency or agencies in relation to supporting and supervising forensic patients in the community?**

CSNSW notes that it does not have a role in supervising forensic patients in the community. S.76 (K) applies to CSNSW in respect only of forensic patients in custody[B1].

**Issue 6.88**

**Are the provisions regarding the entitlement to be released from detention upon ceasing to be a forensic patient adequate and appropriate? If not what else should be provided?**

CSNSW agrees with paragraph 7.43 that the MHPA requires amendment to clarify the entitlement of a person to be released from detention especially in the cases cited, namely:

- where a person ceases to be a forensic patient and becomes an involuntary patient (paragraph 7.40);
- where a person who is in a detention centre ceases to be a forensic patient and is not reclassified as an involuntary patient (paragraph 7.41) and
- where a person who is UNA has become fit to plead but there are no further proceedings to be taken (paragraph 7.42).

**Issue 6.90**

**Should the MHFPA be amended to exclude the detention of forensic patients in correctional centres?**

CSNSW notes that the requirement of accommodating forensic patients in correctional centres is one imposed rather than sought by CSNSW. CSNSW supported the introduction of the Forensic Hospital to alleviate the problems posed by detaining forensic patients in correctional centres. Currently this facility is unable to manage forensic patients who pose a serious dangerous behavioural challenge to staff.

CSNSW has also established improved mental health facilities in the form of a new Long Bay Hospital and the Mental Health Screening Units at Silverwater. The primary objective of these units is to divert people with acute mental illness from custody.

CSNSW has also created the Additional Support Units at Long Bay and at Goulburn for housing people with cognitive and other disabilities. Whilst the Forensic Hospital may be in due course be an appropriate placement choice for dangerous and other people with a mental illness there appears to be no similar secure facility for people with intellectual and other cognitive disabilities. The provision of such a facility would appear to be a necessary concomitant of legislative change that excluded the detention of forensic patients in correctional centres.

A further consideration is that it is possible for an individual to have forensic status and also be sentenced to a term of imprisonment or remanded in custody in relation to other matters. Eg there is an offender currently in custody serving a lengthy sentence in relation to a serious violent offence who subsequently was found NGMI in relation to an offence committed in

custody. Under some circumstances it may be more appropriate to manage such an offender in a correctional centre.

**Issue 6.91**

**If detaining forensic patients in correctional centres is to continue, are legislative measures needed to improve the way in which forensic patients are managed within the correctional system?**

CSNSW welcomes the opportunity to update and correct the Commission's comments in relation the way in which forensic patients are managed in the correctional system.

The report states at paragraph 7.50 that "a person's status as a forensic patient is not part of the information that is required to be recorded when an inmate is received into a correctional centre nor in an inmate's individual case plan" and that " forensic patients will be invisible, for administrative purposes, within the correctional system."

In fact the forensic status of offenders is captured when an offender enters custody or has a change of legal status by CSNSW, Sentence Administration staff and is recorded by way of 'imprisonment status' in the Offender Integrated Management System (OIMS) i.e. they are entered in the database as Forensic Patients as per the detainer warrant.

Forensic status is also entered onto OIMS via the Alerts screen by the Forensic Liaison Officer attached to Sentence Administration. An Alert is visible in all relevant management screens and reports, ensuring that CSNSW staff are aware of a persons forensic status.

With regard to their classification, below is the relevant section of the Inmate Classification and Placement Manual regarding Forensic Patients:-

> *3. All forensic patients, that is inmates jointly managed by DCS and The Mental Health Tribunal, are to be given an appropriate security classification.*
> *4. Inmates under the Management of Mental Health Assessment Team are to be classified, with consideration given to any advice from the Mental Health Team.*
> *5.The inmates are to be involved in the decision making process by being given the opportunity to have input into the case plan and to respond or put forward a case for an alternative placement or classification. Program and placement options are to be presented to the inmate. (refer also to chapter 14 Inmate Request for Review).*

In relation to the comment (par 7.51) that "....many are housed in protective custody and even segregation due to a shortage of appropriate facilities" this misrepresents the rationale for placing offenders in special accommodation units.

