Legal Aid
NEW SOUTH WALES

PEOPLE WITH COGNITIVE AND MENTAL HEALTH IMPAIRMENTS IN THE CRIMINAL JUSTICE SYSTEM

Response to Consultation Papers 5 to 8

31 July 2010

Submission on behalf of Legal Aid NSW to the New South Wales Law Reform Commission

About Legal Aid NSW

The Legal Aid Commission of New South Wales ("Legal Aid NSW") is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW) to provide legal assistance, with a particular focus on the needs of people who are economically or socially disadvantaged. Legal Aid NSW provides information, community legal education, advice, minor assistance and representation, through a large in-house legal practice and through grants of aid to private practitioners. Legal Aid NSW also funds a number of services provided by non-government organisations, including 35 community legal centres. Our criminal law practice represents clients in all criminal jurisdictions from the Children's and Local Courts to the High Court.

Clients with a mental illness are one of the Legal Aid NSW priority client groups. Our Mental Health Advocacy Service ("MHAS") provides and coordinates duty representation in metropolitan and regional NSW for people who are subject to involuntary treatment or detention under the *Mental Health Act 2007* ("MHA"). One of its other core areas is representing forensic patients under the *Mental Health (Forensic Provisions) Act 1990* ("MHFPA"). Our Prisoners Legal Service ("PLS") appears for prisoners at parole hearings, life sentence determinations, segregation appeals and visiting justice hearings.

The principles that underpin our responses

At the outset we would like to identify some of the principles that underpin our responses to the issues raised by the New South Wales Law Reform Commission ("NSWLRC") in its inquiry:

- The concept of criminal responsibility rests on the presumption that individuals possess the capacity to make rational choices to act or refrain from acting. There are some mental states that impair an individual's capacity to make such choices. This principle should be taken into account when determining the extent to which criminal responsibility is to be borne by an individual, irrespective of the seriousness of the offence. Special provisions for people with cognitive and mental health impairments – for example, diversion provisions, special hearings, fitness hearings, and the availability of the defence of mental illness – should therefore operate across all tiers of the court system, and at every stage of proceedings.

- When determining the basis for the detention of people with a cognitive or mental impairment to whom no criminal responsibility attaches, the principle of least restriction should apply. Any restrictions on such a person's liberty can only be justified by reference to considerations of public safety, not punishment. Sentencing principles should therefore only operate as a limit on, and not as a basis for, the court's discretion to make a detention order in relation to people who are found not guilty by reason of mental illness ("NGMI") and people who are unfit to be tried and not acquitted ("UNA").

  If a person, to whom no criminal responsibility attaches, poses a risk of harm only to him- or herself, this is not a sufficient basis for a criminal court to order that person's detention. For the same reasons, mental health facilities not prisons are the appropriate place of detention for people with cognitive and mental health impairments.

- A limit should apply to the length of time a person remains a forensic patient, regardless of whether that person is NGMI or UNA. It is discriminatory to require a person to remain subject to the forensic mental health system, which places more stringent restrictions on a person's liberty than the civil mental health system, for longer than a person who was convicted and sentenced in the ordinary way for the same conduct.

- As the NSWLRC acknowledges in its consultation papers, a lack of appropriate services and treatment options for people with cognitive and mental health impairments, both in and out of prison, underlies many of the difficulties faced in this area. Of particular concern is the absence of any declared facilities where forensic patients who are not mentally ill but have, for example, a cognitive impairment or personality disorder, can be detained and appropriately treated or managed, and infrastructure to assist them in the community.

  Where resources are inadequate, amendments to legislation can only go so far towards resolving these difficulties. For example, legislating specific roles for agencies in relation to supporting and supervising people with an impairment who come into contact with the criminal justice system, cannot fix system difficulties whose root is a lack of resources, and might even hinder cooperation and support between agencies.

Conclusion

Our comments addressing each of the specific issues raised in the consultation papers are attached. Legal Aid NSW is grateful for the opportunity to provide these comments, and we would welcome the opportunity to comment further if necessary.

CONTENTS

Consultation Paper 5: An overview	4
Legislative concepts of cognitive and mental health impairments	4
Identifying the existence of a cognitive or mental impairment	5
Consultation Paper 6: Criminal responsibility and consequences	**6**
Fitness for trial	6
Procedure following a finding of unfitness	8
The defence of mental illness	9
The partial defence of substantial impairment	12
Infanticide	13
Powers of the court following a qualified finding of guilt at a special hearing or a verdict of not guilty by reason of mental illness	13
Management of forensic patients following court proceedings	17
Sentencing: principles and options	23
Consultation Paper 7: Diversion	**27**
Pre-court diversion	27
Diversion under section 32	29
Diversion under section 33	35
Enhancing diversion in the superior courts	35
Consultation Paper 8: forensic samples	**37**

CONSULTATION PAPER 5: AN OVERVIEW

Legislative concepts of cognitive and mental health impairments

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?

Yes. We support a broad umbrella definition of mental health impairment that incorporates mental illness and cognitive impairment. Such a definition could be used to establish threshold criteria for identifying those defendants whose mental impairment may warrant special consideration during sentencing. It could also act as a qualifying condition for diversion, or for consideration of unfitness, or of the defences of mental illness or substantial impairment.

We recognise, however, that the current forensic system is not well-placed to serve everybody who would fall within a broad umbrella definition; for example, people with conditions that are untreatable. Ideally we would like to see improvements to the forensic system so that it can appropriately accommodate people with cognitive impairments as well as those with mental illnesses, or viable community options for people who are not well-served by the current system.

If limited resources make neither of these options realistic, then legislative safeguards should accompany the broad umbrella definition to ensure that people falling within the broad definition are not dealt with inappropriately.

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?

Yes.

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

No. This would erase the important distinction between ss 32 and 33 of the MHFPA.

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 terms "mental condition" and "developmentally disabled" are vague and limited. We support the abolition of these terms and the introduction of the broad umbrella definition as discussed in our response to Issue 5.1.

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"?

Yes. A definition of cognitive impairment or disability would be useful, and the proposed definition is appropriate.

Identifying the existence of a cognitive or mental impairment

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?

Yes.

a) An independent panel of psychiatrists paid for by the court.

b) As suggested in paragraph 5.16 of Consultation Paper ("CP") 5, an assessment report should contain:
   - the nature and degree of the defendant's impairment;
   - the impact that impairment has on his/her behaviour;
   - a statement of suggested and/or available treatment services;
   - a treatment plan; and
   - if relevant, an assessment of whether the defendant is fit to be tried.

c) Yes. Legal Aid NSW shares the concern of the NSWLRC expressed in paragraph 5.19 of CP 5 about the admissibility of any statements made by the defendant during the course of the assessment, and opposes the introduction of a provision similar to s 265 of the *Mental Health Act 2000* (Qld).

CONSULTATION PAPER 6: CRIMINAL RESPONSIBILITY AND CONSEQUENCES

Fitness for trial

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?

Yes. The trial of an unfit person is an abuse of court process. The court should be required to consider the issue of fitness whenever it appears that the defendant may be unfit to be tried.

Issue 6.2: Do the *Presser* standards remain relevant and sufficient criteria for determining a defendant's fitness for trial?

The *Presser* standards are still relevant, but fall short in comparison to similar standards used elsewhere; for example, the decision-making competency standard adopted by the civil law jurisdiction.

Issue 6.3: Should the test for fitness to stand trial be amended by legislation to incorporate an assessment of the ability of the accused to make rational decisions concerning the proceedings? If so, should this be achieved by: (a) the addition of a new standard to the *Presser* formulation, or (b) by amendment of relevant standards in the existing formulation?

Proposal b) is preferable to proposal a). However, overall we prefer the alternative proposed in Issue 6.4.

Issue 6.4: As an alternative to the proposal in Issue 6.3, should legislation identify the ability of the accused to participate effectively in the trial as the general principle underlying fitness determinations, with the *Presser* standards being listed as the minimum standards that the accused must meet?

Yes. An "effective participation" standard would provide greater protection to vulnerable defendants and the *Presser* standards as minimum standards would provide useful guidance to the court.

Issue 6.5: Should the minimum standards identified in *Presser* be expanded to include deterioration under the stress of trial?

Yes.

Issue 6.6: Should the minimum standards identified in *Presser* be altered in some other way?

No.

Issue 6.7: Should the procedure for determining fitness be changed and, if so, in what way?

Yes. Once fitness is raised the process can be a lengthy one, sometimes with the consequence that the potentially unfit person spends much more time in custody than a fit person would have spent in custody.

The sources of these delays include:

- the time needed for defence to obtain appropriate psychiatric reports;
- the need for the Crown to instruct its own psychiatrists;
- the fact that matters are not usually listed for fitness hearing until both sides have obtained their reports; and
- the usual delays caused by unavailability of witnesses, counsel and court time.

