Mental Health
Review Tribunal

NSW MENTAL HEALTH REVIEW TRIBUNAL SUBMISSION REGARDING CONSULTATION PAPERS:

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

Overview (5)

Criminal responsibility and consequences (6)

Diversion (7)

Young People (11)

Scope of Submission

This NSW Law Reform Commission currently has a wide reference concerning the needs of people with cognitive and mental health impairments in their interaction with the criminal justice system. The Tribunal has previously made a submission focussed on the question of appropriate diversion options from the Local and Superior Courts of NSW. This submission does not intend to canvass all of the remaining issues raised in the various consultation papers, but has focussed on the following key areas related to the work of the Mental Health Review Tribunal:

1. Defining cognitive and mental health impairments
2. Court procedures for people with cognitive and mental health impairments
3. Orders made following Court processes for people with cognitive and mental health impairments
4. What happens after Court including the role and procedures of the Mental Health Review Tribunal
5. Young people with cognitive and mental health impairments and the Criminal Justice System

The Tribunal's submission on these issues needs to be viewed in conjunction with its previous submission concerning the concurrent LRC paper on diversion. It is critical that the whole of the Criminal Justice System from arrest, to diversion or court, to detention, and back into the community needs to have regard to the needs of individuals suffering from a mental illness, mental condition, or cognitive impairment. However, the recognition of the individual's needs in relation to any of these particular conditions can not be in isolation or compartmentalised from other issues that may be impacting on their well being and potential criminal offending, such as drug and alcohol issues.

While it is important to have the correct legislative framework in place, most of the submissions made in this document will have resource implications and, in particular, will require a whole of government response and a breaking down of the silos between different government departments, and the walls within some departments.

A critical resource issue with regard to the forensic system is that it is currently 'top heavy' with the highest number of beds being in a high-security setting and the number of available placements reducing as the level of security reduces. This creates a bottleneck for all forensic patients and necessarily results in forensic patients spending more time in a higher security level setting than is required. While the Tribunal understands that this is an issue currently being explored by the Forensic Mental Health Network, the balance of the mix of

placements for forensic patients will be critical for the successful implementation of any legislative reform. This mix also needs to have regard to the location and resourcing of services available in the community into which forensic patients can be discharged.

Equally important to any legislative reform will be the creation of a clear pathway and step-down options for the cognitively impaired. Currently the only detention option for the cognitive impaired is within the correctional system, with no step down options being available prior to discharge into the care of Ageing, Disability and Home Care (ADHC) in the community.

With the aging population, similar issues are also beginning to arise for forensic patients who require placement in an environment where their aged care needs can be safely met.

1. Defining cognitive and mental health impairments

In drafting its submissions on this issue, the Tribunal in particular considered the following issues raised in consultation papers:

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?

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?

Issue 5.3

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

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?

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"?

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?

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?

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?

MHRT Response

The difficulty with the current Act is that the terminology suitable for the criminal process is not helpful for the ongoing review, treatment and rehabilitation process. This is because a very different treatment regime will apply to the mentally ill by comparison to the cognitively impaired. While it may be tempting to align the Court and treatment definitions, this would have its own pitfalls as diagnosis and definitions of illness are constantly evolving and more precise legal definitions would inevitably always be behind clinical developments.

The Tribunal would therefore support the continuation of broad language being used within the legislation so that it can be responsive to changes within the relevant health disciplines.

However, it would be beneficial for the language of the Act, in terms of what happens after the Court process has been finalised, to be varied to more accurately reflect the range of conditions people may have on entering the forensic mental health system. The current Act presumes that the person will have a treatable condition and is very much focussed on mental illness. This can lead to difficulties for those found unfit to stand trial as many do not have a mental illness and therefore their needs are not met within the existing resource framework.

The Tribunal therefore believes that it would be appropriate for there to be a clear recognition in the legislation that those who enter in the system following the court's decision do not necessarily have a mental illness.

Within the issue of definitions, the Tribunal believes that two specific groups require further consideration as to whether they are appropriately diverted from the criminal justice system into the forensic mental health system. These are offenders whose relevant mental health concern is a:

- Personality disorder, or
- Drug/alcohol induced psychosis

There is a concern regarding personality disorders qualifying as impairments for the defence of mental illness as a question remains as to how these disorders should affect an individual's criminal responsibility for the act. This is particularly true for some personality disorders where criminal offending forms part of the diagnostic criteria. Inclusion of these disorders could therefore represent circular reasoning: ie the person has the disorder as demonstrated by the commission of the act, for which they are not criminally responsible due to their disorder.

There are also concerns regarding those found not guilty by reason of mental illness due to drug or alcohol induced psychosis. This diagnosis needs a substantial length of time to be established and often only comes to light after the trial has finished. However, on occasion it has been the accepted diagnosis at trial. Once in the forensic system these forensic patients fit no model of rehabilitation as they do not have a mental illness or mental condition for which care and treatment is available.

The Tribunal believes that the appropriateness of diverting individuals whose relevant mental health concern is personality disorder or drug/alcohol induced psychosis from the Criminal Justice System into the Forensic Mental Health System needs close consideration. Where a person proves to have had a drug induced psychosis with an underlying personality disorder there is no clear basis for determining when, if ever, they may be safe for release back into the community.

2. Court procedures for people with cognitive and mental health impairments

In drafting its submissions on this issue, the Tribunal in particular considered the following issues raised in consultation papers:

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?

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?

Issue 6.2

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

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?

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?

Issue 6.5

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

Issue 6.6

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

Issue 6.7

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

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?

Issue 6.9

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

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?

Issue 6.11

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

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?

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?

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?

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?

Issue 6.16

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

Issue 6.17

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

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]"?

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?

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?

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?

Issue 6.23

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

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?

Issue 6.25

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

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

MHRT Response

Please find outlined below the Tribunal's suggested model for Court Procedures for those with a mental illness or cognitive impairment.

This model is predicated on a diversion system similar to that described in the Tribunal's Diversion Submission paper being available to the District and Supreme Courts.

For the below model to work effectively, the Tribunal would urge the establishment of:

- A dedicated assessment unit for those appearing before the District and Supreme Court as unfit or possible NGMI
- An extension of either the Court Liaison Service (CLS) or Community Forensic Mental Health Service (CFMHS) to provide expert non-partisan advice to the Court about the person's condition, treatment needs and risk.

Fitness to Stand Trial

The Tribunal believes that the current basis and timing of the question of fitness being raised and that the current case law (R v Presser and Kesavarajah v The Queen) regarding the matters which need to be considered when determining whether or not a person is fit to stand trial remain appropriate.

However, with regard to processes, the Tribunal believes that there is unnecessary duplication and consequent delay between the role of the Court and the role of the Tribunal.

Generally the Court is provided with sufficient evidence not only as to whether the person is fit or not, but also as to whether the person's condition is treatable or not. In many cases where the person is unfit due to a permanent or deteriorating condition (such as brain injury, intellectual disability, or dementia) the utility of the person being referred to the Tribunal for a determination as to whether they are likely to become fit within 12 months is questionable. The Tribunal therefore proposes:

- The Court determines not only whether or not the person is fit to be tired or not, but also whether or not the person is likely to become fit to be tried within 12 months. The Court would only refer the person to the Tribunal if the person is likely to become fit to be tried within 12 months or in cases where the Court is unsure as to whether or not the person will become fit to be tried.