The CSNSW Operations Procedures Manual specifies that when a forensic inmate is received in custody, receiving officers are to notify Justice Health immediately and that Justice Health then becomes responsible for the medical management of such inmates. Further any issues in relation to such an inmate that are likely to affect "either the security of a correctional centre or an inmate's placement, classification and/or security", are to be entered into the "alerts" section of the case management file. Such alerts might relate to (amongst others)

- self-harm/suicidal inmates;
- inmates with serious medical problems requiring immediate attention (including psychiatric illness);
- inmates with a disability (including intellectual disabilities).

The Justice Health Nursing Unit Manager at MRRC - where currently there are 27 Forensic Patients housed), has advised that when FP's enter MRRC, they are screened and housed in D Block (reception pod) until assessed by the Mental Health Nurse. They are housed within the centre based on this assessment (not necessarily on protection or in segregation). Placement in protection for the offender would be attributed to the nature of offence, mental health issues and reduced coping ability within normal population. Placement in segregation would be based on offenders 'risk status' to staff and other offenders identified through Mental Health assessment.

CSNSW notes that segregation is never used because of a shortage of other accommodation. In fact the CSNSW Operations Manual states "an inmate may be placed into segregated custody by delegated executive officers **only** where there are no other means of managing the inmate" and that "The Governor/General Manager (delegate) or other authorised person directing the segregated custody must be satisfied that the necessary conditions exist in order to justify the direction, and ensure that precise, detailed reports are provided in support of the direction".

Further the Case management policy states that an inmate's case plan must be reviewed when he/she is placed on segregation. Any indication of mental health deterioration results in the convening of a team meeting involving Justice Health. Further Justice Health are required to visit each offender subject to a segregation order daily. Of those 5 forensic patients subject to a segregation order at any time in the previous few months 3, were segregated following incidents where they either murdered or seriously injured another inmate.

'Protection' status is also often misunderstood and confused with segregation. The most frequently used protection category for Forensic patients is SMAP. SMAP means Special Management Assessment for Placement and as implied by the name indicates that the individual with such a designation can not be placed in the mainstream but requires special consideration prior to placement. SMAP areas in correctional centres do not resemble the 'protection yards" of old in that offenders managed in these areas can have the same level of access to work, programs and services as offender in the mainstream.

CSNSW notes that the opening of new Long Bay Hospital and the Mental Health Screening Units at Silverwater and the Additional Support Units at Long Bay have increased the capacity of CSNSW to house forensic inmates needing treatment including those with cognitive deficits .

An important consideration in the management of forensic patients is that they are not a uniform class of people. There is a high level of co-morbidity. Individuals may have complex presentations including co-existing serious mental illness, substance abuse disorders, personality disorders, anxiety disorders etc. Where this manifests in behaviours that poses a serious risk to the self or others special management and placement may be warranted.

One recent development in CSNSW that may help to reduce the use of segregation is the creation of the Personality and Behaviour Disorders Unit (PBDU). The PBDU was established in 2008 as a state-wide, mobile team providing high-level and intensive multidisciplinary expertise to correctional centres managing offenders with a severe personality disorder and challenging behaviours. These services include:

- Clinical assessment of the offender
- Functional analysis of problem behaviour
- Development and evaluation of individualised behavioural interventions

The PBDU allows the safe progression of these difficult offenders to least restrictive management by conducting thorough assessment of the offenders including assessing the effects of environment, staff practices and other factors and providing a detailed management plan as well as practical assistance in implementing the plan.

There are promising indications in the evaluations of the effects of the PBDU in reducing the time in secure cell placement. For this evaluation Secure cell placement was calculated by summing the number of safe cell and segregation cell placement for the respective time period. It is noted that from the data available, it was not possible to ascertain whether these placements were served concurrently or sequentially. The percentage reduction of days in safe cell placements for all offenders in T2 was 89%;

Whereas paragraph 7.51 states that rehabilitation and other programs are more limited in high security units, CSNSW notes that the work of the PBDU is most often focussed in higher security units.

The developments outlined above post date the case of *R v Adams* (2003) 58[NSWLR] 1 cited in paragraph 7.51.