Dealing more effectively with these issues would improve the process. Enabling fitness to be raised at the earliest possible opportunity and providing more stringent time frames would also assist.

Issue 6.8: What should be the role of: (a) the court; and (b) the MHRT in determining a defendant's fitness to be tried?

A finding of unfitness should be made exclusively by the court with input from expert witnesses as appropriate. Decisions that involve considerations about the person's clinical needs, and the appropriate community setting or facility in which to treat the person, should be made by the MHRT.

Issue 6.9: Should provision be made for the defence and prosecution to consent to a finding of unfitness?

Yes. Provisions that allow the defence and prosecution to consent to a finding of unfitness are in the interests of both parties.

Issue 6.10: Should the *Criminal Appeal Act 1912* (NSW) be amended to provide for the Court of Criminal Appeal to substitute a "qualified finding of guilt" in cases where a conviction is quashed due to the possible unfitness of the accused person at the time of trial?

Yes. We would support a provision that enables the Court of Criminal Appeal to substitute a "qualified finding of guilt", so long as the Court also retains the power to remit the matter to the lower court in cases where it deems this a more appropriate course of action.

Issue 6.11: Should fitness procedures apply in Local Courts? If so, how should they be framed?

Yes, even though fitness applications can be made in the Local Court under common law, it is our experience that magistrates are often unwilling to entertain such applications. Specific fitness procedures set out in the legislation would clarify that fitness applications can be made in this jurisdiction, and could be framed in the way set out at paragraph 1.48 of CP 6. Fitness procedures should also apply in the Children's Court.

Case example

A Legal Aid NSW solicitor represented an intellectually disabled 12 year-old who had committed the offence of aggravated sexual assault. His case took a long time to progress through the Children's Court to the District Court. Because he was only able to raise the issue of fitness when the case reached the District Court, he was forced to spend a significant amount of time on remand before a special hearing took place.

Issue 6.12: Should legislation provide for the situation where a committal hearing is to be held in respect of an accused person who is or appears to be unfit to be tried? If so, what should be provided?

Yes. The earlier a person can be diverted from the criminal justice system, the better. A magistrate could determine the question of fitness at the committal hearing as set out at paragraph 1.55 of CP 6. Determining the question at this early stage would reduce delay, uncertainty and costs.

Procedure following a finding of unfitness

Issue 6.13: Should the special hearing procedure continue at all, or in its present form? If not, how should an unfit offender be given an opportunity to be acquitted?

The special hearing procedure should continue. A finding of unfitness should not operate to deny an accused the opportunity to be acquitted, and the special hearing is an appropriate means of granting this opportunity.

However, we acknowledge a number of difficulties with the process as it currently operates, including the delay often experienced before a special hearing is held. Such a delay can result in a defendant spending longer on remand, and therefore being punished more severely.

A defence solicitor can also face a number of practical and ethical difficulties in running a defended hearing when his or her client doesn't meet the *Presser* standards.

For example, s 21(2) of the MHFPA provides that at a special hearing an accused person "must" be represented "unless the Court otherwise allows" and "the fact that the person is unfit is to be presumed not to be an impediment to the person's representation". However, this places the defence solicitor in a conundrum with regard to whether he or she is bound to act on the instructions of a client who lacks the mental capacity to give them.

One possible solution to this difficulty is to alter slightly the duties of a defence solicitor appearing for a client at a special hearing to the effect that, while the solicitor still has a duty to consider the views of the client, those views are not considered binding.

In a case where the onus of proof is reversed, other difficulties can arise:

Case example

A Legal Aid NSW solicitor appeared for a client in a special hearing in the District Court, where the client had been charged with supply prohibited drug (deemed). In her record of interview the client said she had been handed the drugs to hold for someone else. She gave a few versions of the incident in her interview.

The client was found unfit to be tried because of her intellectual disability. Under the *Presser* standards the court found that she could not understand most of the proceedings and could not give evidence because she would not understand the questions being asked of her.

The nature of the offence the client had been charged with meant that the onus was on the defendant to show that she had the drugs in her possession other than for the purposes of supply. The difficulty for her solicitor during the special hearing was how to raise this defence when the client could not give evidence because of her intellectual disability.

Issue 6.14: Should a procedure be introduced whereby the court, if not satisfied that the prosecution has established a prima facie case against the unfit accused, can acquit the accused at an early stage?

While we agree with the introduction of such a procedure, we do not agree that special hearings should all be limited to considering whether there is a prima facie case.

If, for example, after a "prima facie" hearing, a prima facie case is established, the accused should retain the right to proceed to a full special hearing. Limiting the enquiry to the issue of "prima facie" would restrict the opportunity of the accused to be acquitted.

Issue 6.15: Should deferral of the determination of fitness be available as an expeditious means of providing the accused with an opportunity of acquittal?

We do not support this proposal because of the practical and ethical considerations of running a trial when the defence solicitor cannot obtain proper instructions from the defendant.

Issue 6.16: Should the special hearing be made more flexible? If so, how?

Yes, the special hearing should be made more flexible, so that in appropriate situations certain accommodations can be made for an unfit accused. For example:
- providing for a more informal procedure;
- holding the hearing in a place other than a courtroom; and
- allowing the accused to be accompanied by a support person.

Issue 6.17: Should the MHFPA provide for the defendant to be excused from a special hearing?

Yes. A defendant should be able to be excused from a special hearing, but only if he or she consents.

Issue 6.18: Should the finding that "on the limited evidence available, the accused person committed the offence charged [or an offence available as an alternative]" be replaced with a finding that "the accused person was unfit to be tried and was not acquitted of the offence charged [or an offence available as an alternative]"?

Yes. The proposed new wording better represents the court's finding.

Issue 6.19: Should a verdict of "not guilty by reason of mental illness" continue to be available at special hearings? Are any additional safeguards necessary?

Yes, this verdict should continue to be available, because it represents a finding that the person was not criminally responsible for his or her conduct. A finding that "on the limited evidence available, the accused person committed the offence charged" does not have the same effect.

The defence of mental illness

Issue 6.20: Should the defence of mental illness be replaced with an alternative way of excusing defendants from criminal responsibility and directing them into compulsory treatment for mental health problems (where necessary)? For example, should it be replaced with a power to divert a defendant out of criminal proceedings and into treatment?

No. The current defence of mental illness should be retained because an NGMI verdict signifies that the defendant was not criminally responsible for the offence. Such a verdict should, however, trigger enhanced powers of diversion into treatment.

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?

Yes. A separate defence is not necessary, so long as the disposition options attached to the defence of mental illness are broad enough to provide for the appropriate disposition of people with a cognitive impairment.

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 for others?

Yes, if the nature of the disorder affects a defendant's mental capacity to the extent that he or she should not be held criminally responsible for his or her actions.

Issue 6.23: Should the defence of mental illness be available to defendants who lack the capacity to control their actions?

Yes. Whether an impulse is one that could not be resisted, or one that simply *was not* resisted, is a question of fact that can be left to the jury.

Issue 6.24: Should the test for the defence of mental illness expressly refer to delusional belief as a condition that can be brought within the scope of the defence? If yes, should the criminal responsibility of a defendant who acts under a delusional belief be measured as if the facts were really as the defendant believed them to be?

Yes, but the criminal responsibility of a defendant who acts under a delusional belief should not be measured as if the facts were really as the defendant believed them to be. As noted in CP 6, this approach does not overcome the problem of requiring 'sane' or 'normal' reactions by those whose mental capacity is seriously impaired.

Case example

In the matter of *R v Zaharic* (2000) NSWSC 963, a judge alone trial was held in relation to the defendant's murder of a friend, whom he regarded as responsible for the fact that he and his wife had acquired a herpes virus infection. This was a delusion. Two months previously he had been admitted as a psychiatric patient. Three psychiatrists expressed the view that he knew the nature and quality of his act, but that he was incapable of establishing that he knew that what he was doing was wrong. He was found not guilty by reason of mental illness.

Issue 6.25: Should the current test for determining the application of the defence of mental illness be retained without change?

No. The current defence of mental illness is too narrow, and excludes many defendants with an impairment who should not be held criminally responsible for their actions.

Issue 6.26: If the *M'Naghten* rules were reformulated in legislation, should the legislation define the concept of a disease of the mind? If so, how should it be defined? Should the common law requirement for a "defect of reason" be omitted from the statutory formulation?

The concept of "disease of the mind" is problematic, and we would support replacing the term altogether in favour of a broad umbrella definition. If it is to be retained, the common law is adequate to interpret the term. Any legislative definition could limit its application unnecessarily.

Issue 6.27: If the *M'Naghten* rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge of the nature and quality of the act? If so, should the legislation provide for a lack of actual knowledge, or a lack of capacity to know?