If unfit and will remain so

The Court can then proceed directly to a special hearing without any delay.

If likely to become fit

The presumption in these cases would be for the person to be detained in the proposed dedicated assessment unit.

If the person were to be released on bail, then the Court would need to be provided with information from the proposed CLS/CFMHS service regarding the person's treatment needs and whether or not they are able to be met within the person's community. The bail order should then include or be attached to a treatment order.

Whether the person is detained or granted bail, the Tribunal would review the person's care and treatment and could make orders as to these matters, including as to co-operating with tests and assessments. If the person is detained the Tribunal could make orders as to leave, but not as to release (although could make a recommendation to the Court as to release). If the person is on bail, the Tribunal should be able to breach the

person on the same basis it breaches forensic patients, with the additional requirement that it notifies the Court.

Regarding fitness to stand trial, the Tribunal would report back to the Court either (a) when the person has become fit to stand trial or (b) the Tribunal forms the view that it is unlikely that the person would become fit to stand trial within 12 months of the Court's finding of unfitness or (c) at the expiry of 12 months from the Courts finding of unfitness if the person has not become fit to stand trial.

At the time of its report to the Court, the Tribunal should also advise as to whether the person has a mental illness or mental condition for which treatment is available in a mental health facility (the current requirement as to whether or not the person objects to being detained in a mental health facility should not be continued).

The person would then proceed to trial or a special hearing depending on the Tribunal's advice to the Court.

Special Hearing

The Tribunal believes that the current basic operations for Special Hearings remain appropriate. However, the Tribunal believes that at present there is unnecessary duplication and consequent delay between the role of the Court and the role of the Tribunal.

Generally the Court is provided with sufficient evidence at the time it is considering fitness as to whether or not the person has a mental illness or mental condition for which treatment is available in a mental health facility. The Tribunal therefore proposes that:

- The Court only refers to the Tribunal those cases where this issue is unclear after the limiting term is set. Otherwise the Court should proceed directly to determining the appropriate order.

Not Guilty by Reason of Mental Illness

The Tribunal would support the recommendation that the defence of not guilty by reason of mental illness should be able to be raised not only by the defence but also by the prosecution and potentially by the Court itself. If raised by the Court, then the Court should be able to order that the person participate in the relevant assessments. This is most likely to be best accomplished by referral to the proposed specialist assessment unit or CLS/CFMHS service.

The Tribunal often sees inmates as correctional patients where information is provided in the context of the Tribunal hearing that the person would have had the defence of mental illness available but it was not raised. The absence of this finding limits the ability of the forensic mental health system to respond appropriately and provide the necessary intensive rehabilitation and treatment to reduce the person's risk of harm to the community prior to their release.

Considering fitness to stand trial beyond the Special Hearing

The Tribunal believes that the Act needs to be clearer that the requirement to continue to consider a person's fitness to stand trial applies only to those set a limiting term, and not to those found not guilty by reason of mental illness.

3. Orders made following Court processes for people with cognitive and mental health impairments

In drafting its submissions on this issue, the Tribunal in particular considered the following issues raised in consultation papers:

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?

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?

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?

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?

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?

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?

Issue 6.50

What orders should be available to the court?

Issue 6.51

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

Issue 6.52

What orders should result in a person becomes (sic) a "forensic patient"?

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?

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?

Issue 6.56

Should "harm" be defined in the MHFPA?

Issue 6.57

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

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?

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)?

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?

Issue 6.61

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

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?

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?

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?

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?

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?

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?

Issue 6.102

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

Issue 6.103

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

MHRT Response

Orders available to the Court on setting a limiting term or following finding of NGMI

The Tribunal believes that the same orders should be available both for those found NGMI and those set a limiting term and that the same principles and criteria should apply when the Court is selecting which order is appropriate. That is:

- Presumption of detention – Court may order detention in a correctional centre, mental health facility or other place.
- If considering release, Court must be satisfied of the same matters as the Tribunal would be and can make the same range of conditions as the Tribunal (see s43, 73, 75 MHFPA). Currently, the Court is not provided with objective evidence as to a person's level of risk, if any at all. From transcripts of hearings the Tribunal often sees a lack of testing of the evidence put forward by one side, and it is common that there are merely legal submissions regarding the type of order, rather than reliance on medical or other expert advice as to risk. Even in those cases where expert evidence is available, it is often provided by professionals who are not involved in the forensic mental health system. This means the advice they offer can be theoretical rather than practical, which does not assist the Court in determining the appropriate order which can be implemented in a particular case. The Tribunal would recommend that the Court be provided with non-partisan advice concerning the person's treatment needs, the availability of services to meet those needs, and the person's risk. To that end if the person has already been detained in the proposed specialist assessment unit that unit should be able to provide that information. If the person hasn't been so detained, the Court should be able to make a short order (say for up to 3 months) for the person to be detained for assessment for this purpose. If the person is not detained, then the proposed CLS/CFMHS may be able to provide this information. The Tribunal would recommend that in cases where the offence involved serious violence that the detention option should be the default position. Of course the defence would have its own opportunity to have the person assessed and test the evidence provided by either the assessment unit or the CLS/CFMHS.
- If ordering release, it is critical that the Court also considers the actual availability of the necessary services/treatment/level of care within the person's community (and that the person meets the requisite criteria to access those services), rather than a theoretical availability.
- Those set a limiting term should not be able to be unconditionally released by the Court (although this option should remain available for those found not guilty by reason of mental illness).

The Tribunal would also propose that prior to making the final order for those set a limiting term or found not guilty by reason of mental illness, that the Court should be able to hear the equivalent of a victim impact statement as it does when sentencing those found guilty. Although the verdicts for forensic patients are not convictions and should remain as such, victims often express to the Tribunal their frustration at not being 'heard' by the Court. Victims, understandably, then wish to express their views to the Tribunal, but this is not the appropriate forum as the focus of the Tribunal is on the care, treatment and rehabilitation of the offender and the Tribunal is unable to look behind the decision of the Court.

Time Limited Orders

Not Guilty by Reason of Mental Illness

Assuming that those persons appearing before the Court with a mental illness or cognitive impairment on less serious charges would be diverted under an appropriate scheme, such as that discussed in the Tribunal's Diversion Submission, the Tribunal would not otherwise support the introduction of time limits on those found not guilty by reason of mental illness. The primary issue in this is risk. Those found NGMI are found so precisely because their condition led to the event occurring, therefore there is a public interest in ensuring that they are not released from supervision until that risk is manageable. It is not possible to set a time limit on how long that will take in any individual case. At present, as the Act is silent on the ability of the Court to make orders setting a time limit, Courts have made orders conditionally releasing a forensic patient for a particular length of time, such as 2 years. The Tribunal believes that it should be clear that if the Court has decided not to unconditionally release a forensic patient then the timing of the person being released from their forensic status is a matter for the Tribunal.

There has also been the suggestion of having a time period nominated as a 'guide' rather than an absolute. Advice the Tribunal has received from Victorian colleagues is that the setting of the nominal term for those found not guilty by reason of mental illness has meant that it is very difficult to progress someone through the system ahead of the time set by the Court – which brings an element of punishment into what is meant to be a treatment regime.