CSNSW is of the view that the good management and safety of correctional centres requires that if the practice of detaining forensic patients in correctional centres continues, the measures required to improve the way in which they are managed within the correctional system should continue to be a matter for CSNSW in collaboration with relevant authorities such as the

Mental Health Review Tribunal. CSNSW is of the view that legislation about daily management issues does not permit necessary flexibility required in the interests of either the Forensic patients or other inmates. The Commissioner of Corrective Services and staff have a special 'duty of care' to people in custody and are ultimately responsible for ensuring the safety of individuals, including, inmates, staff and the community. To ensure the best outcomes, the Commissioner must continue to be able to exercise any appropriate authority under the CAS Act for those detained in correctional centres irrespective of forensic status.

**Issue 6.92**

**Under what circumstances, if any, should forensic patients be subject to compulsory treatment?**

CSNSW is of the view that the current provisions governing compulsory treatment of forensic patients in correctional centres (as described in paragraphs 7.59 – 7.63) are appropriate. CSNSW notes that as the range of treatments for forensic patients is focused around treatment for offender with a mental illness it would be rare that the provisions are used in respect of offenders with cognitive disabilities.

CSNSW notes that term "treatment" may not be appropriate for many of the interventions required in respect of people with cognitive disabilities. There is need however to augment the compulsory provisions applying to people with cognitive disabilities in respect of their continued participation in programs or arrangements to reduce their risk. For example CSNSW refers offenders upon release to the Criminal Justice Program (CJP) conducted by Ageing, Disability and Home. This program provides for close guidance and supervision as well as supported accommodation. However should a person choose to exit the CJP there appears to be limited provision for requiring them to return or remain in the program.

**Issue 6.93**

**Should different criteria apply to:**

**(a) Different types of treatment; and/or**

**(b) Forensic patients with different types of impairment?**

CSNSW believes that any criteria defining or detailing proposed compulsory treatment should have reference to the different types of treatment envisaged and the different types of impairments that forensic patients might have.

The term "compulsory treatment" is best understood within the medical model as referring to compulsory treatment using pharmacotherapy, or even compulsory admission to a psychiatric facility. As such, it is not a term that is readily used in referring to the support and management of people with a

"cognitive impairment", whether they are subject to a term of imprisonment or not.

People with a "cognitive impairment" are generally not assisted by the treatment options associated with a psychiatric disorder, unless there is co-morbidity. Rather, to support an offender with a "cognitive impairment", participation in programs and referral to appropriate disability support services is what is required.

Unlike compulsory treatment in the medical model, although an individual may be required to undertake a program, they cannot be compelled to gain anything from that program. Additionally, whilst an individual may be compelled to engage with a particular agency for post release support, most disability support agencies, Government and NGOs, only provide a voluntary service to individuals who give their free consent to do so and in some agencies, the presence of an order mandating such engagement in service is taken to void any consent given by the individual.

**Issue 6.94**

**Is the range of interventions for which the MHA and the MHFPA provide adequate and appropriate for all forensic patients? In particular, are different or additional provisions needed for forensic patients who have cognitive impairments?**

The range of interventions for which the *Mental Health Act* and the *Mental Health (Forensic Provisions) Act* provide place a strong emphasis on mental illness and are therefore inappropriate for all forensic patients.

As noted in Consultation Paper 6, these two pieces of legislation are predominately targeted to people with a mental illness and therefore are administered by NSW Health and based on a mental health framework[3]. The inclusion of cognitive impairment, particularly in reference to the *Mental Health (Forensic Provisions) Act*, in such a framework reduces the adequacy of meeting the needs of people cognitive impairment.

The inadequacy of the legislation in meeting the needs of offenders with a cognitive disability lay both in the interventions available and the overarching framework.

The legislation should be reviewed and amended to allow for:

- The transfer of individuals with severe and profound cognitive disabilities[4] into the least restrictive community option and out of the legal system

[3] NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequence*s (2009) at para 7.66

[4] A severe or profound intellectual disability is diagnosed where a person's intellectual functioning is scored at below 35-40 on a recognised psychometric test.