If the *M'Naghten* Rules were reformulated in legislation, the option of satisfying the defence by lack of knowledge of the nature and quality of the act should be retained and expanded by reference to capacity to know.

Issue 6.28: If the *M'Naghten* rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge that the criminal conduct was wrong? If so, should the legislation provide any guidance about the meaning of this alternative? For example, should it require that the defendant could not have reasoned with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong? Should the legislation require a lack of capacity to know, rather than a lack of actual knowledge?

Yes. The legislation should recognise, as one way of satisfying the defence, a lack of knowledge that the criminal conduct was wrong.

Issue 6.29: Should the approach for determining the application of the defence of mental illness under the *M'Naghten* rules be replaced with a different formulation? If so, how should the law determine the circumstances in which a defendant should not be held criminally responsible for his or her actions due to mental illness or other impairment of mental function?

Yes, the *M'Naghten* Rules should be replaced. We support the cognitive competency approach outlined at paragraphs 3.81 to 3.83 in CP 6. We do not support the approach based on symptoms and presumed causation.

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?

Yes, in those circumstances in which the defendant has a medically-recognised clinical condition such as addiction or alcoholism.

Issue 6.31: Should the defence of mental illness apply to a defendant's involuntary act if that involuntary act was caused by a disease of the mind? If yes, should legislation provide a test for determining involuntary acts that result from a disease of the mind as opposed to involuntary acts that come within the scope of the defence of automatism, and if so, how should that test be formulated?

Yes, the defence of mental illness should apply to a defendant's involuntary act if that involuntary act was caused by a disease of the mind.

Issue 6.32: Should the MHFPA be amended to allow the prosecution, or the court, to raise the defence of mental illness, with or without the defendant's consent?

No. In order to uphold the general principle that you can defend yourself as you choose, the defendant's consent should be a prerequisite for the defence. This is particularly so given the potential consequences of a NGMI verdict (such as being detained indefinitely).

Issue 6.33: Should the MHFPA be amended to allow for a finding of "not guilty by reason of mental illness" to be entered by consent of both parties?

Yes.

Issue 6.34: Should the court have the power to order an assessment of the defendant for the purpose of determining whether he or she is entitled to a defence of mental illness?

Yes, with the consent of the defence.

Issue 6.35: Should a process other than an ordinary trial be used to determine whether a defendant is not guilty by reason of mental illness?

No. The current system is appropriate.

Issue 6.36: Should the defence of mental illness be available generally in the Local Court and, if so, should it be available in all cases?

Yes. The defence of mental illness should be available generally in the Local Court and available in all cases.

The partial defence of substantial impairment

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

Yes.

Issue 6.38: As an alternative to an umbrella definition of cognitive and mental impairment, should the mental state required by s 23A be revised? If so, how?

Yes, as proposed in CP 6.

Issue 6.39: Is the requirement in s 23A of the Crimes Act that the impairment be "so substantial as to warrant liability for murder being reduced to manslaughter" sufficiently clear? If not, how should it be modified?

No. The current formulation works well, in that it leaves the ultimate decision about whether the partial defence is proved in the hands of the trier of fact, rather than the medical experts.

Issue 6.40: Should the defence of substantial impairment be retained or abolished? Why or why not?

The partial defence of substantial impairment should be retained because, as outlined in CP 6, it reflects the continuum of mental illness, and facilitates community involvement by way of the jury, in making a moral judgement as to the level of criminal responsibility that should attach to the offender's conduct. We also agree that if the defence were to be abolished, it would give both the jury and the defendant less options for verdict and pleas, and could lead to perverse outcomes that are not reflective of what actually happened.

Infanticide

Issue 6.41: Is there a continuing need for infanticide to operate, either as an offence in itself, or as a partial defence to murder?

Yes, there is a continuing need for infanticide to operate, both as an offence in itself, and as a partial defence to murder. Given the tragic and unique nature of infanticide, it is inappropriate for women who kill their infant children in particular circumstances to be prosecuted for murder. Infanticide as an offence also enables the woman charged to avoid the burden of proving that, at the time of the killing, her mental state was so diminished as to rob her of the capacity to control her actions, or to know that they were wrong.

Issue 6.42: Should the continued operation of the infanticide provisions be conditional on the retention of the partial defence of substantial impairment?

No.

Issue 6.43: If infanticide is to be retained, should it be recast? If so, how?

We support the offence being retained but amended in the following ways:

- removal of the 12 month age restriction;
- removal of the reference to lactation; and
- revision of the qualifying mental condition, to provide that the balance of the woman's mind must be disturbed by reason of the effect of giving birth or circumstances resulting from the birth.

Powers of the court following a qualified finding of guilt at a special hearing or a verdict of not guilty by reason of mental illness

Issue 6.44: Should the MHFPA be amended to provide a mechanism and/or requirement for the court to notify the MHRT of the terms of its order under s 27 of the MHFPA?

Yes, such a mechanism and/or requirement would be useful.

Case example

In the case of *TD v State of NSW* [2010] NSWSC 368, TD was a woman suffering from schizophrenia and intellectual disability and being detained at Mulawa correctional centre. The District Court made a s 27 order that TD be detained in a "hospital" (under the former MHCPA – the equivalent of a "mental health facility" under the current MHFPA).

Rozelle hospital resisted an immediate transfer on the basis that a security assessment had to be made. TD was therefore transferred to the D Ward of the Long Bay Prison Hospital (an all male ward for the most acute mentally ill inmates). The MHRT subsequently intervened, holding an urgent CTO hearing. Doctors from Rozelle Hospital were involved and a

placement was facilitated. TD was transferred from Long Bay Prison Hospital to Rozelle Hospital.

Had the MHRT been notified by the Court of the s 27 order, it could have conducted an urgent CTO hearing much earlier to facilitate and ensure a smooth transfer from Mulawa to Rozelle Hospital.

Issue 6.45: To what extent (if any) should sentencing principles continue to apply to the court's decision whether to detain or release a person who is UNA?

Sentencing principles should only operate as a limit on, but not as a basis for, the court's discretion to detain a person who is UNA. The duration for which a person remains a forensic patient should only be referable to the need to protect others from serious harm.

The current "all or nothing" approach that is employed in relation to persons who are UNA – unconditional release on the one hand or detention in a "mental health facility" or "place other than a mental health facility" (ie prison) on the other – is unsatisfactory. As noted in CP 6, in practice it is rare for the court to regard unconditional discharge as an acceptable outcome in a case where a sentence of imprisonment would have been imposed at an ordinary trial. For this reason it is worth considering the possibility of conditional release orders, like those available under s 39 for persons who are NGMI.

Issue 6.46: Should the MHFPA be amended to provide additional guidance to the court in deciding whether to order detention or release of persons found NGMI?

Yes. There should be further statutory guidance to assist the court in deciding whether to order detention or release of persons found NGMI.

Issue 6.47: Should the MHFPA be amended to provide guidance to the court in relation to the conditions that may be attached to an order for conditional release?

Yes. There should be further statutory guidance to assist courts in making conditional release orders.

Issue 6.48: Is there any reason to retain a distinction between the orders available to the court in cases where the person is UNA or NGMI?

No. There is no basis for maintaining any distinction between UNA and NGMI persons.

Issue 6.49: If the present frameworks are to be retained: (a) should the definition of "forensic patient" be amended to include a person who is UNA and in respect of whom a non-custodial order is made? (b) should the MHFPA be amended to provide a power for the court to order conditional release if it does not make an order for detention under s 27?

If the present framework is to be retained (an option we do not support):

(a) Yes.

(b) Yes.

Issue 6.50: What orders should be available to the court?

Option D is the most preferable. However, any legislative amendment allowing a referral of the UNA/NGMI person by the Court to the MHRT should preserve the ability of the Court to

set certain parameters or conditions, particularly in relation to the *place* of any detention. If a court is minded to ensure that a particularly vulnerable UNA/NGMI person is not detained in prison, it should retain some role in achieving that outcome.

Ideally, the court should have the power to make the orders determining the placement, and the MHRT should have the power to make the necessary mental health orders to give effect to those placement orders. If necessary, further statutory criteria could be developed (eg vulnerability indicators, risk of harm etc) to give the court guidance as to when a mental health facility placement should be specifically ordered.

Issue 6.51: Should the same orders be available both for persons who are UNA and for those who are found NGMI?

Yes.

Issue 6.52: What orders should result in a person becoming a "forensic patient"?

The person would become a "forensic patient" if detained or conditionally released by the court.

Issue 6.53: To what extent (if any) should the court take into account a risk of harm to the person him- or herself, as distinct from the risk (if any) to other members of the community?

Where a person poses a threat only to him or herself and no one else, this is not a sufficient basis for a criminal court to order a person's detention.