Limiting Term

The Tribunal agrees with comments made by the judiciary in several cases that many of the general sentencing principles are not applicable to the calculation of a limiting term. The only sentencing principle which consistently applies to those found unfit to stand trial is protection of the public. Therefore the seriousness of the crime should be considered when the Court determines the length of the limiting term. However, other principles such as general or specific deterrence rarely are applicable.

However, the Tribunal notes that the current calculation of the limiting term tends to overestimate the real length of time a person would have served/been sentenced for given that certain discounts (e.g. early plea of guilty) are automatically unavailable. The legislation should allow for some adjustment of the limiting term in view of this inherent bias against those with a mental illness or cognitive impairment.

The decision of the High Court in Muldrock also makes it clear that consideration of the subjective impact on the individual with a cognitive impairment should be considered in setting the limiting term.

Definition of Forensic Patient

The Tribunal would propose that the definition of forensic patient be adjusted to include:

- Those set a limiting term or found NGMI and ordered by the Court to be detained or released subject to conditions
- Those found unfit to be tried by the Court and referred to the Tribunal (whether detained or on bail) – NOTE: this assumes that the Mental Health Act 2007 has been amended to allow for forensic patients to be subject to the civil mental health provisions.

In all cases where the Court makes an order which results in the person falling within the definition of forensic patient, the Court should be required to notify the Tribunal of the order and provide the Tribunal with a copy of the relevant material including (but not limited to) the terms of the order, judgement, and relevant evidence (ie medical, psychiatric, psychological etc). In cases where the person has been found unfit to stand trial and granted bail, the Court should notify the Tribunal if the bail conditions are varied and of the terms of the new order.

4. What happens after Court including the role and procedures of the Mental Health Review Tribunal

In drafting its submissions on this issue, the Tribunal in particular considered the following issues raised in consultation papers:

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?

Issue 6.74

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

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?

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?

Issue 6.77

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

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?

Issue 6.79

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

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?

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?

Issue 6.82

Are the current provisions relating to people who are UNA who become fit to be tried 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?

Issue 6.84

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

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?

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?

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?

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?

Issue 6.89

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

Issue 6.90

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

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?

Issue 6.92

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

Issue 6.93

Should different criteria apply to:

- different types of treatment; and/or
- forensic patients with different types of impairment?

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?

Issue 6.95

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

Issue 6.96

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

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?

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?

Issue 6.99

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

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?

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?

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?

MHRT Response

MHRT Review cycle

For those found unfit to stand trial and for whom a special hearing has not been held, the Tribunal proposes that the current mechanism of review as soon as practicable followed by regular reviews at least once every six months (with the option of extending this out to 12 months) remain.

For those set a limiting term or found not guilty by reason of mental illness and ordered to be detained or released subject to conditions, the Tribunal recommends that the review cycle be adjusted as follows:

- Tribunal to review as soon as practicable and consider the treatment plan—this could involve a further hearing if the treating team has not yet assessed treatment needs
- Thereafter, the Tribunal is to conduct formal 3 member panel reviews at least once every 12 months. The same provisions regarding early reviews at the request of specific key individuals (Medical Superintendent, Commissioner CS NSW, Ministers etc) should continue. With regard to holding reviews at the request of patients, although the Tribunal in practice currently allows for forensic patients to apply for a review of his or her case, and is happy for patients to be able to express a desire for a review, there should be no compulsion for the Tribunal to continuously respond to such requests as some patients would wish to have their matter reviewed each week seeking release etc where no evidence exists to support such an application.
- Between formal reviews, the Tribunal can hold 'directions' style hearings conducted by a single member (President or Deputy President). These hearing would be to touch base with treating teams and other key participants that any issues identified at the formal hearing are being progressed over the intervening 12 month period. There would be no expectation for treating teams to provide formal reports at these hearings, merely to provide oral evidence or brief updates on individual issues.

The Tribunal believes that the resources that will be released by the Tribunal moving from a 6 month to a 12 month review cycle would then be able to be redirected.

MHRT Orders

Orders for Detention

It is important to retain the provision allowing for the detention of forensic patients in correctional centres. As discussed above not all forensic patients fit a mental health rehabilitation model and at present there are no other facilities available. Even if facilities do come on line for the cognitively impaired, there are still a small number of patients who fit neither model for whom a corrective services rehabilitation pathway may be most appropriate. As discussed above, for those who do not have a mental illness, mental condition, or cognitive impairment, the correctional centre system is the only viable pathway to address their criminogenic risk factors. There needs to be the ability under the legislation for these people to progress through corrective services rehabilitation pathways and be supervised in the community by parole.

There is however an issue about the availability of adequate services within the correctional system for forensic patients. The Tribunal would like to see the declaration or gazettal of beds in the Mental Health Screening Units both in the Sydney metropolitan area and in the

additional Mental Health Screening Units currently being rolled out. The implementation of Forensic Community Treatment orders would also be facilitated by this.

Orders for Release Subject to Conditions

Generally, the current broad provision for the range of conditions the Tribunal is able to impose remains appropriate. However, it would be of benefit for the Tribunal to be able to specifically require certain assessments occur by imposing conditions on the services managing the forensic patient while on leave or release.

Care and Treatment of Forensic Patients

Mental Health Treatment

Forensic patients who are detained are involuntary patients under the MHA and those principles apply to any compulsory treatment they receive. The Tribunal believes it is appropriate for the standards and principles of compulsory treatment for those with a mental illness to apply to both civil and forensic patients.

Broader Rehabilitation and Other Programs

The Tribunal has received Crown Advice which suggests that the current provision for the Tribunal to make orders as to 'care and treatment' is very broad and would include a range of treatments other than mental health. While a non-exhaustive list might be helpful to make this broader power more apparent within the legislation, the Tribunal would be concerned that any list would become a limiting factor. Any such list would need to be sufficiently broad in its language as to allow the Tribunal to respond to the needs of any forensic patient which can be wide ranging and difficult to predict.

Examples of the types of broader treatments and programs the Tribunal currently makes orders about include engagement in programs such as Drug & Alcohol, violence, and sexual offending.

Treatment for people with a cognitive impairment

As noted previously, the key issue in this area is simply the lack of adequate resources/identified responsible agency. Therefore even if the language of the Act is modified to better acknowledge the range of mental health and cognitive impairments that forensic patients might face, if no change is made to the underlying resources and structure across agencies, then there will be little difference made to the outcomes for individual patients.

Additionally, at least half of the forensic patients with a cognitive impairment also have a mental illness. It is therefore vital that there is an appropriate mechanism to provide for joint management in appropriate cases. This may also require a broadening/strengthening of s76G re Tribunal requesting co-operation of relevant agencies in providing appropriate services to forensic patients.

Considerations Prior to Order for Release

The key issue in the current legislation that requires amendment is for the Court and Tribunal to have regard to the same criteria and considerations prior to ordering the release of a forensic patient.