- Diversion from local court when supported by a community justice support plan (as opposed to a treatment plan with the connotations of pharmacotherapy and medical intervention)
- Understanding that cognitive impairments are lifelong and not cyclical like mental illness, thus the removal of the ability to make an order that an individual will be fit to plead within 12 months
- Discharge from court on the condition that the offender undergo appropriate life skills programs and receive case management from a suitable disability support service
- Consideration of the creation of a distinct branch of the Mental Health Review Tribunal, or designated members with expertise in cognitive impairment to undertake the reviews of individuals with a cognitive impairment. .

**Issue 6.99**

**Should a requirement to impose only the "least restriction" apply to all decisions regarding forensic patients?**

CSNSW supports an amendment to the relevant legislation to expressly require the Mental Health Review Tribunal to impose only the "least restriction" to all decisions regarding forensic patients. This support is dependent upon the condition that the MHRT have the ability to return an individual under their review to a secure facility, including a correctional centre, if required.

However, the concept of "least restriction" is fluid and is dependent on the needs of the individual, the availability of appropriate support and/or treatment and the level of risk that is posed to the community. Although the MHRT may make a decision to release a forensic patient from a secure environment it is possible that critical elements of that environment can dissipate, or the patient might depart the environment. Where the level of risk to the community thereby increases, it is in the interests of both the individual and the community that they be returned to a secure facility.

CSNSW notes that in Victoria, under s180 of the *Disability Act 2006* (Vic), a forensic patient with an intellectual disability can be transferred to an appropriate residential facility.

**Issue 6.100**

**How should any such principle of "least restriction" be expressed in the MHFPA? Should it be expressed differently for the purposes of different types of decisions?**

CSNSW supports a recommendation that the principle of "least restriction" be expressed consistently in respect of all decisions made by the Mental Health

Review Tribunal and that the principle be considered with regard to listed considerations.

The considerations that the MHRT should have regard to include:

- The safety of the community
- The suitability and availability of support and treatment options in terms of the assessed risks and needs of the forensic patient
- The risk of physical or psychological harm posed by the more restrictive option
- The suitability of less restrictive options

Any considerations should be worded in a manner that applies equally to issues of cognitive impairment and mental illness.

**Issue 6.101**

**Should a limit apply to the length of time for which people who are UNA and/or people who are NGMI remain subject to the forensic mental health system.**

CSNSW has no comment on this issue. However in the background comments to this question the Report notes at paragraph 7.98 “unless and until” “systemic issues” arising in respect of detention are resolved then it is arguable that a time limit remains necessary. CSNSW repeats the response to Issue 6.91 above and notes that the Report does not sufficiently canvass nor describe CSNSW efforts in respect of the management of forensic patients.

**Issue 6.104**

**Should s21A of the CSPA be amended to include “cognitive and mental health impairment” as a factor in sentencing?**

CSNSW supports a recommendation that s21A of the Crimes (Sentencing Procedures) Act be amended to expressly include cognitive impairment and mental illness as factors the court is to consider as part of sentencing.

**Issue 6.105**

**Further, should the CSPA contain a more general statement directing the court’s attention to the special considerations that arise when sentencing an offender with cognitive or mental impairments? If so, how should that statement be framed?**

CSNSW supports the inclusion of a general statement to be included in the Crimes (Sentencing Procedures) Act that directs the court’s attention to the

special considerations that arise when sentencing an offender with a cognitive impairment or mental illness. However, CSNSW repeats that any general statement should fall short of empowering the court to make a direction, as opposed to a recommendation, as to how agencies charged with the role of sentence administration allocate resources in relation to a specific offender as part of sentencing.

In giving recognition to these special considerations, the courts are dealing with offenders on an individual basis. Agencies responsible for sentence administration, including CSNSW, are dealing with a high number of offenders and are taking into account a range of factors including vulnerability and risk, and as such, are making decisions as to the allocation of resources with respect to the totality and safety of the offender population.