Issue 6.54: Should the 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 herself?

Yes.

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?

Serious physical harm, including sexual violence, should be the only kind of possible "harm" that should be relevant to decisions by the court to detain or release persons who are UNA or NGMI. This position is in line with the High Court decision in *Chester v Queen* (1988) 165 CLR 611.

Issue 6.56: Should "harm" be defined in the MHFPA?

Yes.

Issue 6.57: How should the relevant degree of risk of harm be expressed in the MHFPA? Should it be defined?

The relevant degree of risk of harm should be defined in the MHFPA as: "likely to pose a significant risk of serious physical harm occasioned by criminal conduct to other members of the community."

Issue 6.58: Should a presumption in favour of detention continue to apply when courts are making decisions about persons who are UNA or NGMI?

No.

Issue 6.59: When deciding what order to make in respect of a person who is UNA or NGMI, should the court be required to apply a principle of least restriction consistent with: (a) the safety of the community? (b) the safety of the person concerned? and/or (c) some other object(s)?

No. The presumption of least restriction should apply consistent with the safety of the community.

Issue 6.60: In relation to court proceedings involving people who are UNA or NGMI, are the current provisions concerning notification to, and participation by: (a) victims; and (b) carers, adequate and appropriate?

Yes.

Issue 6.61: What principles should apply when courts are making decisions about persons who are UNA or NGMI?

Apart from the principle of least restriction, the only principle that should apply when courts are making decisions about persons who are UNA or NGMI is the "public interest".

Issue 6.62: What factors should courts be allowed and/or required to take into account when making decisions about persons who are UNA or NGMI?

Courts should be required to take into account lack of appropriate detention facilities.

Issue 6.63: In cases where the person is UNA, should the possibility that the person will become fit to be tried be a sufficient basis for the court to make an order of some kind?

No. There should be no restrictions on the person's liberty unless it is warranted in the public interest.

Issue 6.64: Should legislation specify what standard of proof applies to facts which form the basis of the court's decision as to what order to make in respect of a person who is UNA or who has been found NGMI? If so, what standard of proof should be specified?

Factual matters adverse to the person should be established beyond reasonable doubt, and favourable matters should be established on the balance of probabilities.

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?

The court would be aided by the establishment of a court liaison service, particularly in relation to resources or facilities available to implement detention orders.

Issue 6.66: Should legislation provide a mechanism for the court to notify the MHRT of its final order in cases where the person is UNA or NGMI?

Yes.

Issue 6.67: In what circumstances (if any) should the *Criminal Appeal Act* provide for the person the subject of the proceedings to appeal against: (a) a verdict of NGMI; (b)

orders by the court in cases where the person is NGMI; (c) non-acquittal at a special hearing? (d) orders by the court in cases where the person is UNA?

An appeal right should exist in relation to all of the above. Although an appeal against a verdict of NGMI would be rare, there should be provision for it, consistent with the broad interpretation of the Court of Criminal Appeal. The verdict of NGMI should be deemed to be a conviction, and as a result, the person would be able to appeal against an order by the trial court for detention or conditional release consistent with the human rights principle that a person who is detained is entitled to judicial review of the lawfulness of the detention.

Issue 6.68: In what circumstances (if any) should the *Criminal Appeal Act* allow the prosecution to appeal against: (a) a verdict of NGMI? (b) orders by the court in cases where the person is NGMI? (c) orders by the court in cases where the person is UNA?

In the circumstances currently provided for.

Issue 6.69: Should the *Criminal Appeal Act* be amended to require the Court of Criminal Appeal to consider the safety of the person and/or the community prior to making an order for release?

The Act should be amended to require the Court of Criminal Appeal to consider the safety of the community prior to making an order for release.

Issue 6.70: What manner of appeal is most appropriate for reviewing: (a) findings; and (b) consequent orders in cases where the person is UNA or NGMI?

The manner of appeal in cases involving people who are UNA or NGMI should be the same as ordinary appeals – by way of rehearing of evidence which was before the trial court with the court having a discretion to allow fresh evidence.

Issue 6.71: Should any ancillary powers be provided to assist the Court of Criminal Appeal in deciding such cases?

No.

Issue 6.72: Is there any reason why Local Court magistrates should not have power to make orders in respect of persons who are UNA or NGMI?

No.

Issue 6.73: If the Local Court should have powers for cases involving persons who are UNA or NGMI, should they be the same as the powers of the District and Supreme Courts? If not, what should be provided?

Yes, the Local Court should have the same powers as the District and Supreme Courts for cases involving persons who are UNA or NGMI.

Management of forensic patients following court proceedings

Issue 6.74: Should the MHFPA provide for a forensic patient to apply for a review of his or her case?

Yes. Frivolous applications could be avoided by attaching requirements similar to those currently found in s 65(3) of the MHA in relation to the variation or revocation of orders by the MHRT.

Issue 6.75: Are the provisions regarding the conditions that may attach to leave or release adequate and appropriate? If not, what changes should be made?

The conditions are generally adequate and appropriate. We note, however, that it is often MHRT practice to apply as a standard condition the "drug testing" condition, even when the forensic patient has no history of alcohol or drug abuse. In these circumstances such a condition can be unfairly onerous.

Issue 6.76: Should the MHFPA be amended to abolish the requirement for the MHRT to notify the Minister for Police; the Minister for Health; and/or the Attorney General of an order for release?

We agree that the requirement for the MHRT to notify the Minister for Police should be removed. This is inappropriate under the current legislative framework and attaches an unnecessary stigma to forensic patients.

Issue 6.77: Should legislation provide specific roles for an agency or agencies in relation to supporting and supervising forensic patients in the community?

No. On the whole, agencies work well together in providing services to forensic patients who have been released, and we find it difficult to envisage how legislating specific roles for agencies in relation to supporting and supervising forensic patients could be effective. The difficulties that arise in this area are more often the result of a lack of resources, and legislating specific roles would not resolve this issue. We are also concerned that mandating supervisory roles, for example, could result in less flexibility in the way that forensic patients are supervised, and could lead to a lower level of cooperation between agencies.

Decisions about what level of support and supervision are appropriate should be based upon the needs of the individual patient.

Issue 6.78: Are there any legislative changes that should be made in relation to the making and implementation of orders for: leave; and/or conditional release of forensic patients?

While we have found that the current system works effectively, we agree that creating uniform requirements in relation to forensic patients being released, regardless of where they are being released from, is appropriate. We agree, therefore, that a legislative amendment should be made so that authorised officers are required to take "all reasonably practicable steps" to make arrangements for a person's release or leave when that person is a forensic patient who is being released from a place other than a mental health facility.

Issue 6.79: Are the procedures relating to breaches of orders adequate and appropriate? If not, what else should be provided?

Yes. The current procedures are generally adequate and appropriate.

Issue 6.80: Are the current provisions concerning notification to, and participation by victims in proceedings of the MHRT adequate and appropriate? If not, what else should be provided?

We acknowledge the right of a victim to make a written submission in relation to the care, treatment, detention and release or a forensic patient, to be notified about the release of a forensic patient, and to attend the MHRT hearing. However, there are some stages of the hearing process at which it is inappropriate for the victim to be in attendance due to privacy

issues; for example, when a patient's medical history is being detailed. We would support an increased use of the Tribunal's discretion to limit access to the hearing at such points in the proceedings if the forensic patient does not consent to the victim being present.

Issue 6.81: Are the current provisions concerning notification to, and participation by carers in proceedings of the MHRT adequate and appropriate? If not, what else should be provided?

We agree that there should be a formal requirement for carers to be notified about proceedings in the MHRT.

Issue 6.82: Are the current provisions relating to people who are UNA who become fit to be tried adequate and appropriate?

Yes, the current procedures are adequate and appropriate.

Issue 6.83: Should a person cease to be a forensic patient if he or she becomes fit to be tried and the Director of Public Prosecutions decides that no further proceedings are to be taken?

Yes. After this point, there is no reason why a person should be a forensic patient any longer.

Issue 6.84: Should legislation specify circumstances in which, or a period after which, fitness ceases to be an issue?

Yes, but with the following reservation.

Finding somebody "permanently unfit" after a specified amount of time denies the forensic patient an opportunity to face trial and be acquitted. There are of course forensic patients whose impairment is of such a nature that it will not change; for example, forensic patients with certain cognitive impairments. In such cases an option to declare a person permanently unfit is useful. However, it is submitted that an order that provides that fitness is no longer an issue should never be made without the consent of the forensic patient.

Issue 6.85: Should the requirement that the MHRT have regard to whether a forensic patient who was UNA has spent "sufficient" time in custody be abrogated?

Yes, for the reasons set out in CP 6.

Issue 6.86: Are the provisions of the MHFPA which define the circumstances in which a person ceases to be a forensic patient sufficient and appropriate? If not, are there any additional circumstances in which a person should cease to be a forensic patient?