While the Tribunal supports that the principle of 'least restrictive' environment consistent with 'safe and effective care' should apply to forensic patients as it does to civil involuntary patients, there is a risk that the application of this principle by the Courts would consider the theoretical 'least restrictive' rather than considering what 'safe and effective care' can be delivered within the available resources. This is key in the forensic system where resources are limited and arguably 'top heavy' with more high secure mental health beds than medium secure mental health beds. This necessarily means that queues develop for placement in the medium secure units and therefore an individual may need to stay in an environment that is not the 'least restrictive' in an absolute sense, but is rather the 'least restrictive option consistent with safe and effective care' available at a particular point in time. The primacy of public safety in the forensic mental health system means that this practical reality needs to be considered when balancing least restrictive with safe and effective care.

A non-exhaustive list could also be created of further issues that the Tribunal should consider prior to release. This could include the Tribunal having regard to the nature and circumstances of the index event; the patient's condition at the time of the index event (NB present condition already covered under s74); and the patient's treatment history before and after the index event. While this is part of a good risk assessment it is not always included as risk assessments can be 'point in time' rather than holistic. However, it is critical that the Tribunal is confident that the patient has received a sufficient period of assessment and treatment to manage any risk issues in the individual case and explicitly providing for these issues to be addressed prior to release would ensure that these issues are considered by all participants involved in the care, treatment, and management of forensic patients.

Sufficient time in custody

The Tribunal would support the removal of the requirement for a person set a limiting term to have spent 'sufficient time in custody' prior to being released. This hurdle for conditional release is too high for many people on a limiting term due to the lack of facilities which offer treatment and/or rehabilitation programs in a detained environment (eg aged care, brain injury, and in many cases intellectual disability). This means that these individuals currently necessarily spend a substantial proportion of their limiting term detained and without access to appropriate programs which perversely means they may not have a sufficient period of treatment and rehabilitation to address their needs and risk issues prior to the expiry of their limiting term.

If this provision is retained, then clear guidance as to what it means and how it should be applied would be required. The High Court's decision in Muldrock would no doubt be of assistance in drafting any guidance on this issue.

Whether or not this provision is removed, the Tribunal believes that consideration needs to be given as to whether it would be appropriate to unconditionally release a person on a limiting term other than in exceptional circumstances, such as for deportation/repatriation.

This may depend to some extent, upon the manner in which the length of the limiting term is calculated.

Breach Provisions

The Tribunal has made the following request to the Ministry of Health Legal Banch for Miscellaneous amendments to the current provisions relating to orders for breach of leave or release:

1. When an order for apprehension is made the Act needs to provide similarly to the CTO breach provision:
   a) That the person is to be considered detained for the purpose of assessment and treatment.
   b) That the person's mental state is to be assessed by a medical practitioner
2. On review by the Tribunal after apprehension, there should be a clear provision allowing for a period of adjournment so that the person's response to treatment can be assessed before the Tribunal makes a final decision whether to revoke leave or release.

   If a matter is adjourned under the new option (b) then it would be of assistance if it was clear leave could also be granted during this interim period, in accordance with the criteria like s49 (i.e. Tribunal satisfied re risk).

A related requested amendment is to the MHA to make it clear that a bailed or conditionally released forensic patient can also be scheduled under the MHA rather than treating teams needing to wait to contact the Tribunal and the Tribunal issuing a breach order before the person can be lawfully held and treated involuntarily in a mental health facility if their condition deteriorated. This is particularly important as the first contact when a patient deteriorates is often with police or emergency departments who won't necessarily know for some time that the person is a forensic patient.

Another possible reform in this area would be to allow a lower level of 'breach' by the treating team, akin to a breach of a civil CTO to allow the treating team to intervene as required (e.g. upon the development of early warning signs, need for medication review etc). Ideally such a mechanism would provide for the Director of the relevant mental health service to issue a direction that the patient attend the facility/ a specified hospital for treatment, assessments, or tests. While the person is held in the mental health facility they should be considered an involuntary patient for the purpose of the MHA. The Director should also be required to provide notice to the Tribunal if such an order is issued. If the person fails to comply with this direction, this could be the basis for the Tribunal to then issue a formal breach and apprehension order.

Ceasing to be a Forensic Patient

Generally the Tribunal believes that the current provisions relating to when individual's cease to be forensic patients and providing for their release from custody upon ceasing to be a forensic patient remain appropriate. The only exceptions are cases where a forensic patient leaves the jurisdiction, either with or without approval by the Tribunal.

In the case of those forensic patients that leave the jurisdiction with the approval by the Tribunal (be it for the purpose of repatriation/deportation or moving interstate) the Tribunal would recommend the introduction of a clause similar to that provided by Queensland legislation whereby if the person thereafter remains out of NSW then their forensic patient status remains 'active' but 'suspended' for a nominal period (e.g. 5 years) after which it ceases to have effect. This would allow for the person to be picked up if they re-enter the

jurisdiction, but puts an end date. The Tribunal wouldn't have to review the person while they remain out of the jurisdiction.

For those who leave the jurisdiction without the Tribunal's approval, their status should be suspended while they remain out of the jurisdiction, but it would not be appropriate for their status to cease following the expiry of a nominal period (unless it is a sufficiently lengthy period e.g.25 years). Again, while the person remains out of the jurisdiction the Tribunal wouldn't have to conduct reviews.

Continued Treatment upon ceasing to be a forensic patient

Current legislation adequately provides for the ongoing treatment (and if necessary detention) of individuals with a mental illness who have ceased to be a forensic patient. However, the same is not true for forensic patients who continue to pose a significant risk to themselves or the public due to a mental condition or developmental disability at the end of their term but would not meet the criteria for classification as an involuntary patent under the Mental Health Act 2007. The Tribunal has developed a proposal for a mechanism to provide for the protection of the public by providing an accountable system of control and supervision of such patients as Compulsory Patients beyond the end of their term without the net widening that could occur with the use of a more general provision. This paper is attached at Attachment One.

Such a proposal would require and benefit from wide consultation and public discussion, as it is has a preventive detention dimension that would, no doubt, need to be considered with due regard to best policy and community attitudes. Commitment now would need to be given to an appropriately high standard of proof of relevant factors (such as risk) being required to be established before such orders could be made. The experiences of other jurisdictions should be examined and considered.

Agencies involved in the care and treatment of forensic patients

The legislation needs to be flexible enough to accommodate a wide variety of agencies (both government and non government, federal and state) to be involved in the care and treatment of forensic patients. The particular responsibilities of agencies varies from time to time, as does the range of needs experienced by forensic patients and the legislation needs to be sufficiently flexible to accommodate this.

While the current legislation provides for agencies involved in the care and treatment to co-operate and use its best endeavours in their dealings with the Tribunal, the legislation is less clear about agency's responsibilities to each other when multiple agencies are providing services to particular forensic patients. This causes particular issues with regard to the release of information between agencies involved in the management of an individual patient due to privacy legislation. It is vital that for the safe management of forensic patients the legislation allows for the passing of information between agencies without the consent of the forensic patient. This provision needs to apply both when more than one agency or service is involved in a case simultaneously, and when a case is being handed over from one agency or service to another. The current barriers to information sharing present a major obstacle to safe and effective risk management.

On a related issue, when the Tribunal conducts a review, it needs to be able to access all material held concerning a patient's care and treatment, whether held by public or private practitioners. Currently, it is common that private practitioners require a subpoena prior to releasing this information to the Tribunal. This mechanism causes undue delays, which can at times be critical if there is an urgent issue which needs to be addressed, and is in any

event generally unsustainable as the primary mechanism by which the Tribunal can access these records.