CSNSW welcomes recommendations from courts and the MHRT as to how an individual offender should be managed in custody and respects that such bodies are privy to a range of information about the offender upon which they make such recommendations. However, the decision as to how to allocate resources and manage offenders under a custodial or community supervision order must ultimately be left to the agency vested with the responsibility of sentence administration to be discharged through the case management and classification processes used by those agencies.

**Issue 6.107**

**Should the CSPA be amended to make it mandatory for the court to order a pre-sentence report when considering sentencing offenders with cognitive or mental health impairments to prison?**

**If so:**

**(a) What should the report contain?**

**(b) Should the contents be prescribed in the relevant legislation?**

CSNSW agrees with the comments in paragraph 8.58 that mandatory reports of the type noted would both significantly overstress the resources of the Probation and Parole Service and would be outside the competency of Probation and Parole Officers.

Paragraph 8.57 suggests that the types of information canvassed in the report might include “assessment as to the nature and severity of the offender’s cognitive or mental state”. This is repeated at paragraph 8.64. CSNSW notes that an assessment such as this would need to be completed by a psychologist not a probation and parole officer. Further where the cognitive impairment is due to brain injury then an assessment would need to be completed by a neuropsychologist. The availability of neuropsychologists is extremely limited both within Corrective Services and generally.

An assessment of the likely impact of incarceration, the suitability of the offender for various interventions and the availability of programs within the

criminal justice system is more within the expertise of probation and parole officers and the mandatory requirement of reports canvassing these issues could be met if the resource issue were addressed.

CSNSW suggests that if the contents of a report were prescribed the prescription should be inclusive rather than exclusive to permit of individualised reports and provision of additional information deemed relevant.

CSNSW notes also that a common problem arising in respect of assessment is the limit on information sharing arising from the *Privacy and Personal Information Protection Ac*t 1998 and suggests that any legislation creating a mandatory pre-sentence report requirement also provide exemptions from that Act to permit sharing of information between relevant agencies.

**Issue 6.108**

**Should the CSPA be amended to give courts the power to order that offenders with cognitive or mental health impairments be detained in facilities other than a prison? If so how should such a power be framed?**

CSNSW supports this proposal in principle but notes the practical issues raised in paragraph 8.64 regarding the lack of suitable facilities and the absence of power to compel non government organisations to house and detain offenders with cognitive or mental health impairments.

A further practical issue is linked with issue 6.107 and that is that without comprehensive assessment reports courts will be unable to make appropriate referrals. As mentioned in relation to issue 6.107 the types of assessment reports required would need to be completed by psychologists. Currently there are no resources to complete such reports.

CSNSW also notes that in paragraph 8.60 it is stated that in NSW "approximately 38% of sentenced inmates have some form of mental illness or impairment". For the sake of completeness CSNSW notes that the 'mental impairment' referred to statistics such as this is very broadly defined and includes conditions such as drug and alcohol dependencies, depression, anxiety, personality disorder and ADHD in addition to the psychoses. The *2009 Inmate Health Survey* published by Justice Health reports that 9.2% of inmates reported having received assessment or treatment for manic depressive psychosis whilst 8.8% reported treatment for schizophrenia (note that these categories are not necessarily discrete – some inmates may have received treatment for more than one disorder).

**Issue 6.109**

**Should the CSPA provide a mechanism for courts to notify other agencies and tribunals of the needs of offenders with cognitive and mental health impairments who are sentenced to imprisonment?**

**If so, should the legislation state that the sentencing court:**

**(a) May make recommendations on the warrant of commitments concerning the need for psychiatric evaluation, or other assessment of an offender's mental condition as soon as practicable after the reception into a correctional centre; and/or**

**(b) May forward copies of any reports concerning an offender's impairment-related needs to the correctional centre, Justice Health, MHRT, or the Disability Services Unit within DCS, if appropriate?**

CSNSW supports a recommendation that the Crimes (Sentencing Procedures) Act be amended to make express provision for:

(a) The sentencing court to make recommendations on the warrant of commitment for an offender to be assessed for a cognitive impairment or mental illness as soon as practicable following reception into a correctional centre; and

(b) That the sentencing court has the duty to forward copies of any reports concerning an offender's impairment and related needs to Justice Health, the MHRT or Statewide Disability Services as appropriate.