The provisions are appropriate. However, see our response to Issue 6.101 in relation to time limits.

Issue 6.87: Should there be provisions for referring a person who is UNA into other care, support and/or supervision arrangements at the expiry of the limiting term? If so, what should they be?

Yes, although such provisions would have to be carefully worded. We have similar concerns with this proposal as those expressed in our response to Issue 6.77.

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?

We agree that the legislation should be amended to require the discharge of a person who is detained in a correctional centre or "other place" immediately prior to the termination of his or her status as a forensic patient and who is not reclassified as an involuntary patient. Additionally, if a person ceases to be a forensic patient because he or she was UNA and has become fit and no further proceedings are to be taken, there should be a clear provision requiring his or her discharge.

Issue 6.89: Are the provisions for appeals against decisions by the MHRT adequate and appropriate? If not, how should they be modified?

The current appeal provisions appear to be working well. We question, however, why a forensic patient must apply to the Court of Appeal regarding release, when an appeal to the Supreme Court (which has jurisdiction in relation to other MHRT determinations) would be adequate.

Issue 6.90: Should the MHFPA be amended to exclude the detention of forensic patients in correctional centres?

Yes, but taking the following into account.

We agree that forensic patients should not be detained in correctional facilities, and that the MHFPA should be amended to ensure that this does not occur. The presumption that forensic patients should be detained in correctional centres violates Australia's human rights obligations. Prisons are not equipped to properly treat forensic patients, and the conditions can exacerbate their health situation. However, before such an amendment is legislated, appropriate alternative facilities need to be established, particularly for those forensic patients who do not have a mental illness.

Because of the inadequacies of the current mental health system to accommodate forensic patients who do not have a mental illness, we have found that there is a small group of forensic patients who in fact prefer to be housed in correctional facilities rather than in mental health facilities. While a proportion of these forensic patients lack the insight as to what is in their best interests, some of them have practical and reasonable grounds for expressing this choice. In a mental health facility, which is geared towards mental health treatment in a medical framework, the forensic patient is subject to compulsory treatment, and might receive inappropriate or ineffective treatment with side effects that decrease his or her quality of life, as well as have certain freedoms curtailed. We would be wary of any amendment that removed the ability of forensic patients to make this choice.

Given the statistic that a significant proportion of the prison population is forensic patients, a reallocation of the resources currently used to keep forensic patients in prison could instead be directed towards health and supported accommodation in the community.

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?

Yes. If the detention of forensic patients in correctional centres remains a reality, a special classification should be created for forensic patients in prison to ensure that appropriate custody arrangements and programs are made available to them, and to avoid them being housed in protective custody or segregation unnecessarily. This is required because as

currently drafted, the MHFPA operates in a discriminatory way against persons in prisons (compared to their counterparts in mental health facilities, as well as those serving sentences with parole periods) in relation to, for example, pre-release planning, treatment, access to rehabilitation.

In particular, legislation should prohibit forensic patients from being confined to their cells for any longer than is necessary, and any decision to do so should take into account their clinical need.

Issue 6.92: Under what circumstances, if any, should forensic patients be subject to compulsory treatment?

The NSW forensic provisions should comply with the National Principles, and specifically, the inherent principles that a forensic patient should not be subject to medical treatment without his or her informed consent and that if such consent cannot be given, then the treatment should only be given in accordance with safeguards that are on par with those that apply to other members of the community.

Issue 6.93: Should different criteria apply to: different types of treatment; and/or forensic patients with different types of impairment?

While unable to comment on the question of whether different criteria should apply to different types of treatment, we agree that different criteria should apply to forensic patients with different types of impairment; in particular those with intellectual disabilities and/or cognitive impairments.

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?

No, the range of interventions for which the MHA and the MHFPA provide are not adequate or appropriate for all forensic patients.

Specific provisions should apply to forensic patients with intellectual disabilities and/or cognitive impairments, consistent with the National Principles. The range of interventions should be determined by the nature of the cognitive impairment.

Issue 6.95: Are the present safeguards regarding compulsory treatment of forensic patients adequate? If not, what other safeguards are needed?

No, the present safeguards regarding compulsory treatment of forensic patients are not adequate. Consistent with the civil criteria, a person who is a forensic patient should not be subject to compulsory treatment unless the person is either a "mentally disordered person" or, "a mentally ill person", and in need of treatment in order to prevent a risk of harm to themselves or others.

Issue 6.96: Should the MHFPA provide any additional factors to which the MHRT must have regard when making decisions about forensic patients?

The MHFPA should specifically provide that, when making decisions about forensic patients, the MHRT must have regard to:

- issues concerning consent to treatment, including capacity and reasons for refusal consistent with the National Principles;
- culturally appropriate treatment, services and placement; and

- placement of services as close as possible to family to enable visits by family members.

Under s 43, there should be a presumption in favour of release of a forensic patient. In addition, the criteria in s 43(a) should be confined to seriously endangering a member of the public and not the patient.

Issue 6.97: Should the relevant risk of harm be expressed and defined in the same way for the purposes of decisions by the Forensic Division of the MHRT as it is for the court? If not, how should the provisions relating to the MHRT be different?

Yes, the relevant risk of harm should be expressed and defined in the same way for the purposes of decisions by the Forensic Division of the MHRT as it is for the court.

Issue 6.98: In what circumstances, and to what extent should the Forensic Division of the MHRT be required to have regard to a risk of harm only to the person concerned, in the absence of any risk to others?

There is no justification for detaining a person in the forensic mental health system if that person poses a danger only to him- or herself. Such a patient should be transferred to the civil mental health system if treatment for a mental health condition would assist. If on the other hand, the person has an intellectual disability or cognitive impairment, that person should be released or transferred to an appropriate facility, if such a facility exists.

Issue 6.99: Should a requirement to impose only the "least restriction" apply to all decisions regarding forensic patients?

Yes.

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?

In the MHFPA the principle of "least restriction" should be consistent with the statement of principle in the MHA.

In the context of decisions about detention or release, the principle of "least restriction" should be expressed as "least restriction consistent with the safety of the community."

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?

Yes. Indeterminate orders can:

- mean that people are left to languish in the forensic mental health system far longer than they would be detained in the correctional system had they been tried and convicted of the offence;
- entrench a negative perception about a forensic patient's criminality;
- affect a forensic patient's self esteem and confidence, can be counter-therapeutic and can create a sense of hopelessness about the future;
- mean that people are subject for an indeterminate period to greater restrictions than they would be in the civil mental health system; and
- deter people with mental impairments from relying on the defence of mental illness and seeking a declaration they are unfit to be tried.

Concerns about persons posing a risk of harm to others at the end of their time limit could be allayed by legislation that provides for transfer to the civil mental health system or other care, support and/or supervision arrangements.

Issue 6.102: If there is a time limit, on what basis should it be determined?

As acknowledged in CP 6, a sentencing-based time limit is problematic, both conceptually and in practice. Since UNA and NGMI forensic patients have not been convicted of an offence, it is inappropriate for their period of detention to be referable to a sentence served by a person convicted of an offence. Sentencing principles should only operate as a limit on, and not as a basis for, the court's discretion to make a detention order.

This is to avoid the situation where a person is detained longer in the forensic mental health system than they would be in the correctional system had they been sentenced for the offence, and in conditions that are more restrictive than the general corrective system or the civil mental health system.

We also propose that at a point in time equivalent to the non-parole period that would have applied had the person been convicted for the offence, the presumption in favour of detention should be reversed (as discussed in our response to Issue 6.85).

We agree that statutory time limits are inappropriate because of the arbitrary relationship they would create between the offending conduct and the outcome.

Issue 6.103: Should the same approach be used both for persons who are UNA and for those who have been found NGMI?

Yes, the same approach should be used for both persons who are UNA and for those who have been found NGMI.

Sentencing: principles and options

Issue 6.104: Should s 21A of the CSPA be amended to include "cognitive and mental health impairment" as a factor in sentencing?

Yes.

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?

Yes, the CSPA should 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. That statement should be framed to reflect the principles in *Hemsley* as set out in paragraph 8.41 of CP 6, as well as the considerations set out in paragraph 8.42 of CP 6.

Issue 6.106: Should the purposes of sentencing as set out in s 3(1)(a) of the CSPA be modified in terms of their relevance to offenders with cognitive and mental health impairments? If so, how?

Yes, the purposes of sentencing as set out in s 3(1)(a) of the CSPA should be modified.

Section 3(1)(a) of the CSPA should state that in sentencing an offender with a cognitive or mental health impairment, where the impairment is considered sufficient to mitigate the

severity of the sentence, or to reduce an offenders moral culpability for an offence, the aim of the sentencing process is to promote the offender's prospects of rehabilitation, to be balanced against the harm done to the victim and the community, and to protect the community from any serious risk likely to be posed by the offender.