Victims

The current provisions allow for victims to make applications for non-association or place restriction conditions to be attached to any leave or release order made by the Tribunal. This is consistent with the provisions of the Victims Charter.

While this role is appropriate, there is a broader issue that arises in the context of the Tribunal that does not arise in other bodies where victims participate such as the Parole Board, and is not envisaged within the Victims Charter.

The Tribunal has an ongoing review function where it regularly reviews a forensic patient's care and treatment, regardless as to whether there is an application for leave or release. As the hearings are notionally public, this means that victims can attend to observe each review.

There is a real concern for the welfare of both the victim and the patient when victims regularly attend routine care and treatment reviews. There is a real risk of (and anecdotal evidence of) revictimisation through such frequent exposure to the forensic patient. Victims also often express frustration at the frequency of the review cycle and that the focus of the hearing is only on the forensic patient where there is no question of leave or release, even though the only issue before the Tribunal is the patient's care and treatment.

From the patient's perspective there is also the potential deleterious effect of having victims expressing anger and at times quite blatant threats on such a frequent basis. There is also an understandable inhibitive factor to the victims' attendance at these hearings not only on the patient and any of their family members in attendance, but even on the treating teams and the Tribunal members who do not wish to canvass sensitive personal issues in the presence of the victims.

The Tribunal believes it would be beneficial to make it clear in the legislation that the victims role and right to notice is only when the issue of leave or release is before the Tribunal – as is provided for under the Victims Charter – and that otherwise the victims do not have a right to attend any Tribunal hearings, without leave of the Tribunal.

Correctional Patients

The Tribunal would like to take this opportunity to raise two issues relating to its review functions in relation to correctional patients.

1. The Tribunal believes that some clarification is required regarding the purpose of allowing the Tribunal to make Correctional Patients Involuntary Patients in the 6 months prior to when they would otherwise cease to be a Correctional Patient (ie non-parole period or sentence expiry) and what impact making a correctional patient an Involuntary Patient has on the person's sentence. In broad terms the Tribunal believes that this provision is to facilitate a smooth transition of care (which in most cases would only require weeks rather than months) or to facilitate access to a treatment that is not available within Long Bay Prison Hospital (e.g. the person requires a long course of ECT).
2. The Tribunal believes that some clarification is required regarding the purpose of informal reviews for persons awaiting transfer from a correctional centre to a mental health facility. The Tribunal understands that the primary purpose is to check on the

reason for the delay in transfer. However, the Tribunal is frequently requested to determine whether or not the person is a mentally ill person who requires transfer. While the Tribunal believes that if it determines that the person is not a mentally ill person (and the person does not consent to the transfer) then the Tribunal should have the power to revoke the order for transfer, the Tribunal also believes it should be made clear that the Tribunal does not have to positively determine that the person is a mentally ill person to confirm that the order for transfer stands.

Other issues relating to MHRT

The Tribunal would like to take this opportunity to raise a number of other issues relating to its functions.

1. Tribunal hearings are currently presumed to be public, although there are provisions whereby the Tribunal can partly or wholly close the proceedings. In reality, however, as most forensic hearings are held within secure establishments with Health and Corrective Services NSW understandably controlling who may enter the secure premises, there is a real issue as to whether the hearings of the Tribunal in the Forensic Division can actually be considered to be held in public.

   More generally, while the need for public hearings is understandable in the context of why the Tribunal was first established, with the advent of health information privacy legislation there is a question as to whether this remains appropriate. While the Tribunal has heard arguments for the Tribunal hearings to remain open to the public on the basis of public access to justice, the Tribunal believes that this is not an accurate characterisation of the Tribunal's functions which is to review an individual's care and treatment, which necessarily involves the exploration of information that is otherwise protected as private by legislation.

   If hearings do not remain public, then consideration would need to be given to listing parties who are presumed to be able to attend, regardless of the patient's wishes such as treating team members and the primary carer, and a further mechanism by which individual's with a sufficient interest in the matter could apply to attend.

2. The Tribunal has raised with the Ministry of Health the need for a stronger provision around non-disclosure of a report or other document (or part thereof) where there is a clear risk of harm to someone. Of particular relevance to the appropriate balance between having a fair process and risk to others the Tribunal believes that the sexual assault privileges legislation and s194 of the Crimes (Administration of Sentences) Act may be informative.

3. The Tribunal believes that S76A needs to be clarified so that the ability of the Tribunal to inform itself in any way it sees fit applies not only when conducting hearings but pre/post hearings and otherwise in performing its functions. This would be particularly relevant to the Tribunal's functions in relation to assessing whether or not a breach order is required to be issued.

Wider referrals to MHRT by Court

The LRC discussion papers question whether the Court should have the power to refer the following to the Tribunal:

- Individuals who do not meet the definition of forensic patient being referred to the Tribunal's civil jurisdiction.
- Individuals sentenced to imprisonment whose mental health or cognitive impairment needs require assessment.
- Individuals sentenced to imprisonment being referred to the Tribunal for assessment for a Forensic Community Treatment Order.

All of these questions presume that the Tribunal has an independent ability to assess an individual and make orders of its own motion, which is not an accurate characterisation of the Tribunal's role. Rather, the Tribunal's role in these types of cases is to consider the merits of applications brought before it by health care agencies concerning involuntary treatment of an individual. It may be more appropriate for the Court to refer these cases to the extended Court Liaison Service who could then undertake the necessary assessments/referrals that may in due course lead to an application being brought before the Tribunal under the provisions of the *Mental Health Act 2007* or *Mental Health (Forensic Provisions) Act 1990*.

While it may certainly be appropriate to alert relevant agencies such as Corrective Services NSW and Justice Health of an offenders particular needs, the Tribunal would not be able to take any action if it is provided with that same information unless or until Justice Health bring forward an application for a Forensic Community Treatment Order or the person is transferred from a correctional centre to a mental health facility.

5. Young people with cognitive and mental health impairments and the Criminal Justice System

In drafting its submissions on this issue, the Tribunal in particular considered the following issues raised in consultation papers:

Issue 11.16

Does s 22 of the Mental Health Act 2007 (NSW) operate satisfactorily in relation to young people with cognitive and mental health impairments? If not, how should it be modified?

Issue 11.17

Are the existing categories of eligibility for diversion under s 32 and/or s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW) adequate and appropriate in the context of young people with cognitive and mental health impairments? If not, how should the criteria be modified?

Issue 11.18

Should s 32 and s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW) contain particular provisions directed at young people? If so, what should these provisions address?

Issue 11.19

(1) How, if it all, should s 32 or s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW) be amended to clarify who is responsible for supervision of orders?
(2) Would a greater supervisory role by the Mental Health Review Tribunal be desirable in this context?

Issue 11.20

Are the orders presently available under s 32 and s 33 of the Mental Health (forensic Provisions) Act 1990 (NSW) appropriate for young people with cognitive and mental health impairments? If not, how should the orders be modified?