CSNSW submits that where an offender has a cognitive impairment, excluding mental illness, such reports should be forwarded to Statewide Disability Services as the arm of the agency that is tasked with overseeing the management of offenders with a disability in custody and the community.

**Issue 6.110**

**Should the CSPA be amended to empower the court when considering imposing a sentence of imprisonment on an offender with a mental illness, to request that the MHRT assess the offender with a view to making a community treatment order pursuant to s. 67(1)(d) of the MFPA**

and

**Issue 6.111**

**What similar powers, if any, should the court have with regard to offenders with other mental conditions or cognitive impairments?**

CSNSW does not oppose the suggestion and agrees that if powers were to exist in relation to ordering a CTO in respect of an offender with a mental illness similar powers should exists with regard to offenders with other mental

conditions or cognitive impairments. However CSNSW suggests that its Reception and Screening processes conducted in conjunction with Justice Health are such that these powers are unlikely to significantly increase the number of inmates identified as having the relevant impairments, nor reduce the time taken to identify them.

**Issue 6.112**

**Should provisions regarding parole be amended to refer specifically to offenders with cognitive and mental health impairments? In particular should the relevant legislation require specific consideration of an offender's cognitive or mental impairment:**

**(a) by the Probation and Parole Service when preparing reports for the Parole Authority;**
**(b) by the court when setting parole conditions ;or**
**(c) by the parole Authority when determining whether to grant or revoke parole, and when determining parole conditions?**

CSNSW notes that in practical terms where an inmate has been treated for or placed in a program related to a cognitive or mental health condition a pre-release report prepared by the Probation and Parole Service will reflect that fact and will contain an assessment of the effects of that treatment or program.

Any added requirements for assessments or advice to the parole Authority or the courts raises the same resources issues as were canvassed in respect of issues 6.107 and 6.108.

**Issue 6.113**

**Should the relevant legislation dealing with periodic detention, home detention, community service orders and good behaviour bonds be amended to increase the relevance and appropriateness of these sentencing options for offenders with cognitive or mental health impairments?**

CSNSW does not support the amendment of relevant legislation to increase the relevance and appropriateness of alternative sentencing options for offenders with cognitive impairments or mental illness. However, CSNSW is supportive of any amendment that specifies that an offender with a cognitive impairment or mental illness should not be considered unsuitable for such sentencing options due merely to their diagnosis, although they may be deemed unsuitable due to factors flowing from their impairment.

CSNSW notes that a new Intensive Corrections Order (ICO) has recently come into effect by virtue of the *Crimes (Sentencing Legislation) Amendment (Intensive Correction Order) Act* 2010. This order is designed to replace

orders of Periodic Detention. Unlike with Periodic Detention the presence of a 'major psychiatric or psychological condition" does not render a person unsuitable for an ICO. Under the Regulations, an assessment must consider the suitability of the offender for an ICO including "any physical or mental health conditions of the offender that would affect the offender's ability to comply with the offender's obligations under an intensive correction order"

CSNSW staff are trained to determine eligibility and suitability for these various orders. Decisions as to the appropriateness of sentencing options such as home detention, community service orders and good behaviour bonds are determined on an individual basis and with regard to the totality of the offender's needs and level of risk, rather than solely focussing on their impairment. In addition, there is a wide discretion regarding the conditions that can be attached to any such order. In the case of an ICO CSNSW has undertaken that the ICO Management Group which is established under the Act will provide advice on enforcement of the order by people with cognitive impairments.

CSNSW notes also that inappropriate diversion of an offender to a community option could have the unintended consequence of disadvantaging that offender. This occurs where the breach of an order results in a sentence of imprisonment and the offender then has a criminal record showing not only the offence but also the breach. As a result future community based orders could be considered inappropriate.

**Issue 6.114**

**In particular, how could:**

(a) **The eligibility and suitability requirements applicable to each type of order; and**

(b) **The conditions that may attach to each semi or non-custodial options be adapted to meet the requirements of offenders with cognitive or mental health impairments?**

CSNSW refers to the discussion in response to Issue 6.113.