Issue 6.107: Should the CSPA be amended to make it mandatory for a 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?

The CSPA be should be amended to make it mandatory for a court to order a pre-sentence report when considering sentencing offenders with cognitive or mental health impairments to prison, but only where the offender is unrepresented.

The report should contain an assessment of:

- the nature and severity of the offender's impairment;
- the type and availability of community based services;
- the offender's suitability for semi- and non-custodial sentencing options, taking into account the type and availability of community based services; and
- the availability of a mental health facility, or a specialist unit for intellectual disability in which the offender might serve a sentence of imprisonment, rather than a prison.

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 prison? If so, how should such a power be framed?

Yes. The CSPA should be amended to provide that:

- where the offender has a cognitive or mental health impairment, and
- the impairment is considered sufficient to mitigate the severity of the sentence, or to reduce an offender's moral culpability for an offence, and
- the court intends to impose a sentence of full time imprisonment

the court is required to order that the offender serve that sentence in a mental health facility, or a specialist unit for intellectual disability, rather than a prison, where such facilities are available.

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 commitment concerning the need for psychiatric evaluation, or other assessment of an offender's mental condition as soon as practicable after 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, the MHRT, or the Disability Services Unit within DCS, if appropriate?

While there are Local Court and District Court Practice Notes that require the transmission of psychiatric and psychological reports tendered in proceedings from the courts to DCS, as noted by the NSWLRC, there is evidence that the information concerning offenders' impairments is not routinely transmitted from the courts to DCS.

DCS are currently formalising procedure to comply with the Practice Notes, so that such reports are delivered to Justice Health.

It would be preferable if the CSPA provided a mechanism for courts to notify other agencies and tribunals, including Justice Health, the MHRT, or the Disability Services Unit within DCS of the needs of offenders with cognitive and mental health impairments who are sentenced to imprisonment, and for such legislation to provide specifically for the transmission of such reports.

In addition, it would be desirable if the legislation provided that the sentencing court may make recommendations on the warrant of commitment concerning the need for psychiatric evaluation, or other assessment of an offender's mental condition as soon as practicable after reception into a correctional centre.

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?

Yes.

Issue 6.111: What similar powers, if any, should the court have with regard to offenders with other mental conditions or cognitive impairments?

The CSPA should be amended to empower the court, when considering imposing a sentence of imprisonment on an offender with a mental condition other than a mental illness, or a cognitive impairment, 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.

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.

Yes. We support the amendment of provisions to include express reference to offenders with cognitive and mental health impairments for the reasons set out in CP 6.

We note, however, that currently, even when consideration of an offender's impairment occurs, it is a factor that has little impact on the parole decisions that are made when there are no appropriate community services available to assist that person.

Legislation requires that consideration of an offender's impairment is balanced against the other legislated considerations: for example, the likelihood of the offender being able to adapt to normal lawful community life, as required by s 135A(a) of the *Crimes (Administration of Sentences) Act 1999*; the risk of the offender re-offending (s 135A(b)); the measures to be taken to assist the offender while on release on parole (s 135A(c)); and the likelihood of the offender complying with the conditions of parole (s 135A(h)).

In the common situation where there are no appropriate community services available to assist the offender, the State Parole Authority may not grant parole, for example, because without appropriate structured treatment and accommodation for the offender the risk of that person re-offending is too high.

Another legislative amendment that would assist is an amendment to s 183 of the *Crimes (Administration of Sentences) Act 1999*, which provides for the constitution of the State

Parole Authority. The section should be amended to require that the membership of the State Parole Authority include person(s) with expertise and knowledge in the area of mental and cognitive impairment.

Other jurisdictions have incorporated such an approach. For example, in New Zealand, when an inmate is serving a life sentence, preventative detention or a long-term determinate sentence of more than seven years, an extended panel of at least five NZ Parole Board members meet to consider the case. While the membership of the Extended Board is at the Chairperson's discretion, in practice a psychiatrist is always one of the sitting members. The NZ Parole Board membership also includes two forensic psychiatrists, a clinical psychologist, and a psychotherapist.

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 impairments?

Yes. However, in our experience the level of compliance required for home or periodic detention is regularly proved to be too high for people with cognitive or mental health impairments. The result is that many such orders are breached, and offenders end up in full-time imprisonment.

Community service orders (CSOs) and good behaviour bonds are more appropriate options for people with a cognitive or mental health impairment because, as the legislation is currently drafted, a court dealing with a breach has more discretion. In the case of a CSO it can resentence the offender for the original offence. In the case of a bond it can waive the breach or adjourn the proceedings to give the offender another chance to comply.

Therefore, we support amending the relevant legislation dealing with CSOs and good behaviour bonds to increase the relevance and appropriateness of these sentencing options for offenders with cognitive and mental impairments.

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 option be adapted to meet the requirements of offenders with cognitive or mental impairments?

As stated above, access to semi- and non-custodial sentencing options would be more relevant and appropriate for offenders with cognitive or mental impairments if there was more latitude for these impairments to be taken into account by the court in the event of a breach, and greater community support for such offenders to assist them complying with the orders.

For example, when considering what orders to make following a breach of a CSO or a good behaviour bond, we suggest that, in addition to current requirements, the Court is required, in relation to offenders with a cognitive or mental impairment, to consider giving the offender another opportunity to comply. Additionally, legislation could provide that in cases where an order or bond is breached by an impaired person, an order of full time imprisonment should only be made as a matter of last resort.

Issue 6.115: Should s 11 of the CSPA concerning deferral of sentencing be amended to refer expressly to rehabilitation or intervention programs for offenders with cognitive or mental health impairments?

Yes.

CONSULTATION PAPER 7: DIVERSION

Pre-court 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 of mental illness or cognitive impairment?

(1) We support a legislative scheme but one with appropriate safeguards, including a requirement that the offender is provided with:

- independent legal advice at appropriate stages of the process; and
- an appropriate support person.

Without proper legal advice in particular, there is a danger that people with cognitive and mental impairments could end up with a number of warnings and cautions in relation to offences they did not actually commit.

(2) Any legislative scheme that is established should apply to the same matters that Part 3 of the MHFPA applies to; namely, criminal proceedings in respect of summary offences or indictable offences triable summarily, being proceedings before a Magistrate, and any related proceedings under the *Bail Act 1978*, but not committal proceedings. With regard to the types of mental illnesses and cognitive impairments that would fall under the scheme, its scope should be consistent with s 32 of the MHFPA, whether that section remains as it is or is amended.

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?

We believe that, with appropriate police training, a legislative scheme of cautions and warnings could work well in practice. The *Law Enforcement (Powers and Responsibilities) Act 2002* already requires the police to identify persons with certain vulnerabilities when undertaking particular duties, including providing support people to vulnerable persons: see clauses 24 to 27 *Law Enforcement (Powers and Responsibilities) Regulation 2005*.

Issue 7.3: Does s 22 of the MHA work well in practice?

While s 22 of the MHA is appropriately drafted, it only works well in practice if there are adequate hospital beds available and police are trained to deal appropriately with people with mental and cognitive health impairments, which is not always the case. Police do not always obtain adequate support people for interviews, and sometimes ask inappropriate questions designed to elicit answers from people who, by reason of a cognitive or mental health impairment, have particular difficulty coping with pressure. Further police training to provide minimum standards of knowledge and behaviour would be helpful.

Issue 7.4: Should the police have an express, legislative power to take a person to a 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 s 22 of the MHA?

Yes. We support the introduction of an express legislative power to take a person to a hospital and/or appropriate social service if that person appears to have a cognitive impairment and is posing a risk to themselves or others. However, the difficulty is again the lack of services available. Such a legislative provision would need to be supported by resources, as well as co-ordination between the police and health workers to ensure that the person is referred to the appropriate service.

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 the discretion to prosecute or charge an alleged offender?

Based on the large number of persons currently appearing before the Local Court who would qualify for diversion, it appears that the relevant Police and DPP policies do not place enough emphasis on the option of diverting such people out of the criminal justice system.

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, we agree that the provisions of the *Bail Act 1978* make it harder for a person with a mental illness or cognitive impairment to be granted bail than for other alleged offenders because the lack of treatment and appropriate care available to that person means that concerns about community safety cannot be allayed.

Issue 7.7: Should the *Bail Act 1978* (NSW) include an express provision requiring the police or the court to take account of a person's mental illness or cognitive impairment when deciding whether or not to grant bail?

Section 32 of the *Bail Act 1978* already requires that, in deciding whether to grant bail, the court must consider the interests of the accused person having regard to whether they have an intellectual disability or are mentally ill. This requirement should be extended in scope so that it covers the types of mental illnesses and cognitive impairments covered by s 32 of the MHFPA.