Issue 11.21

Should a supervised treatment or rehabilitation program be implemented for young people with cognitive and mental health impairments? If so:
(a) Who should supervise the program?
(b) Should the program be voluntary?
(c) Should guidance be included in legislation regarding when it would be appropriate to refer a defendant to the program?
(d) How should eligibility for the program be determined?
(e) How could such a program appropriately address the needs of young people with cognitive impairments?
(f) What should be the consequences of completion of the program?
(g) Should a supervised program be formulated as an extension of s 32 or s 33 diversion under the Mental Health (Forensic Provisions) Act 1990 (NSW) or should it be separate?

Issue 11.22

If diversionary provisions under s 32 and s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW) are not extended to the District and Supreme Courts generally, should they be extended where the subject is a young person?

Issue 11.23

Should legislative powers and procedures dealing with unfit defendants be extended to the children's Court? If so, should they be framed in a different manner from those available in the higher courts?

Issue 11.24

(1) Are the Presser criteria suitably framed for application to young people?
(2) If not, should the criteria be expanded or modified?
(3) Should particular criteria relevant to young people be developed? If so, what should they be?

Issue 11.25

Do any issues arise with respect to the operation of doli incapax and an assessment of fitness to stand trial where a young person suffers from cognitive or mental health impairments?

Issue 11.26

Does the current test for the defence of mental illness adequately and appropriately encompass the circumstances in which a young person should not be held criminally responsible for his or her actions due to an impaired mental state? If not, should the circumstances be differently defined for young people than they are for adults?

Issue 11.27

Should the defence of mental illness be available in the Children's Court? If so, should processes following a finding of not guilty by reason of mental illness be different to those available in the higher courts?

Issue 11.28

Does the interaction of doli incapax and the defence of mental illness present any particular issues? If so, how should these issues be addressed?

Issue 11.29

Should the Mental Health (Forensic Provisions) Act 1990 (NSW) be amended to provide additional protections for young people and/or other provisions that meet their needs? If so, what principles should these amendments reflect and how should they be incorporated into the Act?

Issue 11.30

How can the application of the forensic mental health framework to young people be improved? Particularly:
(a) What problems arise in relation to young people who are found unfit to stand trial, or found not guilty by reason of mental illness?
(b) Is there a need for specific forensic provisions that apply to young people? If so, what should these provisions address?

Issue 11.33

Should special sentencing options be available for young offenders with a cognitive or mental health impairment? If so:
(a) How should existing options be modified or supplemented?
(b) Should these options be available for serious children's indictable offences?

MHRT Response

- Same concerns for the extension of unfit to be tried and NGMI to the children's court as to the Local Court (discussed in Tribunal's Diversion Submission paper). If anything this is of even greater concern for young offenders as there is a real risk of institutionalisation and harm to an individual's development if they enter the forensic mental health system unnecessarily. Diversion would in the vast majority of cases be the most appropriate course of action. Could have similar option as discussed in the diversion document for more serious or repeat offenders.
- Otherwise, generally same comments re whole system apply to juveniles with some issues needing special consideration:
  - Often the diagnosis for young people is less certain than for adult offenders which might present issues for diversion and unfit/NGMIfindings
  - While generally true, the concept of a 'meaningful life' is key for young people if they are spending formative years in institutions.
- Consideration should be given to providing additional protections under the *Mental Health (Forensic Provisions) Act 1990* as apply to juveniles in detention centres. For example as to disclosing a juvenile's name and location.

ATTACHMENT ONE

Serious Risk Patients

With a mental condition or developmental disability

Proposed Legislative Response

OVERVIEW

Some Forensic Patients or Correctional Patients at the end of their term pose a significant risk to themselves or the public due to a mental condition or developmental disability[1] but would not meet the criteria for classification as an involuntary patent under the Mental Health Act 2007.

The intention of this amendment is to protect the public by providing an accountable system of control and supervision of such patients as Compulsory Patients beyond the end of their term without the net widening that could occur with the use of a more general provision.

The initial classification of a person as a Compulsory Patient could only be made if the person is within six months of the end of their limiting term or release from prison and the Tribunal is satisfied that without such an order they would pose a significant risk of serious harm to others. This test is congruent with that used in the mental health legislation.

The initial order could be for detention, and treatment where possible, in an appropriate facility or an order for compulsory supervision (and treatment where possible) in the community under a Compulsory Supervision Order (CSO).

Once a person is subject to an order they would be regularly reviewed by the Forensic Division of the Tribunal similarly to forensic patients. On a review the Tribunal would consider the appropriateness of the order and could vary the order. This could involve: releasing the person from detention onto a CSO or otherwise; varying a CSO; or ordering the detention of someone on a CSO; and releasing the person from their status as a Compulsory Patient.

If a person is in the community subject to a CSO they would be subject to similar breach provisions as conditionally released forensic patients. If detained, the person would have access to leave at the discretion of the supervising agency similar to the situation with involuntary patients detained in a mental health facility.

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[1] The target group of people only includes those who have been sentenced or given a limiting term and have a developmental disability or a mental condition as defined by Section 3 of the Mental Health (Forensic Provisions) Act 1990, namely:

> A condition of disability of mind not including either mental illness or developmental disability of mind.

Some Principles

- At each review the treating team/supervising agency will need to show to the Tribunal that the person still poses a risk such that the proposed order represents the least restrictive option.
- A person's status as a compulsory patient cannot end other than by an express order of the Tribunal to that effect.
- Some compulsory patients may also have a mental illness, although it would not be the primary causal factor of the risk posed by the individual. If they were to suffer a relapse such that they would require admission and treatment under the Mental Health Act 2007, their status as a compulsory patient should not prevent this occurring.
- As there won't always be a clear lead agency due to the mix of conditions in any one patient there may be a need for the Tribunal to nominate a lead agency to take responsibility.
- There should be similar appeal mechanism from Tribunal decisions as per Mental Health Act 2007 for civil patients.

Possible Provisions

Classification as a compulsory patient

(1) The Tribunal may, on a review of the case of a forensic patient detained in a mental health facility, correctional centre or other place following a special hearing, classify the patient as a compulsory patient if the patient would, by virtue of the operation of this Act or any other law, cease to be a forensic patient within 6 months after the date of the review.

(2) The Tribunal may, on a review of the case of a correctional patient under this Act, classify the patient as a compulsory patient if the patient would, by virtue of the operation of this Act or any other law; cease to be a correctional patient within 6 months after the date of the review.

(3) The Tribunal may, after classifying the patient as a compulsory patient under this Act, make an order as to:

(a) the patient's continued detention, care or treatment in a mental health facility, or other nominated facility, or

(b) the patient's discharge into the community subject to a compulsory supervision order.

Criteria for classification as a compulsory patient

The Tribunal may make a compulsory patient order if satisfied that:

(1) The person is suffering from a mental condition or developmental disability and, owing to that condition, there are reasonable grounds for care, treatment or control of the person to be necessary:

(a) for the person's own protection from serious harm, or
(b) for the protection of others from serious harm, and that

(2) No other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available.

Matters for consideration

Without limiting any other matters the Tribunal may consider, the Tribunal must have regard to the following matters when determining what order to make about a compulsory patient under this Part:

(a) whether the patient is suffering from a mental condition or developmental disability
(b) the continuing condition of the patient, including any likely deterioration in the patient's condition, and the likely effects of any such deterioration,
(c) Cultural matters, etc

Further reviews by Tribunal of compulsory patients

(1) The Tribunal must review the case of each compulsory patient every 3 months but may review the case of any compulsory patient at any time.