**Issue 6.115**

**Should s. 11 of the CSPA concerning the deferral of sentencing be amended to refer expressly to rehabilitation or intervention programs for offender with cognitive or mental health impairments?**

CSNSW supports this suggestion.

**Consultation Paper 7**

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

**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?**

CSNSW does not support the use of the term "developmentally disabled" for the reasons discussed in response to Issue 5.4 but supports the use of the term "cognitive impairment", if properly defined, as a general term as discussed in response to Issue 5.5.

**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"?**

As discussed in response to Issue 5.4, the term "developmentally disabled" is an outdated term that does not reflect the correct terminology to be employed when speaking about people with a disability. The correct practice is to place emphasis on the person rather than the disability, which is secondary. As such, while the term "developmental disability" can be used to describe a condition such as Down's syndrome or cerebral palsy, stating that a person with one of those conditions is "developmentally disabled" could cause offence.

Although the term "developmental disability" is preferable to "developmentally disabled", CSNSW does not support the use of either term within the *Mental Health (Forensic Provisions) Act* for the reasons discussed in response to Issues 5.2 and 5.4.

**Issue 7.11**

**Should the term "mental illness" in s 32 (1)(a)(ii) of the MHFPA be defined in legislation?**

CSNSW supports the term being defined. Such a definition would clarify whether the sub section is intended to apply to people with other cognitive impairments or whether they are intended to be included in ss32(1)(a)(iii) of the Act. If the latter, then the comments in relation to Issue 7.13 apply.

**Issue 7.12**

**Should the term "mental condition' in s32(1)(a)(iii) be defined in legislation?**

**and**

**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 it clear that treatment is not limited to services aimed at curing a condition, but can include social services and programs aimed at providing various life skills and support?**

CSNSW supports a recommendation to amend the wording of s32(1)(a)(iii) of the *Mental Health (Forensic Procedures) Act* to remove the requirement of treatment in a mental health facility to better reflect the conditions covered by the general term "mental condition" as defined by the *Act*.

Furthermore, CSNSW supports a recommendation to amend the wording of this section to reflect the diverse services that could be construed as "treatment" under the *Act*, including life skills programs and support.

However, CSNSW would recommend further review of this section with specific reference to the use of the terms "mental condition" and "treatment".

The term "mental condition" as defined by the *Act* is confusing and would be more appropriately dealt with by including the conditions that this term covers, i.e. those other than a mental illness or a developmental disability, under a general term that relates to cognitive impairment.

If a more general term such as "cognitive impairment" was used, the use of the term "treatment" could be avoided, as it is a term that is more appropriately associated with mental health than with cognitive impairment. The term "treatment" commonly denotes pharmacotherapy or psychotherapy

which in most instances will not meet the needs of a person with a cognitive impairment unless there is an underlying mental illness or medical condition that requires such treatment.

**Issue 7.14**

**Should the existing categories of developmental disability, mental condition and mental illness in s32(1)(a) of the MHFPA be removed and replaced by a general term used to determine a defendant's eligibility for a s32 order?**

As discussed in response to Issue 5.4, CSNSW supports the use of an umbrella term to describe a range of conditions that would make a person eligible for diversion under the Mental Health (Forensic Provisions) Act.

**Issue 7.16**

**Are there specific conditions 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 disorder be excluded?**

CSNSW is not in favour of substance abuse generally being included as a condition under the general term used within the Act, but notes that substance abuse is a recognised cause of brain injury and other impairments such as low cognitive functioning. Impairments caused by drug or alcohol abuse should not be excluded from the definition merely because of their aetiology. and therefore should not be an exclusionary factor for eligibility under the Act.

**Issue 7.24**

**Are the orders currently available under s32(3) of the MHFPA appropriate in meeting the needs and circumstances of defendants with a cognitive impairment, as distinct from those with mental health problems?**

The orders currently available under s32(3) of the *Mental Health (Forensic Provisions) Act* are not appropriate in meeting the needs and circumstances of defendants with a cognitive impairment as distinct from those with mental health problems.