Additionally, the fact that an accused person has a mental illness or cognitive impairment should be a factor that is capable of rebutting a presumption against bail. The defence could be required to provide a report that sets out the condition/illness and a proposed treatment plan.

Issue 7.8: What education and training would assist the police in using their powers to divert offenders with a mental illness or cognitive impairment away from the criminal justice system?

Police would benefit from training by psychiatrists, psychologists and other mental health workers to assist them with:

- identifying persons with a cognitive impairment or mental illness;
- understanding the difficulties they face;
- communicating with such people effectively; and
- being sensitive to their needs.

Diversion under section 32

Issue 7.9: (1) Should the term, "developmentally disabled", in s 32(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?

(1) While it is not the experience of Legal Aid NSW lawyers that the absence of a definition has caused particular difficulties, we would support the addition of a definition for the term "developmentally disabled", so long as it is broad enough not to exclude people who are currently able to take advantage of s 32.

(2) All of the mentioned categories of people should be covered in an inclusive but not exhaustive definition.

Issue 7.10: Is it preferable for s 32 of the MHFPA to refer to a defendant "with a developmental disability" rather than to a defendant who is "developmentally disabled"?

The term "with a developmental disability" is preferable to the term "who is developmentally disabled" as it avoids defining a person by his or her disability.

Issue 7.11: Should the term, "mental illness" in s 32(1)(a)(ii) of the MHFPA be defined in the legislation?

Yes. We note, however, that the term "mental illness" is already defined in the MHA.

Issue 7.12: Should the term, "mental condition" in s 32(1)(a)(iii) of the MHFPA be defined in the legislation?

A definition would be helpful, although it is not the experience of Legal Aid NSW lawyers that the absence of a definition has caused particular difficulties. Our experience is that magistrates tend to read the section broadly and accept guidance from mental health experts.

Issue 7.13: (1) Should the requirement in s 32(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 in the community" or alternatively, "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 programs aimed at providing various life skills and support?

(1) Yes. We support a change to "for which treatment is available". The requirement that treatment is available in a mental health facility is too restrictive, since a person might have a condition that significantly affects his or her functioning, but for which the most appropriate treatment is more likely to be available through private treatment providers; for example, cognitive behavioural therapy.

A change to "for which treatment is available" would also remove the hurdle often faced when magistrates require proof that treatment is available in a "mental health facility" before they will grant a s 32 application. In such a scenario defence solicitors must seek an adjournment to obtain the appropriate reports to specifically address that issue.

(2) Yes, the legislation should make this clear because, as currently drafted, it creates obstacles for people with certain conditions; for example, those with a developmental disability. While such people cannot be "cured", they are generally assisted by social services programs aimed at providing various life skills and support. For the same reason a treatment plan should not always be required.

Issue 7.14: Should the existing categories of developmental disability, mental condition, and mental illness in s 32(1)(a) of the MHFPA be removed and replaced by a general term used to determine a defendant's eligibility for a s 32 order?

A general definition could work, but only if properly defined. Of key importance is that the definition adopted does not discourage magistrates from dealing with matters under s 32.

Issue 7.15: What would be a suitable general term to determine eligibility for a s 32 order under the MHFPA? For example, should s 32 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?

In our view, "mental impairment" should not replace the current conditions listed in the Act. If a list of conditions is adopted, it should be inclusive and not exhaustive.

Issue 7.16: Are there specific conditions that should be expressly excluded from the definition of "mental impairment", or any other term that is preferred as a general term to determine eligibility under s 32 of the MHFPA? For example, should conditions related to drug or alcohol use or abuse be excluded? Should personality disorders be excluded?

We do not support the express exclusion of any condition from the definition of "mental impairment".

While drug or alcohol use or abuse on its own would rarely be an appropriate reason for a s 32 order, such conditions often coexist with mental illness. Excluding conditions related to drug or alcohol abuse may mean that people with a dual diagnosis are inappropriately excluded from the ambit of the section.

Nor should personality disorders be excluded, since it is our experience that people with personality disorders can benefit from diversion. Often such disorders go undetected and untreated until a psychological or psychiatric report is obtained.

Under the current legislation it can be a challenge to convince a magistrate to consider diversion as an option for an accused person with a personality disorder. If anything, the legislation should clarify that diversion is available in such cases.

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 s 32 of the MHFPA? Why or why not?

As the consultation paper notes, s 31 of the MHFPA already defines what offences can be dealt with by way of s 32: namely summary offences or offences triable summarily. The category of offences that it is appropriate to deal with by way of a s 32 order should be curtailed no more than this. It is therefore our view that a magistrate should not take account of the seriousness of the offence when deciding whether or not to divert a defendant according to s 32. A magistrate should only be restricted in this respect by the limitations of s 31.

Issue 7.18: Should the decision to divert a defendant according to s 32 of the MHFPA depend upon a direct causal connection between the offence and the defendant's developmental disability, mental illness, or mental condition?

No. The fact the offender has a mental illness, developmental disability or a mental condition should be sufficient to warrant an application under s 32. As argued in CP 7, it is overly simplistic to try to identify a direct cause for criminal conduct in the case of an accused with a mental illness or impairment. The existence of one of these conditions leads to other difficult issues for offenders: for example, social isolation; drug and alcohol issues; the breakdown of families; and lack of support networks. In this sense offending behaviour for people who have one of these conditions, while it might not be obviously connected to the condition, may be the indirect result of a number of factors that have stemmed from the condition.

Issue 7.19: Should the decision whether or not to divert a defendant according to s 32 of the MHFPA take into account the sentence that is likely to be imposed on the defendant if he or she is convicted?

Yes, but only as one of many factors to be considered. For example, it might be relevant to consider that a defendant who is likely to receive a term of imprisonment if convicted is unlikely to cope well in the corrective system due to a mental or cognitive impairment.

Issue 7.20: (1) Should s 32(1)(b) of the MHFPA include a list of factors that the court must or can take into account when deciding whether it is appropriate to make a diversionary order? (2) If s 32(1)(b) were to include a list of factors to guide the exercise of the court's discretion, are there any factors other than those discussed in paragraphs 3.28-3.41 that should be included in the list? Are there any factors that should be expressly identified as irrelevant to the exercise of the discretion?

(1) While we can see the attractiveness of providing a list of factors and in this way guiding magistrate discretion, we do not support a list because we are of the view that it would unreasonably limit the factors a magistrate can take into account.

(2) See above.

Issue 7.21: (1) Do the interlocutory orders available under s 32(2) of the MHFPA give the Local Court any additional powers beyond its existing general powers to make interlocutory orders? (2) Is it necessary or desirable to retain a separate provision spelling out the Court's interlocutory powers in respect of s 32 even if the Court already has a general power to make such interlocutory orders?

(1) No.

(2) No.

Issue 7.22: Are the interlocutory powers in s 32(2) of the MHFPA adequate or should they be widened to include additional powers?

The current interlocutory powers are adequate.

Issue 7.23: Is the existing range of final orders available under s 32(3) of the MHFPA adequate in meeting the aims of the section? Should they be expanded?

The existing powers are adequate.

Issue 7.24: Are the orders currently available under s 32(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?

It may be that depending on the nature of the cognitive impairment and what assistance is available to these offenders, the orders currently available need to be expanded.

Issue 7.25: Should s 32(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?

No. Legislation should not require the Court to consider the person or agency that is to implement the order or whether that person or agency is capable of implementing it. Nor should the legislation provide for any means of compelling a person or agency to implement an order that it has committed to implementing.

If the legislation compelled supervision, it is our view that the availability of s 32 applications would dramatically decrease. Medical practitioners do not see their role nor want to see their role as being about enforcing court orders. We believe that if placed in such a position, doctors and psychiatrists would be reluctant to commit to implementing the order. As a result, people requiring treatment would miss out on the option of diversion.

Legal practitioners rely on the co-operation of medical agencies, doctors and psychiatrists for the reports that need to be filed in support of a s 32 application. The prospect of compulsory supervision orders may well negatively affect their advice to the court in relation to the appropriateness of a s 32 application.

These proposals are also opposed on the ground that people on treatment plans pursuant to s 32 often receive assistance from a number of agencies, none of whom could be called "the agency responsible for the plan".

Case example

In a recent s 32 application before the Local Court, a magistrate attempted to incorporate into the s 32 orders a formal commitment from a particular agency to implement the treatment plan. This attempt resulted in opposition from the relevant agency and caused delays in the resolution of the matter.

Issue 7.26: Should s 32 of the MHFPA specify a maximum time limit for the duration of a final order made under s 32(3) and/or an interlocutory order made under s 32(2)? If so, what should these maximum time limits be?