(2) The period within which a particular review under this section must be held may, on the motion of the Tribunal or on the application of the patient, be extended by the Tribunal to a maximum of 12 months.

(3) The Tribunal may grant an application to extend the review period if it is satisfied that:
(a) there are reasonable grounds to grant the application, or
(b) an earlier review is not required because:
(i) there has been no change since the last review in the patient's condition, and
(ii) there is no apparent need for any change in existing orders relating to the patient, and
(iii) an earlier review may be detrimental to the condition of the patient.

Orders on further Tribunal reviews of compulsory patients

(1) The Tribunal may, after reviewing the case of a compulsory patient under section, make an order as to:
   (a) the patient's continued detention, care or treatment in a mental health facility, or other nominated facility, or
   (b) the patient's discharge into the community subject to a compulsory supervision order, or
   (c) the patient ceasing to be a compulsory patient.
(2) On a review, the Tribunal may make an order for the transfer of a compulsory patient to a mental health facility or other place.
(3) The Tribunal may make an order in the absence of the compulsory patient, if the patient has been given notice of the application under this Part.

Form of detention orders for compulsory patients

(1) A detention order for a compulsory patient is to:
   (a) nominate the facility in which the patient is to be detained
   (b) nominate the agency or agencies responsible for the delivery of services to the patient while detained
   (c) nominate at least one authorised person responsible for the grant of leave from the facility and any discharge planning.
   (d) nominate what treatment, if any, is to be provided

Planning for leave and discharge

(1) The authorised person of the facility in which a compulsory patient is detained must, if the compulsory patient is to be discharged or granted leave under this Part, take all reasonably practicable steps to ensure that the patient and any carer of the patient are consulted in relation to planning the patient's discharge and leave and any subsequent supervision or other action considered in relation to the patient.
(2) In planning the discharge of any such patient and any subsequent supervision or other action considered in relation to any such patient, the authorised person must take all reasonably practicable steps to consult with agencies involved in providing relevant services to the patient, any carer of the patient and any dependent children or other dependants of the patient.
(3) The authorised person must take all reasonably practicable steps to provide a patient who is discharged or given leave of absence from the facility with appropriate information as to follow-up care.

Leave of absence on compassionate grounds, medical grounds or other grounds

(1) The authorised person or delegate may permit a patient to be absent from the facility in which the compulsory patient is detained for the period, and on the conditions, that the officer thinks fit.
(2) Permission may be given on compassionate grounds, on the ground that medical treatment is required or on any other ground the authorised person or their delegate thinks fit.

(3) The authorised person may not grant leave of absence unless satisfied that, as far as is practicable, adequate measures have been taken to prevent the patient concerned from causing harm to himself or herself or others.

Apprehension of compulsory patients not permitted to be absent from the facility

(1) The authorised person of a facility in which the compulsory patient is detained may apprehend a patient, or cause a patient to be apprehended, if:
  (a) the patient fails to return to the facility on or before the expiry of a permitted period of absence granted under this Part or fails to comply with a condition of the permission, or
  (b) the patient absents himself or herself from the facility otherwise than in accordance with this Act.

(2) The patient may be apprehended by any of the following persons:
  (a) an authorised person or any other suitably qualified person employed at the facility,
  (b) a police officer,
  (c) a person assisting a person referred to in paragraph (a) or (b).

(3) A patient who is apprehended is to be conveyed to and detained in the facility from which the patient absented himself or herself.

Police assistance

(1) The authorised person or delegate may request that a police officer apprehend, or assist in apprehending, a patient under this Division if they are of the opinion that there are serious concerns relating to the safety of the patient or other persons if the patient is taken to the facility without the assistance of a police officer.

(2) A police officer to whose notice any such request is brought may:
  (a) apprehend and take or assist in taking the patient to the facility from which the patient absented himself or herself, or
  (b) cause or make arrangements for some other police officer to do so.

(3) A police officer may enter premises to apprehend a patient under this section, and may apprehend any such patient, without a warrant and may exercise any powers conferred under section *** on a person who is authorised under that section to take a patient to the facility or another nominated facility.

Note. Section ** sets out the persons who may take a patient to a facility and their powers when doing so.

Compulsory Supervision Orders

(1) The Tribunal may make a compulsory supervision order for a compulsory patient if the Tribunal determines that:
  (a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient and that the compulsory patient would benefit from the order as the least restrictive alternative consistent with safe and effective care, and
  (b) an agency has an appropriate supervision plan for the compulsory patient and is capable of implementing it

(2) A compulsory supervision order is to:
  (a) nominate the agency or lead agency that is to implement the supervision plan for the compulsory patient, and
  (b) require the compulsory patient to be present, at the reasonable times and places specified in the order to receive the proposed services in accordance with the supervision plan.
  (c) contain the supervision plan the agency is to implement
  (d) contain any conditions set under s XX

(3) The authorised person must discharge a compulsory patient who is detained in a facility when a compulsory supervision order is made about the patient and any order authorising the patient's detention ceases to have effect.
(4) The Tribunal may defer the operation of a compulsory supervision order made under this Part for a period of up to 14 days thereby delaying the discharge of a patient, if the Tribunal thinks it is in the best interests of the patient to do so.

Requirements for Supervision Plans under Compulsory Supervision Orders

A supervision plan for a compulsory patient is to consist of the following:

(a) in general terms, an outline of the proposed supervision, counselling, management, rehabilitation or other services to be provided
(b) in specific terms, the frequency with which, and the place at which, the services would be provided for that purpose.

Conditions that may be imposed by Tribunal in compulsory supervision orders

(1) The Tribunal may impose conditions relating to the following matters on compulsory supervision orders under this Part:
(a) the appointment of a case manager or other relevant professional to assist in the supervision and care of the compulsory patient,
(b) the care, treatment and review of the patient by persons referred to in paragraph (a), including home visits to the patient,
(c) medication,
(d) accommodation and living conditions,
(e) enrolment and participation in educational, training, rehabilitation, recreational, therapeutic or other programs,
(f) the use or non-use of alcohol and other drugs,
(g) drug and alcohol testing and other medical tests,
(h) agreements as to conduct,
(2) This section does not limit the matters in relation to which a condition may be imposed.

Breach of compulsory supervision order

(1) The President of the Tribunal may make an order for the apprehension of a compulsory patient if it appears to the President that:
(a) the patient has breached a condition of an compulsory supervision order, or
(b) the patient subject to a compulsory supervision order has suffered a deterioration of their mental condition or developmental disability and is at risk of causing serious harm to himself or herself or to any member of the public because of his or her mental condition or developmental disability.
(2) The Tribunal must review the case of a patient apprehended under this section and may:

(a) confirm the patient's compulsory supervision order and discharge them, or
(b) order the patient's detention, care or treatment in a mental health facility or other place, and in the manner, specified in the order.

Note: section ** provides that the Tribunal may delay the operation of a compulsory supervision order for a period of up to 14 days such that the patient's discharge from the facility is delayed if the Tribunal thinks that it is in the patient's best interest to do so.

(3) A police officer to whose notice an apprehension order is brought must:
(a) apprehend and take or assist in taking the patient to the mental health facility, or other place specified in the order, or
(b) cause or make arrangements for some other police officer to do so.