The orders available under s32(3)(b) focus on "care" and "treatment", concepts which are more appropriately associated with mental health than with cognitive impairment. Although a person with a cognitive impairment may require further assessment, as provided for within this section, the term

"treatment" commonly denotes pharmacotherapy or psychotherapy which in most instances will not meet the needs of a person with a cognitive impairment unless there is an underlying mental illness or medical condition that requires such treatment.

CSNSW would support an amendment to this section of the *Act* to incorporate a provision for an order to be made for an offender with a cognitive impairment to attend on a person or at a place specified for assessment or case management or both. However, in undertaking a review of this section, the LRC should have regard to the voluntary nature of disability support services and the intake processes of those services, which are distinct from mental health services and may not have the capacity to implement such orders made by the court.

**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?**

CSNSW supports a recommendation that the court should consider the capability of a person or organisation to implement an order made under s23 (3) of the *Mental Health (Forensic Provisions) Act* prior to making such an order. The requirement of a court to expressly turn their mind to this issue would ensure that an offender was not being set up to fail by orders that had no ability to be implemented on a practical level.

However, CSNSW does not support any amendment to legislation that would provide the court with the power to compel a person or agency to implement an order, unless that order was made on the basis, wholly or in part, of the person or agency making an express commitment to the court of implementing the order.

Such a distinction is required to prevent the courts from making orders that are required to be implemented by agencies charged with sentence administration, where the content of those orders would be more appropriately determined by the case management process in place within the agency. CSNSW, as one of those agencies, has stringent case management process in place that are used for the effective management of offenders.

**Issue 7.30**

**Should the MHFPA clarify the role and obligations if the Probation and Parole Service with respect to supervising compliance with and reporting on breaches of orders made under s32(3)? What should these obligations be?**

As noted in paragraph 3.70 CSNSW agrees that clarification is required. CSNSW notes also that where a Magistrate has made an order dismissing the charge and discharging the defendant, Probation and Parole Officers would not normally be involved in supervising compliance with any conditions.

**Issue 7.32**

**Is there a need for centralised systems within the Local Court and the NSW Police for assessing defendants for cognitive impairment or mental illness at the outset of criminal proceedings against them?**

CSNSW supports the enhancement of processes within the NSW Police and the Local Court level to increase identification of defendants with cognitive impairment or mental illness at the outset of criminal proceedings, but does not believe that implementing an assessment system would accurately achieve this.

At the outset of criminal proceedings, particularly at the point of arrest, there are a number of factors, including drug and alcohol intoxication, acute un-medicated mental illness and stress, affecting many offenders that can lead to inaccurate identification of cognitive impairment. These factors would often render formal assessment at the point of entering the criminal justice system invalid, particularly in regard to cognitive impairments. However, such identification is required to ensure the provision of a support person where required, the adequately assess risk and to identify diversionary processes if suitable.

This issue was recently considered by Lord Bradley's review of people with mental health problems or learning disabilities[5] in the criminal justice system (The Bradley Report). Although the Bradley Report noted that there is a need for early identification, a formal assessment system was not recommended by the review due to the difficulties in obtaining valid assessment at that stage[6].

A more appropriate method of enhancing identification at this stage would be through the implementation of a screening process that can be undertaken by NSW Police to try and identify offenders that may have a cognitive impairment or mental illness. This would require the provision of training to police officers in the areas of mental health and disability awareness. Although such a

[5] The terminology used in the United Kingdom differs from that used in Australia. The term "learning disability" in the Bradley Report refers to intellectual disability.

[6] Department of Health (UK) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system* (2009) at 50

system would not identify all offenders in these categories, and would be based on self-report and observation, it is the most appropriate method of early identification for this target group. To further enhance effectiveness, this process should be supported by information sharing protocols between key agencies to confirm an offender's mental illness or cognitive impairment and liaison officers to provide appropriate support and advice to personnel undertaking the screening process.

There is also scope to introduce a similar system in NSW Local Courts to identify offenders that may not have been picked up through initial screening at the police station or through the screening processes used by CSNSW or Juvenile Justice.