Section 32 should not specify any maximum time limit. The provisions currently set out in s 32(3A)-(3D) that allow a magistrate to call on a defendant to appear before the court within 6 months of the order being made, are already problematic. Allowing a matter to be brought back before the court during a specific time frame, to be heard as if it had not previously been dealt with, undercuts the diversionary ambition of the section. It also prolongs the resolution of the matter, causing confusion and stress to offenders.

It is also our experience that the 6 month time limit on final orders under s 32 does not encourage magistrates to apply the section, as was the purpose of the amendment. Rather it leads magistrates with concerns about the offender's compliance with treatment plans to

choose a supervised bond under s 9 or s 12 over a s 32 order, because they can impose a bond for longer than 6 months. This means that the offender misses out on the opportunity to be diverted from the system. While it is tempting to say that a longer time limit on final orders would solve this problem, we believe that it would only undercut the diversionary ambition of the section, as discussed above.

There should be no time limits in place at all. Once final orders are made under s 32, this should constitute the end of the matter.

Issue 7.27: Should the Mental Health Review Tribunal have power to consider breaches of orders made under s 32(3) of the MHFPA, either instead of or in addition to the Local Court?

Yes. If the legislation continues to impose a time limit imposed under s 32, the MHRT should have the power to deal with breaches of orders instead of the Local Court. This would maintain the diversionary ambition of the section and avoid the possibility of the matter being dealt with further under the criminal law.

Issue 7.28: Should there be provision in s 32 of the MHFPA for the Local Court or the Mental Health Review Tribunal to adjust conditions attached to a s 32(3) order if a defendant has failed to comply with the order?

Yes. If there are to be continued time limits on final orders, then there should be a specific provision in s 32 for the MHRT to adjust conditions attached to an order.

Issue 7.29: Should s 32 of the MHFPA authorise action to be taken against a defendant to enforce compliance with a s 32(3) order, without requiring the defendant to be brought before the Local Court?

No. This would presumably involve further police intervention, which in our experience would have a negative impact on vulnerable persons and is to be avoided.

We also oppose this proposal on the basis that if there is to be any action taken by a court against a defendant to enforce compliance, the defendant has a right to appear before that court and to have legal representation for that appearance.

Issue 7.30: Should the MHFPA clarify the role and obligations of the Probation and Parole Service with respect to supervising compliance with and reporting on breaches of orders made under s 32(3)? What should these obligations be?

No. No agency or person should be under a legislative obligation to ensure compliance. This approach is unworkable for the reasons stated in our response to Issue 7.25 above.

A better solution would be to increase the resources of the Probation and Parole Service to enable it to provide more appropriate specialist services to this client group.

Issue 7.31: Are there any other changes that should be made to s 32(3A) of the MHFPA to ensure the efficient operation of s 32?

Yes. We would support the repeal of s 32(3A) for the reasons set out in our response to Issue 7.26.

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?

Yes. We agree that a centralised system within the Local Court and NSW Police for assessing defendants for cognitive impairment or mental illness at the outset of criminal proceedings is needed. The current provision of a psychiatric court liaison nurse from Justice Health could be expanded so that there is a nurse at every Local Court in the state.

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 s 32? (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?

(1) No. The submission of specific reports should not be expressly required by the legislation. It is our experience that if a more flexible approach regarding the types of documents that are required for s 32 matters were to be adopted by magistrates, this would reduce the unnecessary delays currently experienced in many matters. In some case it is not possible or feasible to obtain a comprehensive psychological or psychiatric assessment, bearing in mind the time and cost involved.

Sometimes it is clear from the facts, the offending behaviour and the police custody management records that a matter should be dealt with under s 32. At other times the report of a Justice Health Clinical Nurse discloses a mental condition, mental illness or a developmental disability. Psychologist reports can also be a useful source of information, as can previous reports, medical records or hospital discharge summaries.

If, for example, an offender is scheduled to a hospital under the MHA shortly after an offence takes place and is kept in for some time before being released on a community treatment order, the discharge summaries and a copy of the CTO should be sufficient documentation for a s 32 application.

(2) No. The Act should not spell out what is required in these reports. Given the variables of type of impairment, the circumstances of the alleged offence, and potential treatment plans, this approach is not feasible and would most likely result in a list that is too restrictive.

Issue 7.34: Should the MHFPA allow a defendant to apply for a magistrate to disqualify himself or herself from hearing a charge against the defendant if the same magistrate has previously refused an application for an order under s 32 in respect of the same charge?

Yes. There was once a provision, now repealed, that required a magistrate who refused a s 32 application to disqualify himself or herself from any further hearing of proceedings if requested to do so by the defendant. Such a provision should be reintroduced. It is inappropriate for a magistrate who is privy to matters such as the defendant's criminal history to then preside over a defended hearing.

Issue 7.35: (1) Should there be alternative ways of hearing s 32 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 to 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?

(1) While we agree that it is worth considering alternative methods of hearing s 32 applications, if such applications are still to be heard before a magistrate, then the current

adversarial arrangements should be maintained. In a conference-style setting it is possible certain parties would dominate the proceedings and not allow the other parties a fair hearing.

(2) While it is important that there is a legislative basis for alternative models, prescriptions in acts and regulations could be supplemented by way of practice notes, practice directions and departmental protocols.

Diversion under section 33

Issue 7.36: Should s 33 of the MHFPA require a causal connection between the defendant's mental illness and the alleged commission of the offence?

No, for the same reasons as set out in response to Issue 7.18 in relation to s 32. The fact an offender has a mental illness should be sufficient for an order under s 33.

Issue 7.37: Are the existing orders available to the court under s 33 of the MHFPA adequate and are they working effectively?

The orders available are by and large adequate. However, for the reasons set out in our response to Issue 7.26 in relation to s 32 orders, it is inappropriate for matters diverted by means of a s 33 order to be brought before the court again once the order has been made. This undercuts the diversionary ambition of the section. It also prolongs the resolution of the matter, causing confusion and stress to offenders.

Issue 7.38: Should legislation provide for any additional powers to enforce compliance with an order made under s 33 of the MHFPA?

No. The mechanisms currently in place are adequate.

Issue 7.39: Is it preferable to abolish s 33 of the MHFPA and broaden the scope of s 32 of the MHFPA to include defendants who are mentally ill persons?

No. It is appropriate to have a specific section for persons who are "mentally ill" under the MHA and who need to be hospitalised to prevent harm to themselves or to others.

Enhancing diversion in the superior courts

Issue 7.40: Does 10(4) of the MHFPA provide the superior courts with an adequate power to divert defendants with a mental illness or cognitive impairment?

No. The powers under s 10(4) are too limited.

Issue 7.41: Should s 32 and 33 of the MHFPA apply to proceedings for indictable offences in the Supreme and District Courts as well as proceedings in the Local Court?

Yes. Offenders who would be eligible to apply for a s 32 or s 33 order in the Local Court should have the same opportunity for diversion in the higher courts.

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?

(1) No. Including a statement of principles in the legislation would make the applications unnecessarily complex.

(2) See (1) above.

CONSULTATION PAPER 8: FORENSIC SAMPLES

Issue 8.1: Should the *Crimes (Forensic Procedures) Act 2000* (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a diversionary order under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW), or should the legislation be amended in some other way referable to the particular order made?

Requiring the destruction of forensic material where the person is found to have committed an offence but has had no conviction recorded, but not where a person as been diverted pursuant to ss 32 or 33, is an inconsistency in the current legislative scheme.

Therefore, presuming ss 32 and 33 remain in their current form, the Act should be amended to require the destruction as soon as practicable of forensic material taken from a suspect where:

- the person has been unconditionally discharged under s 32 or s33; or
- the person has been conditionally discharged under s 33; or
- the person has been conditionally discharged under s 32, and has complied with those conditions during the first 6 months of discharge.

Issue 8.2: Should the *Crimes (Forensic Procedures) Act 2000* (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a verdict of not guilty on the ground of mental illness?

Yes.

Issue 8.3: Should the *Crimes (Forensic Procedures) Act 2000* (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following: (a) a decision by the Director of Public Prosecutions not to continue with the proceedings, or (b) a finding at a special hearing that, on the limited evidence available, the defendant has committed an offence? If so, in what way?

(a) Yes.

(b) No, because it is still possible in these circumstances for a defendant to become fit to stand trial again.

Issue 8.4: Should the *Crimes (Forensic Procedures) Act 2000* (NSW) be amended to require the compulsory retention of forensic material in any of the following cases, namely: (a) persons who, because of cognitive or mental health impairment, are diverted from the criminal justice system under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW); (b) persons found not guilty by reason of mental illness; (c) persons, having been found unfit to be tried, are found, on the limited evidence available at a special hearing, to have committed an offence? If so, in what way should the legislation be amended?

(a) No.

(b) No.

(c) No.