(4) A police officer may enter premises to apprehend a patient under this section, and may apprehend any such patient, without a warrant and may exercise any of the powers conferred on a person who is authorised under section ** to take a patient to a facility.
Note. Section ** sets out the persons who may take a patient to a facility and their powers when doing so.

Procedures at facility after breach notice or breach order

(1) Where a compulsory patient has been apprehended and taken to a facility under this Part:

(a) the patient is to be detained until further order of the Tribunal, and

(b) the patient may be assessed by a medical practitioner for involuntary admission to a mental health facility.

Termination of classification as compulsory patient

A compulsory patient ceases to be a compulsory patient if the person is released from that status in accordance with an order by the Tribunal under this Part.

Release from facility on ceasing to be a compulsory patient

A person who ceases to be a compulsory patient must be discharged from the facility in which the person is detained.

Person who is or ceases to be a compulsory patient may be subject to the Mental Health Act 2007

Nothing in this Part prevents the application of the *Mental Health Act 2007* to a person who is or ceases to be a compulsory patient or any such person from remaining in a mental health facility as an involuntary or voluntary patient.

Duties of certain agencies

Amend S76(K) to include compulsory patients

Issues not covered –
- Who sets security conditions while they are detained?
- Notice requirements?

Some Notes on Other Jurisdictions:

Disability Act 2006 (Vic)

- Only those with an intellectual disability as per ADHC criteria
- Application made by ADHC equivalent (so already receiving services)
- Criteria are:
  - History of violent/dangerous behaviour
  - Significant risk of harm unable to be managed on less restrictive regime
  - Unable or unwilling to submit to nec level of treatment voluntarily
  - Order is nec to ensure compliance and prevent significant risk of serious harm to another person.
- Allows for 'Supervised Treatment' as well as detention, although distinction is not defined.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (NZ)

The IDCC&R Act allows the court to make a compulsory care order for up to three years, which can be renewed by the Family Court if the care recipient's behaviour still poses significant risk, and will direct whether the care recipient requires secure or supervised levels of care.

The Act also allows for the transfer of people from prison or mental health services where they meet the criteria for intellectual disability under the Act.
There are three ways people can become subject to the Act:

- an order made in the course of criminal proceedings;
- by transfer from prison;
- by transfer from the Mental Health (CAT) Act for special patients; or former special patients.

The Act provides for two different levels of care:

- Secure Care (hospital level or community based) or
- Supervised Care.

The Act contains statutory powers to require care recipients to comply with their care order and to seclude, restrain and medicate under certain limited and defined circumstances. These are balanced by specific safeguards and rights.

Who it captures:

- Only those with an intellectual disability as per ADHC criteria
- Only those who have come into contact with the criminal justice system
- Applies to children as well as adults

Risk test 'a serious danger to the health or safety of the care recipient or of others'

Content Care Plan
(1) Every care and rehabilitation plan must identify the following matters:

- the social, cultural, and spiritual needs of the care recipient:
- any medical or psychological treatment that the care recipient requires:
- any requirements for medication needed to manage the care recipient's condition:
- the circumstances in which the care recipient is likely to behave in a manner that endangers the health or safety of the care recipient or of others:
- any aptitudes or skills of the care recipient that should, if practicable, be maintained and encouraged:
- any special concerns or aversions of the care recipient:
- any special dietary needs of the care recipient:
- any other special needs of the care recipient.

(2) The identification, under subsection (1)(a), of the care recipient's needs must take into account any cultural assessment completed under section 23.
(3) Every care and rehabilitation plan must indicate the extent to which, and the manner in which, the needs identified under subsection (1) can be met.
(4) Every care and rehabilitation plan must deal with the kind of supervision the care recipient requires to avoid undue risk to the health or safety of the care recipient and of others.

The overall impression provided by Prof Anthony Duncan (anthony.duncan@ccdhb.org.nz) is that there are many teething issues caused by the legislation including:

- Strict definition of what qualifies as an intellectual disability in the legislation (IQ below 70 etc). This causes issue as test results can vary from time to time, particularly with the release of new WAIS versions, and issues of the validity of the tests on specific populations, eg Maori.
- Range of offenders that can be referred, limited earlier diversion
- 3 year orders only - can be extended, but there is an assumption that rehabilitation can be achieved within 3 years which often isn't realistic particularly for high risk individuals. This also seems counterintuitive as those with a mental illness, which is largely treatable is indefinite but intellectual disability which is largely intractable is limited to 3 years.
- Ill definition of the rights of the offenders, particularly in relation to coercive treatment.

Offender Personality Disorder (UK)

Uses existing mental health and corrections legislation. For example, requirement for admission in UK is 'mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital' rather than 'mentally ill person'.

The Dangerous with Severe Personality Disorder (DSPD) Programme running since 1999 brings together the Ministry of Justice (originally part of the Home Office), the Department of Health, Her Majesty's Prison Service and the National Health Service to deliver new mental health services for people who are or have previously been considered dangerous as a result of a severe personality disorder(s).

A candidate for the DSPD high secure units can be admitted for treatment if assessment confirms that:

- S/he is more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover; and
- S/he has an identifiable severe disorder of personality (defined later) and
- There is an evidential link between the disorder and the risk of offending.

Not free from controversy it has received criticism as a 'political intervention' rather than based on psychiatric/psychological principles and the cost/benefit analysis has been hit and miss in terms of the vast funds in the programme and the evidence of successful treatment of the target group (although this could in part simply reflect the fact that there are limited treatment options for personality disorder and any treatments are longer term than the usual medical models).

Nonetheless, in February 2011 UK govt released consultation paper to extend programme.

'By disinvesting funding of the pilot DSPD units at Broadmoor, Rampton and the three Medium Secure services and organising these services differently we will be able to significantly increase treatment capacity, mostly in prisons. In addition, we will aim to provide additional psychological support (in prisons and the community) for those making progress, and strengthening oversight for those released from custody.'

Target group is:

The pathway is intended to meet the needs of all offenders who meet the criteria for an assessment using the Offender Assessment System (OASys); and who have a severe personality disorder; and

- are assessed as presenting a high likelihood of violent or sexual offence repetition
- present a high or very high risk of serious harm to others;
- and where there is a clinically justifiable link between their psychological disorder and the risks they pose.
- The age threshold for the services described in the pathway is 18 years.

Treatment offered in

- High secure correctional settings 'if in the community would present an imminent risk of serious harm to others' & Has a minimum of three years still to serve.
- High secure hospital settings – as per high secure correctional but also meet Mental Health Act
- Lower security correctional settings - The target population is those prisoners who fall short of the criteria of the high secure programme but, due to the complexity of their needs, are unlikely to progress through existing accredited programmes, including democratic therapeutic communities. Places will also be available for prisoners progressing from the high secure units
- Accredited programmes – within main gaol and community (parole) settings
- Medium and low security health settings - for those patients for whom the NHS pathway is appropriate, medium and low secure step-down units enabling progression from the PD directorates of the high secure NHS services. An increasing number of community forensic services are providing appropriate treatment and management for offenders with personality disorder in community settings. Will include supported housing options.

  NB this does not extend the time under which they are subject to supervision but all occurs within sentence.....